Bundle Strategic Development Committee 16 May 2022

1.0.0 STANDARD BUSINESS

Led by Chair: Stephen Harries

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 FOR APPROVAL

Led by Chair: Stephen Harries

2.1.0 Minutes of the Committee Meeting held on 23rd March 2022

Led by Chair: Stephen Harries

2.1 PUBLIC - Strategic Development Committee Mins 23.03.22 - LF-SH.docx

2.2.0 Action Log

Led by Chair: Stephen Harries

2.2 PUBLIC - Strategic Development Committee Action Log 23.03.22.docx

3.0.0 ITEMS FOR REVIEW/DISCUSSION

3.1.0 Enabling Strategies

Led by Carl James, Director of Strategic Transformation, Planning and Digital
Sustainability
People
Digital
Estates
Endorse for Approval

3.1 SDC trust strategy enablers approval 16 may 2022 FINAL.docx

3.1 Sustainability Strategy v13 14 april 22.docx

3.1 People Strategy final draft cj 4 may 2022.docx

3.1 Digital Strategy v0.8 10 may 2022.docx

3.1 Estates Strategy version 13 april14 2022 cj.docx

3.2.0 Performance Management Framework

Led by Carl James, Director of Strategic Transformation, Planning and Digital
For Discussion/Review

3.2 SDC Cttee 16.05.22 PMF Scorecards KPIs version Final.docx

3.3.0 Patient Engagement Strategy

Led by Cath O'Brien, Chief Operating Officer
Endorse for Approval

3.3 Patient Engagement -Strategic Committee May 2022 Final 3.5.22.docx

3.3 DRAFT Patient Engagement Strategy STRATEGIC May 2022.pdf

3.4.0 Trust Assurance Framework

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

3.4 Trust Assurance Framework -SDC-16.05.2022 -LF-Final.docx

3.4 TAF DASHBOARD - 11.05.22 -LF.pdf

3.5.0 Nuffield Trust Progress Report

Led by Carl James, Director of Strategic Transformation, Planning and Digital
For Noting

3.5 SDC Nuffield Trust Recommendations Progress - as at 19 16 may 2022 cj.docx

3.6.0 Developing the South East Wales Cancer System

Led by Carl James, Director of Strategic Transformation, Planning and Digital
For Noting

3.6 SDC Developing SE Wales cancer system next steps 16 may 2022 cj.docx

3.7.0 Implementation of Hepatitis B Core Antibody Testing

Led by Cath O'Brien, Chief Operating Officer
For Noting

3.7 HepB Core Testing- Strat Dev Com 16052022FINAL.docx

3.8.0 Research, Development & Innovation (RD&I) Highlight Report

Led by Prof Andrew Westwell, Independent Member and Chair of RD&I Sub Committee

3.8 RDI Highlight Report to SDC 160522 (JA) (003).docx

4.0.0 ANY OTHER BUSINESS

Led by Chair: Stephen Harries

5.0.0 REVIEW OF THE MEETING

Led by Chair: Stephen Harries

6.0.0 DATE AND TIME OF NEXT MEETING

Thursday 7th July @ 2.00pm
Via Microsoft Teams

Minutes
Public Strategic Development Committee
Velindre University NHS Trust

Date:	23/03/2022
Time:	10:00am
Location:	Microsoft Teams

Chair:		
Stephen Harries	Vice-Chair, Independent Member	SH
Members:		
Gareth Jones	Independent Member	GJ
Andrew Westwell	Independent Member	AW
Prof Donna Mead	Chair	DM
In Attendance:		
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
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
Cath O'Brien	Chief Operating Officer	COB
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Scientists	NW
Sarah Morley	Executive Director of Organisational Development & Workforce	SM
Emma Rees	Interim Deputy Head of Internal Audit	
Katrina Febry	Audit Lead	KF
Suzanne Rodgers	Head of Digital Programmes	SR
Daniel Price	Deputy Chief Officer, Community Health Council	DP
Lenisha Wright	Business Support Officer / Secretariat	LW
Apologies:		
Steve Ham	Chief Executive Officer	SH
Stephen Allen	Chief Officer, Community Health Council	SA
Dr Jacinta Abraham	Executive Medical Director	JA

1.0.0	STANDARD BUSINESS	Action
1.1.0	**Welcome & Introductions** SH welcomed all present to the meeting of the Strategic Development Committee.	
1.2.0	**Apologies** Apologies were noted.	
1.3.0	**Declarations of Interest:** There were no declarations of interest.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**For Approval**	
2.1.1	**Minutes of the Committee Meeting held on 9th December 2021** The **APPROVED** the minutes of the meeting held on 9th December 2021 as a true accurate record.	
2.2.0	**For Noting**	
2.2.1	**Action Log** Stephen Harries took the committee through key aspects of the Action Log. Gareth Jones noted the consistency of the action logs across meetings. The action log shared in this SDC meeting was not very clear. This will be reviewed. • Format of Action Log to be reviewed The Committee **NOTED** the action log with the following correction: • In relation to the action for Jacinta Abraham, the target date needs to be amended given there is no Strategic Development Committee (SDC) meeting in April.	LF
3.0.0.	**ITEMS FOR REVIEW / DISCUSSION**	
3.1.1	**Strategy Update** Carl James provided a verbal update on this item highlighting the following: The new Trust Strategy was approved by the Board in January.. This is accompanied by a 5 year service plan for the Velindre Cancer Centre and the Welsh Blood Service. These documents frame our ambitions and staregoes for the next 5-10 years.	

	A comprehensive update on the enabling strategies will be provided in May as time was needed for further engagement. A wide range of communication has been sent out via social media welcoming feedback. Support has been acquired to ensure improvement in the readability of the document.	
3.1.2	**Integrated Medium Term Plan (IMTP) 2022 – 2025** Carl James advised that the key messages in the plan are quality, safety and assurance. The plan provides a framework which act as a guide for service planning for example, the digital framework. The main Trust programmes are highlighted which include quality, sustainability, value based health, research development and innovation and systems based leadership,collaboration. These feature in each of the service plans. Also incorporated in the plan are considerations on the economy and social value, and in addition, the ambition to become an anchor organisation in Wales and in the Communities we serve. Cath O'Brien discussed key highlights for year one along with challenges. There are a number of key change projects that have already, including the implementation of the Integrated Radiotherapy Solution (IRS) programme. Service improvement is a priority. There is awareness of the challenges but confidence that the organsation is equipped to manage the task ahead. Nicola Williams highlighted some aspects covered in the paper. The priority in the coming year is the finalisation and implementation of the quality and safety framework for the organisation. This forms a key enabler for the delivery of the Health and Social Care Quality and Engagement Act for Wales. We are expecting statutory guidance, which will enable the Trust to enact the legislation by April 2023. From a policy, process and ways of working perspective there is a challenge ahead but the Trust is looking forward to its implementation. Inherent in this work is continuous improvement and demonstrating our infrastructure for improvement. Matthew Bunce advised that the plan explains the core financial position, cost pressures and risks in respect of COVID-19 funding. Other discussion and queries are noted below: • Stephen Harries refered to page 46 of the document, questioning how performance will be measured and reported. As an example comparing performance between 2019-2020 and 2022-2023 will show varying pictures. Cath O'Brien responded that the 2019-2020 baseline will be used to measure data in terms of planning	

	and capacity at a systems level. It is difficult to predict what will happen at a patient level. • Stephen Harries questioned what plans are in place to address outpatient increases. Cath O'Brien responded that planning is currently ongoing on the matter. Teams are looking into how to optimise site utilisation, along with the task and finish group to support management of patient flow. Outreach sites are an option but consideration is given to how this may impact on travel times for patients. A culmination of all of these aspects are being worked on to ensure effective capacity and flow. • Gareth Jones commented that given the length of the document, it may be worthwhile having an executive summary. Phil Hodson advised that the Board Cover Paper will be written in a way that covers the key points. It was also noted that an easy read version of the document of approximately 4 pages will be drafted. • Specific errors noted by Gareth Jones and Andrew Westwell will be addressed by Phil Hodson and Peter Gorin as part of the quality assurance check. Any further queries identified by Independent Members can be forwarded to Peter Gorin. • Peter Gorin added that the plan is lengthy and detailed. This ensures all required information required by Welsh Government is included. • It was noted that all queries and questions raised by Independent Members (IMs) is being addressed. Comments received in writing by IMs will be raised at the Board Meeting. • Carl James concluded that the plan was written with the intended audience in mind. It is detailed and tells our story. It provides a picture of the complexity of what we do and are expected to achieve. We will ensure the cover paper covers adequate information in as simplified a way as possible. The Strategic Development Committee **ENDORSED** the IMTP for consideration by the Trust Board on 31st March 2022.	
3.1.3	**Trust Assurance Framework (TAF)** Lauren Fear noted that the new framework has been transferred to a format to enable the best use for managing strategic risks. In time, these risks will be migrated to Datix. As these are strategic risks they will be separate to operational risks. The TAF enables an additional level of transparency and structure to the process. The following comments and questions were noted: • Gareth Jones questioned whether issues are being captured, as issues are more serious than risks. Lauren Fear responded that the TAF relates to the organisations long term risks in conjunction with its long term strategic goals. Cath O'Brien added that should there be problems or issues relating to risks, these will be reported to the respective	

	committee. It was noted that the TAF is a standard framework, adopted by organisations in England and Wales. No specific action in terms of the discussion on issues was noted. Gareth Jones added he will reflect on the discussions and documents shared and discuss further with Lauren Fear. • Formatting noted by Stephen Harries and Gareth Jones will be addressed, for example colour formatting. • Stephen Harries noted review and due dates for some risks have passed. • Sarah Morley noted the difference between the high level risks in the TAF, and other operational risks. Together with the senior team, there is work underway to clarify actions and dates, and alignment of these actions to ensure they are firmly defined. • Nicola Williams noted to the committee that following the paper being published, TAF 06 has been updated to an amber due to recent work that has been undertaken. Lauren Fear noted that recent updates, will be made to the TAF prior to the paper being published to Board. • Gareth Jones asked about the cumulative impact of a number of these risks manifesting at same time and how this could be considered. There was a discussion on the concept of reverse stress testing and this way of thinking would be considered and built into the development of approach going forwards. The Strategic Development Committee: • **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, included at Appendix 1. • **ENDORSED** the updated Trust Assurance Framework Dashboard that will be submitted to Trust Board in March 2022. • **NOTED** the progress made and the next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.	
4.0.0	**ANY OTHER BUSINESS**	
	There was no other business to note.	
5.0.0	**REVIEW OF THE MEETING**	
	None to note.	
6.0.0.	**DATE & TIME OF NEXT MEETING**	
	SH confirmed the date and time of the next meeting: 16th May 2022 at 10am Via Microsoft Teams	

Strategic Development Committee

23rd March 2022

Action Summary

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
4.1.0	CJ to raise the option of considering a seat at the Regional Partnership Board at the next Trust Board	Carl James	12/08/21	May-22	The Trust Strategy was approved in January which includes our ambitions for further development of regional working and collaboration. It is proposed that the specific question of whether the Trust attend Regional Partnership Boards is transferred to a discussion in the June Board Development session on ways of working. Following that discussion, if it is agreed a specific paper should be brought to the Strategic Development Committee, this will be added to the next agenda.	**CLOSED**
4.3.0	Velindre @ UHW Progress Update: C J to create a timeline for each workstream to clearly show what's involved within each workstream and estimated completion dates.	Carl James	12/08/21	May-22	Regional progress against delivering on the Nuffield Recommendations, including Velindre@UHW, is shared and agreed at the South East Wales Cancer Collaborative Leadership Group now at each meeting. This is following work at start of this year across the Trust and the four commissioning Health Boards in baselining the position. The summary will now also be shared at each Strategic Development Committee – see item 3.1.5	**CLOSED**

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
9.0.0	DM highlighted that within the Terms of Reference the RD&I to submit a highlight report to this committee should that deem necessary. There were a number of issues discussed at the last RD&I committee which would demonstrate the difficulties in achieving some of the objectives that have been set out in the various plans discussed today. DM suggested a highlight report is brought to the Strategic Development Committee	Jacinta Abraham	08/11/21	May-22	Included as item 3.1.8 and included on cycle of business going forwards.	**CLOSED**
2.2.1	Format of action log to be reviewed	Lauren Fear	23/3/22	May-22	Format of action log now in line with other Trust Committees.	**CLOSED**

STRATEGIC DEVELOPMENT COMMITTEE

Developing our Future: Strategic Direction: 2022 – 2032: enabling strategies (sustainability, people, digital and estates)

DATE OF MEETING	16/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carl James, Director of Strategic Transformation, Planning and Digital
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	9th May 2022	Endorsed

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust has been working to refresh its strategic plans with the aim of setting up a clear strategic direction of travel for the 2022 - 2032 period. This includes a Trust mission and vision; goals; and a coherent set of strategies and plans to deliver them.

1.2 The process commenced with a number of Board sessions regarding the mission and vision for the Trust. This was followed by a series of conversations with the wider organization on the mission and vision; a set of strategic goals for 2032; together with discussions regarding the vision for blood and transplantation services; non-surgical tertiary cancer services; and what supporting plans are required to deliver them.

1.3 A series of engagement activities occurred from December 2019 which were progressing well (including engagement with Senior Management Teams; various teams across the Trust; patient/donor groups; and professional bodies). These were run face-to-face with approximately 350 people being involved by the end of March 2020. Unfortunately, the process was paused at the end of March as a result of the COVID-19 pandemic.

1.4 The process recommenced in 2021 with further engagement on the Trust strategy together with the wider strategic development programme (service and enabling strategies). A further set of engagement activities have taken place including with regard to developing the Trust strategy. This included:

- internal Teams events;
- a public engagement event using social media (Facebook; Twitter etc)
- focus groups with key stakeholders.

1.5 A final Trust strategy 'Destination 2032' was approved by the Trust Board on 27th January 2022. The Velindre Cancer Service Centre five year plan is in place and the Blood and Transplant service five plan is being finalised.

1.6 In support of these are a suite of enabling strategies which have been developed to facilitate the delivery of the Trust strategy and the clinical ambition set out in the cancer and blood services. The development of these have been based on engagement over a period of time with internal staff, patients, donors and wider

partners, with much of the information being collected via business as usual processes.

1.6 A number of presentations have been delivered setting out the high level shape of these strategies and work has progressed to translate that intent further.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 This programme of work has been significantly disrupted by the Covid pandemic. Notwithstanding this, continuous progress has been made as follows:

Strategy	Current position	Expected Board approval date
Velindre University NHS Trust 2022 – 2032	Approved	27th January 2022
Velindre Cancer Centre 2016 - 2026	Existing	Complete
Welsh Blood Service	Final draft being developed with sign off by WBS Senior Leadership Team June 2022	July 2022
Enablers		
People	Final draft	May 2022
Digital	Final draft	May 2022
Sustainability	Final draft	May 2022
Estates	Final draft	May 2022

2.2 Given the ongoing challenges presented by the pandemic, a practicable approach has been adopted to initial development i.e. initial scoping discussions; use of existing information/evidence base. This has allowed good working drafts of a number of the enabler strategies to be developed.

2.3 A number workshops have been held to achieve alignment and integration between the strategic goals for 2032; the known priorities/service models of blood and cancer services (i.e. service delivery/targets via a hub and spoke) and the key

policy/strategic requirements (e.g. carbon reduction; increasing use of technology; staff well-being (agile working).

2.4 The Executive Management Board requested sight of the suite of strategies at the February 2022 meeting. Since this time, the Welsh Blood Service Senior Leadership Team has completed its work in developing the draft Welsh Blood Service 5 year strategy. The following documents are attached for review:

Annex 1 Sustainability strategy

Annex 2 People strategy

Annex 3 Digital strategy

Annex 4 Estates strategy

2.6 Following this, further engagement was undertaken between March and April 2022 on the sustainability, digital and estates strategies via social media platforms and Teams meetings. The analysis is set out in Figs 1- 4 below.

2.7 The feedback was very positive and final amendments have been made to the strategies to take account of it.

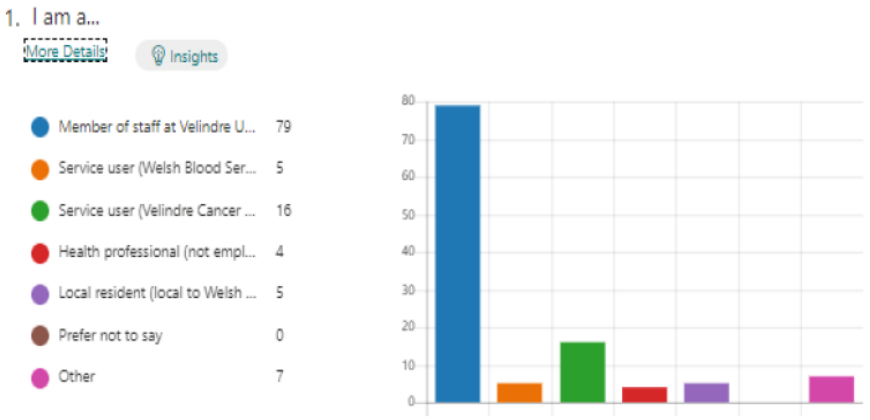
2.8. It is important to note that the strategies are intended to set out a clear vision, direction of travel which enables tactical implementation of them through the Integrated Medium Term Plan. Therefore, each of the strategies have not been definitively costed at this stage. Similarly, a number of the Measures of Success may be amended as the Trust progresses through the development / implementation work.

2.9 The development of an overall prioritized blueprint for the Trust will be undertaken in June – September 2022 as part of the development of the Executive Management Boards Transformation programme/ways of working.

Fig.1 Overall Feedback

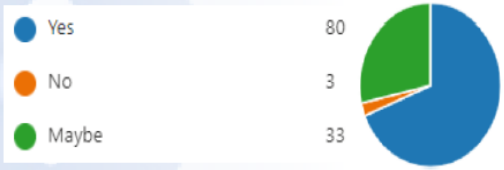
Headline Figures

- In total, the engagement survey received 116 responses. 68% of responses came from Velindre employees.
- The survey was shared extensively across internal comms and on each of the Trust and divisional social media channels



- Asked if each strategy (Digital, Sustainability and Estates) had prioritised the right areas, respondents told us:

Digital



Sustainability

Estates

Fig.2 Feedback on digital strategy

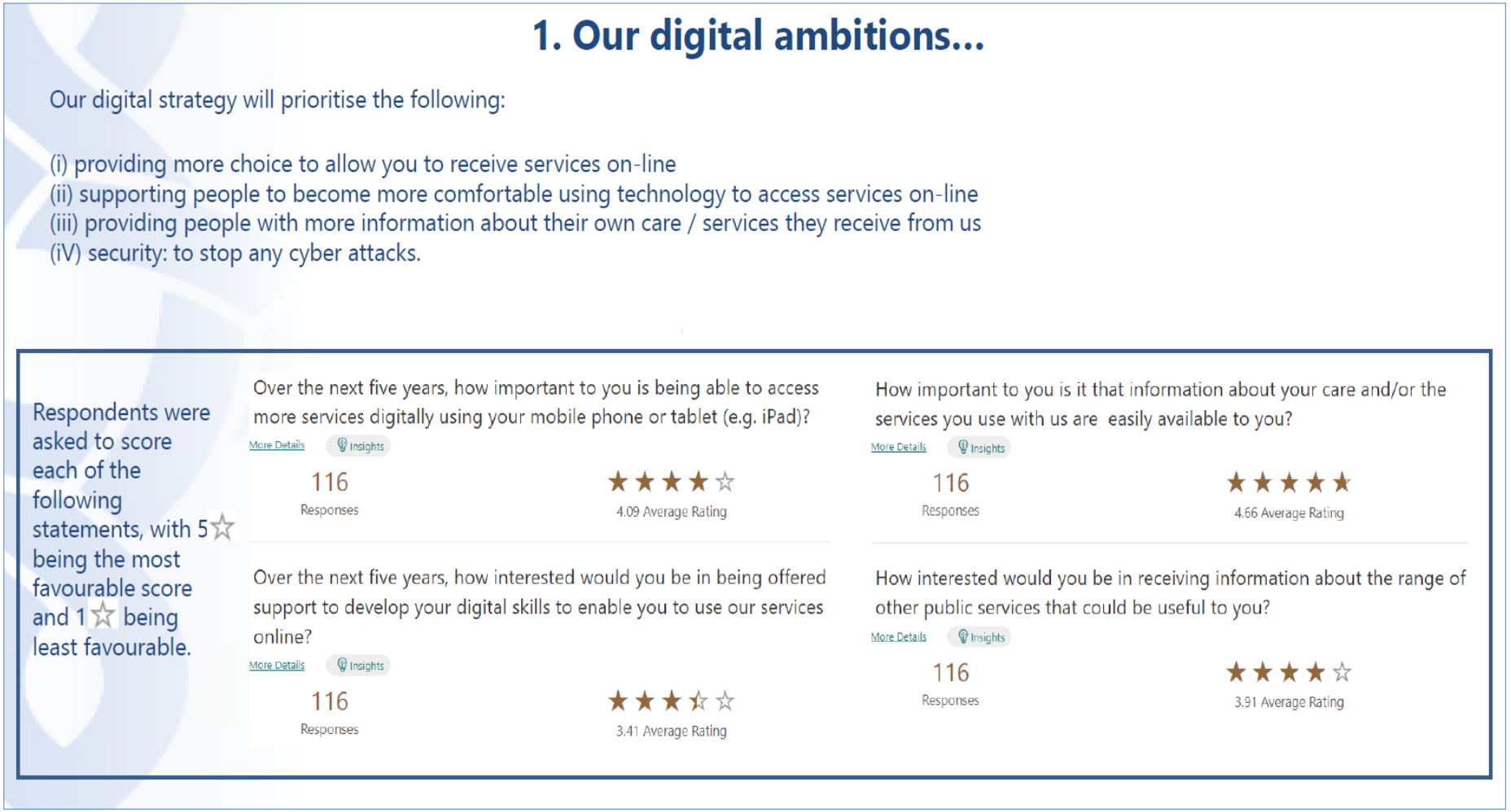
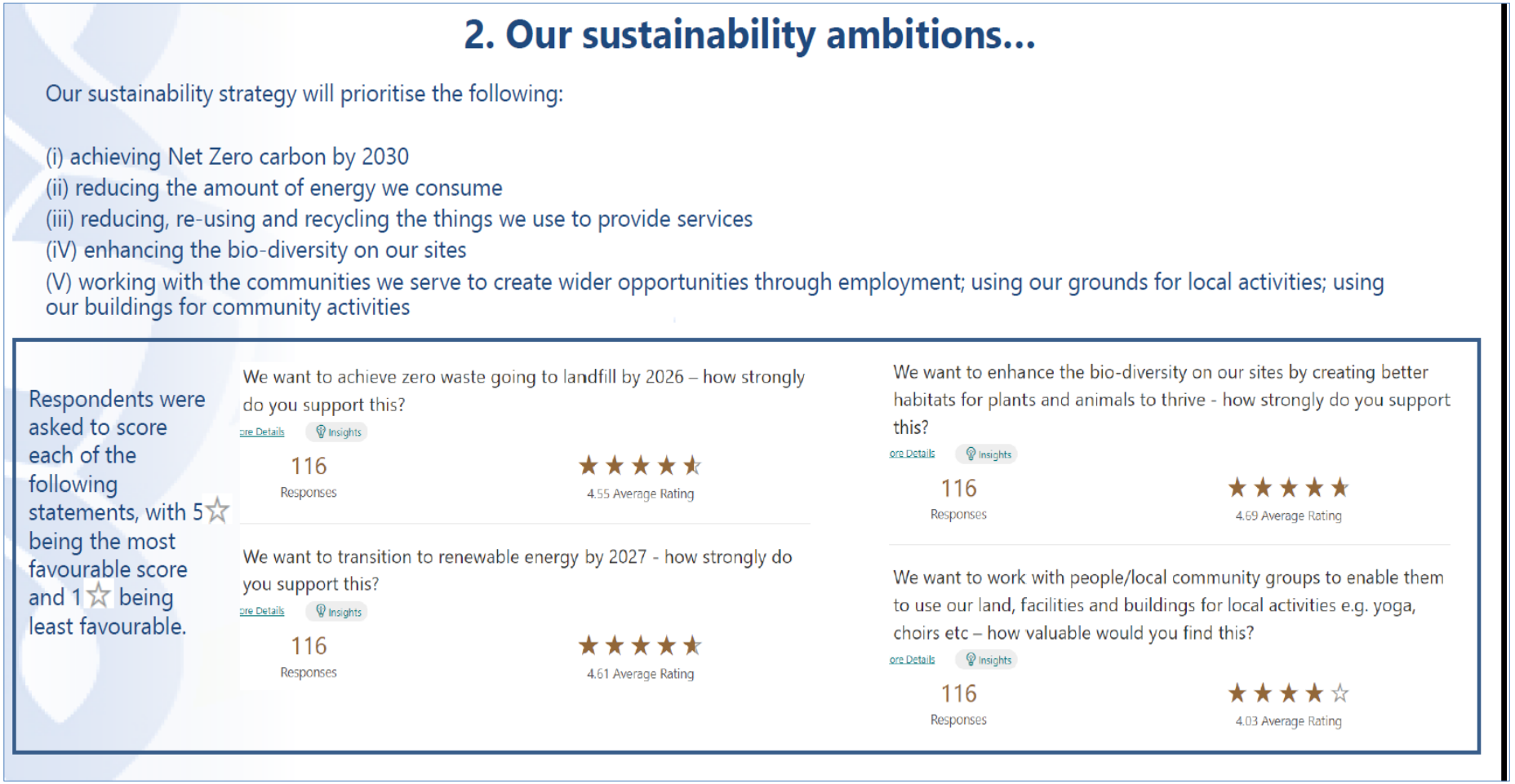
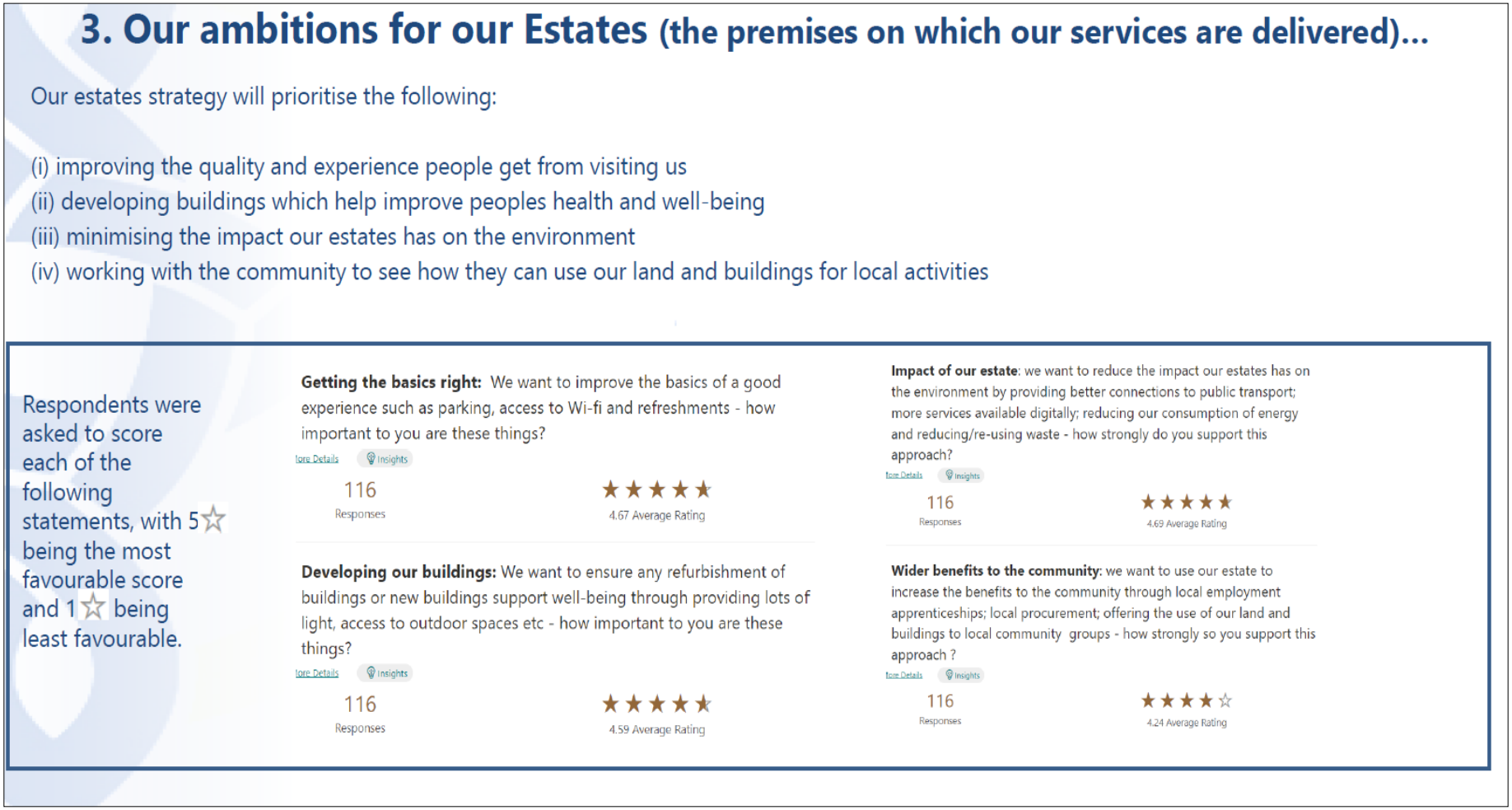


Fig. 3 Feedback on sustainability strategy



Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Fig. 4 **Feedback on estates strategy**



2.7 A communications and engagement plan is being developed to support the launch of the Trust strategy and supporting plans in June 2022.

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	No (Include further detail below)
	Will be undertaken once further development undertaken
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:

(i). discuss the final sustainability, people, digital and estates strategies.
(ii). endorse them for consideration by the Trust Board on 26th May 2022.
(iii). note that Equality Impact Assessments will be undertaken on all strategies prior to them being considered by the Trust Board on 26th May 2022 (subject to Strategic Development Committee endorsement).

Annexes

Annex 1 Sustainability Strategy

See attached

Annex 2 People Strategy

See attached

Annex 3 Digital Strategy

See attached

Annex 4 Estates Strategy

See attached

Sustainability Excellence: our strategy 2022 -2032

Ensuring we contribute to a better world for future generations in our community and across the globe…

…acting today, for a more sustainable tomorrow

Published: TBC

WORKING DRAFT

Foreword

Introduction

Why do we need a Sustainability Strategy?

Where are we now?

Moving Forward, Moving Faster…

What we want to achieve

Sustainability Excellence - Our themes

- Theme 1 - Creating Wider Value: our organisational approach
- Theme 2 - Sustainable Care Models
- Theme 3 - Eliminating Carbon
- Theme 4 - Sustainable Infrastructure
- Theme 5 - Transition to a Renewable Future
- Theme 6 - Sustainable Use of Resources
- Theme 7 - Connecting with Nature
- Theme 8 - Greening our Travel and Transport
- Theme 9 - Adapting to Climate Change
- Theme 10 - Our People as Agents for Change

Measuring our Success

Foreword

A very warm welcome to 'Sustainability Excellence', the sustainability vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors and wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that digital technology and insight can make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' strategy sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of environmental interventions, sustainable solutions and working with our communities to deliver safe, high quality services and our long-term goals cannot be overstated.

"Sustainability Excellence' sets out our sustainability vision and strategy for the next ten years and will help us use technology and insight to support our vision of excellence.

Introduction

As a public service organisation in Wales we recognise the responsibility vested in us by the people we serve to make the country a better place to live, work and enjoy. We fully recognise the impact we have on the environment, the communities we operate in, the people we provide services for, and the staff who work for us.

Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

Therefore, we are really excited to be able to set out our journey to sustainability and the benefits it will realise over the coming years. As an anchor organisation in Wales, we are committed to embedding sustainability within our own organisation and become an exemplar for others to come and learn with, and from. We are committed to placing sustainability at the heart of everything we do and to maximise the benefits we can provide for people across Wales.

This Sustainability Strategy will create a roadmap for to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

Why do we need a Sustainability Strategy?

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

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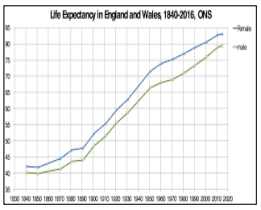
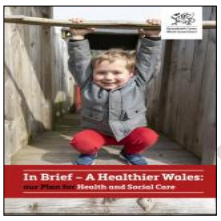


We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities. This requires us to make a broader contribution to the communities we serve to improve their health, wealth and prosperity



A Healthier Wales sets out a clear path to move from ill-health to well-being.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to

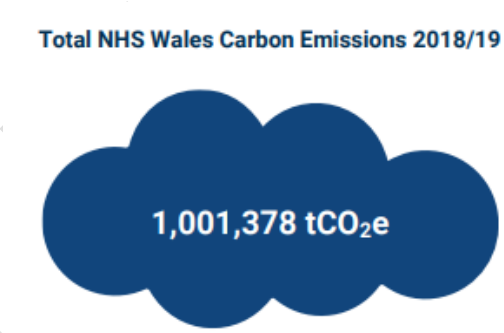
We need to reduce carbon emissions, drive energy efficiency, reduce plastics and waste, improve air quality and use resources more efficiently to move from ill-health to well-being

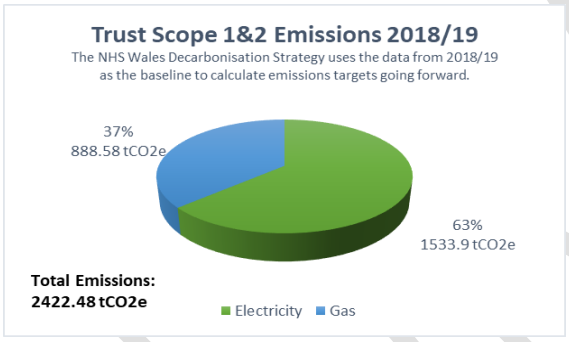
Technology, the 4th Industrial revolution, provides healthcare with the opportunity to transform the way we deliver services, increasing the value for patients, donors and our partners in a more sustainable way.

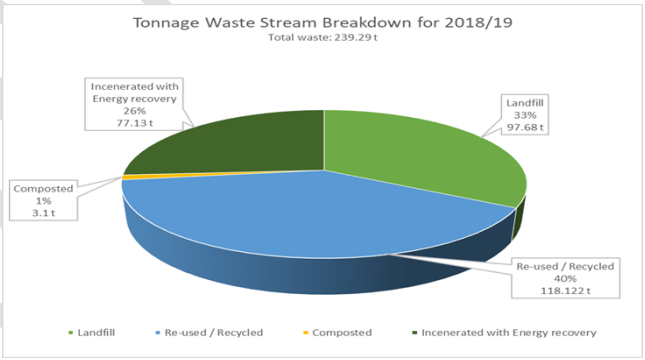
Where are we now?

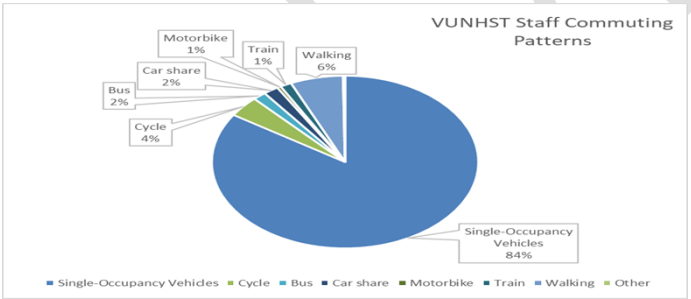
We recognise that, inevitably, our day-to-day operations have an impact on the environment. The NHS is responsible for 2.6% of the total carbon footprint in Wales, and has fallen behind other sectors when it comes to response and reducing environmental impact. Across our estate, there are a number of key areas to tackle including energy consumption, single-use plastic, water usage, fuel and waste.

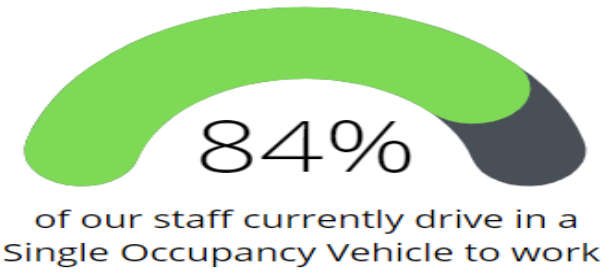
The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value.

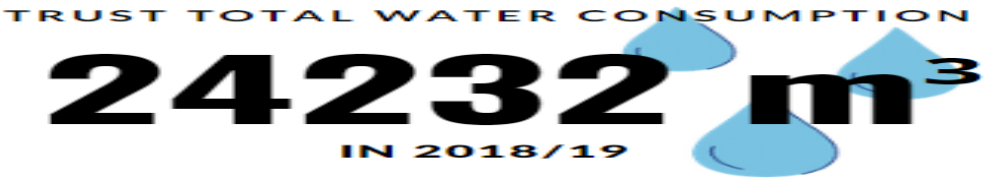












V 0.13 April 14th 2022 CJ

Moving forward, moving faster….

We are passionate about sustainability and we know the communities we serve and our workforce are too. We have an uncomplicated goal; to become a sustainable organisation that plays a part in creating a better future for people across the globe.

World Bank predicts by 2050, there will be 143 million climate refugees *– Environmental migrants are people who are forced to leave their home region due to sudden or long-term changes to their local environment.*

The pioneering 2015 Well-being of Future Generations Act (the "Act") and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and this strategy outlines our sustainability aims and enables real action to create positive and significant change.

This strategy is the start of a new phase of close engagement and collaborative working with others to share our resources and to work together do more with what we collectively have. Delivering our ambitious vision will require a collective effort from us, all.

The Earth is on course to lose up to one in six of all its species, if carbon emissions continue as they currently are.

To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act, which together ensure we achieve the Trust Well-being Objectives.

The Intergovernmental Panel on Climate Changes 6th Assessment Report states the evidence is clear: the **time for action is now.** The world needs to halve emissions by 2030 and the **next few years are critical.**

What we want to achieve…

Our vision: become a sustainable organisations which contributes to a better world for future generations within our locality and across the globe

- **Deliver sustainable services which add wider social value for the communities we serve**
- **Be recognised as an exemplar organisation of delivering the Well-Being of Future Generations Act**
- **A biodiversity net gain and enjoyment of our green spaces to improve health and well-being**
- **Be carbon neutral by 2030**
- **Use minimum resources efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water**

Our Key Themes

We have identified a number of key themes which we will focus on to deliver our ambitions to become sustainable organisation. In each theme we set out what we want to achieve, our objectives and the actions we will take.

Theme 1: Creating Wider Value: our organisational approach

Theme 2: Sustainable Care Models

Theme 3: Eliminating Carbon

Theme 4: Sustainable Infrastructure

Theme 5: Transition to a future of renewables

Theme 6: Sustainable Use of Resources

Theme 7: Connecting with Nature

Theme 8: Greening our travel and transport

Theme 9: Adapting to Climate Change

Theme 10: Our people as agents of change

Theme 1: Creating Wider Value: our organisational approach

What do we want to achieve?

Embed sustainability within our organisation and create more value for the people we work for and the communities we work within

Our objectives are to:

- Ensure sustainability is embedded into our organisational conscience and decision-making
- Improve life for people who lives in the communities we serve

We will:

- Maintain an ambitious and current sustainability strategy
- Routinely report performance against our sustainability goals to senior management, the Board, public and wider stakeholders
- Collaborate with regional health boards and local artists to create an arts programme, to improve wellbeing of patients, staff and visitors. Evidence-based research has shown similar programmes improve the treatment experience, while supporting the local economy, culture, and community integration
- Work with NHS Wales Shared Services Partnership (NWSSP) to drive the greatest benefits from our procurement activities whilst driving down emissions
- Work with the Future Generations Commissioners Office to embed the Well-Being of Future Generations Act and to share our knowledge and learning widely with others
- Adopt the principles within the Place Making Charter and work with our local communities and partners to maximise the benefits of our resources to drive prosperity, health and wealth
- Play an active role as an Anchor Institution, creating broader social value for local communities through employment opportunities, contributing to economic and social prosperity of the local community
- Support our Local Health Boards, Local Authorities and other partners to improve population health and well-being
- Work with stakeholders to identify how people can use our buildings as a community asset

Theme 2: Sustainable Care Models

What do we want to achieve?

We want to deliver the highest quality of care which minimises our impact and supports our journey to a sustainable planet.

Our objectives are to:

- Improve the environmental sustainability of our care pathways
- Maximise the use of technology and digital services to reduce the environmental impact of care
- Collaborate with patients, donors and our partners to deliver models of care that reduce the number of visits to our sites through the provision of care at home or closer to home

We will achieve this by:

- Identifying carbon hotspots for in our clinical services and pharmaceuticals and put in place actions plans to mitigate impacts and source alternatives

- Educating staff about high carbon impact services, equipment and pharmaceuticals and encouraging and supporting them in exploring alternatives

- Further evolve our clinical service models which are based on a 'hub and spoke' model with more services at home and locally

- Delivering our digital strategy which will Increase access to services, information and care for people through mobile devices and wearables

Theme 3: Eliminating Carbon

What do we want to achieve?

We want to be a carbon neutral organisation.

Our objectives are to:

- Be a Net Zero carbon organisation by 2030

We will achieve this by:

- Implementing our carbon reduction plan which includes actions to:
  - reduce the emissions from our estate and facilities
  - reduce our consumption of energy
  - retrofit our existing buildings to improve efficient use of energy
  - reduce the waste we produce
  - green our procurement activities and decarbonising our supply chain

- Reducing unnecessary travel related to our services
- Reducing the footprint of the estate to optimal size that meets operational requirements
- Hardwiring carbon reduction and sustainability requirements into our core business processes and decision-making e.g. business cases; procurement; infrastructure developments
- Accelerating our approach to agile working, enabling a minimum of 30% of our staff to work remotely

Theme 4: Sustainable Infrastructure

What do we want to achieve?

Provide buildings which improve the well-being of our staff, patients, and donors to reduce our environmental impact

Our objectives are to:

- Reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages

We will achieve this by:

- Developing sustainability guidelines for all capital projects including major refurbishments, driving resource efficieny through the implementation of our Estates strategy
- Designing to BREEAM excellent as a minimum standard in all of our new buildings in the major capital programme, together with the requirement for them to be developed on the circular economy principles
- Prioritising access to nature, natural light, ventilation, green space and easily accessible and active travel infrastructure in the development and refurbishment of the Trust estate
- Investing in a range of new building and facilities which includes:
  - major refurbishment and infrastructure upgrade at Welsh Blood Service< Llantrisant by 2022/2024
  - construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
  - construction of a new Velindre Cancer Centre by 2025
- Work with contractors to take a whiole life cycle costing approach to all major capital projects, building refurbishments and new buildings
- Develop the ability to weight and use social value outcomes within our descision-making when procuring new services in the design and building of a new space e.g. the use of a local supply chain and SME's

Theme 5: Transiton to a Renewable Future

What do we want to achieve?

We want to reduce our overall energy requirements and transition to renewable sources.

Our objectives:

- Reduce our consumption of energy by 70% and reduce water usage year on year
- Transition to purchasing 100% of our energy from renewable sources by 2027

We will achieve this by:

- Improve our metering and monitoring of energy across our estate
- Delivering a programme of targeted energy and water efficiency schemes to drive down use.
- Embedding more efficient practices, new technologies and improve staff awareness to improve utility efficiency in our everyday lives
- Respond quickly to any preventable energy inefficiency such as overheating or leaks through effective monitoring and leak detection systems
- Understanding the whole value chain effects of the products we utilise and the sustainability implications of our models of care and service. This will also require a focus on supporting sustainable local supply of appropriate services and products.
- Introduction of new technologies to support the management and control of resource

Theme 6: Sustainable Use of Resources

What do we want to achieve?

We want reduce, re-use and recycle resources annually and adopt a circular economy approach as the 'way we do things around here'.

Our objectives are to:

- Reduce our waste by 33% 2030 in accordance with the Welsh Governments 'Beyond Recycling' targets
- Achieve 'zero waste to landfill' by 2025
- Have 70% of our waste recycled by 2025

We will achieve this by:

- Focus our action on plastic by:
    - Apply the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, moving towards a circular economy
    - Deliver initiatives to reduce waste including:
        - Food: through reduction; re-use and sustainable treatment
        - Plastic: by targeting the 15 plastic product groups the vast majority of waste; replacing single use products and plastic with reusable alternatives where there is a viable and lower carbon option
        - Promoting a culture of re-use, re-purpose, refurbish and pass it on for items where this is possible e.g. furniture and equipment
- Developing a plan which sets out or transition to renewables which includes:
    - Specifying renewable energy when we enter into new energy purchaisng arrangments
    - determing the viable potential of renewable eneregy in our buildings (on-site or sourced
- Work with NHS Wales Shared Partnership Procurement and other partners to procure goods and services with the highest standards of producer responsibility that minimise packiging and offer alternative solutions to waste reduction and take back options

Theme 7: Connecting with Nature

What do we want to achieve?

We want maximise the quality and benefits of our green space, buildings, facilities and resources to enhance nature, biodiversity and well-being.

Our objectives are to:

- Improve the well-being of our patients, donors and staff connection with the natural environment
- Increase biodiversity by protecting and enhancing natural assets
- Maximise the quality and benefits from our green spaces

We will achieve this by:

- Raising awareness of the benefits of nature for physical and mental well being
- Working with local communities, the voluntary sector and business to identify how we can make our land, buildings and facilities available to the public to wider social activities which support health and well-being
- Developing a Biodiversity Enhancement Plan (BEP) which sets out how we will deliver a biodiversity net gain e.g. through reduction of mowing, sowing wildflowers and removing invasive species on all sites; and site refurbishments and new building developments
- Designing services, buildings and facilities which provide people with the opportunity to connect with green spaces and nature at our locations
- Create a wide range of activities and cultural programmes which enhances the place we live, work and play. This will include arts programmes, allotments, nature trails on our estate, community benefits and accessible activities
- Providing patients, donors and staff with opportunities to participate in well-being initiatives on our sites which add wider social value such as art exhibitions walking, yoga, beekeeping, gardening schemes, singing etc.
- Develop our approach to providing locally produced food to reduce the environmental impact and develop local resilience e.g. local food growing schemes and incorporation of products into Trust catering services
- Maximising the use of our green space to help mitigate the effects of climate change e.g. planting of additional trees and carbon sequestration
- We will employ green social prescribing as a holistic method of treatment, to enhance patient experience by connecting them with the surrounding natural environments.

Theme 8: Greening our Travel and Transport

What do we want to achieve?

We want to reduce the health impacts associated with our business and support a transformation in the way we travel

Our objectives are to:

- Decarbonise our transport and travel operations
- Encourage sustainable and active travel wherever possible seeking to reduce business mileage by 70%
- Provide more care and services at home or closer to home

We will achieve this by:

- Strengthening our Green Transport Plan to increase the use of sustainable and active travel
- Work with our strategic partners to better connect our estate to local integrated transport to reduce traffic impacts and increase the use alternative methods (e.g. walking, cycling, bus/metro)
- Improving green travel and access options to our services, buildings and facilities for patients, donors and staff
- electrification of our fleet
- Improving our facilities for staff actively travelling to work e.g. shower and changing facilities
- Actively marketing the Trusts cycle to work scheme, car sharing and use of the bus/metro at discounted prices for public service employees

Theme 9: Adapting to Climate Change

What do we want to achieve?

We want to ensure our organisations is well prepared to manage the impacts of climate change

Our objectives are to:

- Assess and understand the impacts of climate change on our services and communities
- Ensure our infrastructure, services, procurement activities and local communities are well prepared to mitigate and manage them

We will achieve this by:

- Working with Public Health Wales, the Welsh Government and partners to analyse the available data, understand risks and impact and develop solutions
- Invest in mitigation and adoption technologies to build resilience in our services
- Constantly review and adapt our business continuity and resilience plans to reduce the risk of service disruption and the impact on our patients, donors and communities
- Design in climate change adaption measures into all future building refurbishment and new buildings

Theme 10: Our people as Agents for Change

What do we want to achieve?

We want to develop a workforce which place sustainability at the heart of everything we do.

Our objectives are to:

- Support staff to develop the knowledge and skills to improve sustainability at work and home.
- Empower staff to make sustainable choices in the services we provide which improve their well-being

We will achieve this by:

- Delivering education and awareness programmes to raise sustainability and provide staff with opportunities to participate and make a difference
- Provide a knowledge hub of resources for every member of our workforce to access to enable them to deliver sustainable practice
- Include sustainability in all job descriptions and performance reviews
- Develop communities of practice and a range of 'Sustainability Heroes' who can provide leadership, enthusiasm and fun to encourage participation
- Encourage staff to take up opportunities to formal education and training programmes to increase our expertise e.g. degree and MSc
- Strengthen our succession planning by increasing apprenticeship opportunities support and work placements with local universities and NHS Wales Shared Services Partnership
- Integrating sustainability into our research, development and innovation portfolio to develop a compelling evidence base showing the benefits
- Supporting research examining issues relating to sustainable healthcare and environmental issues

Measuring Our Success

The Trust is committed to demonstrating leadership in sustainability and this comprehensive plan represents a route map for it to deliver significant improvements, with the help of its staff, key partners and other stakeholders.

Creating Value with our Communities: our approach	• Creation of social value assessment tool (TOMs) • % apprenticeships/student places offer to local communities • % of building assets available for use by local community stakeholders (i) % availability to local community utilised • Social value: community benefits audits • % of goods and services procured locally
Sustainable Models of Care	• % patients/donors rating care as excellent • % patients / donors rating the environment as excellent • % of patients receiving care at home or in local community • % of consultations carried out digitally
Eliminating Carbon	• Management and reporting of detailed carbon footprint breakdown • % CO2 emissions • % of carbon footprint from procurement activities
Capital Projects and Infrastructure	• % of new buildings and refurbishments achieving BREEAM excellent • Life cycle costs (sustainability) of major refurbishments and new builds • % of our fleet hybrid or electric

Sustainable Use of Resources	• Annual Net Zero Reporting to Welsh Government to
	• Water consumption
	• Energy consumption
	• Gas consumption
	• Annual EFPMS return
	• % of energy from renewable sources
	• % of waste reduction overall
	  - % of waste to landfill
	  - % recycled

Connecting with Nature	• Value of natural capital • Net biodiversity gain from the baseline audit in 2019 • % of trees new trees planted (of overall estate)
Travel and Logistics	• % staff walking to work • % staff cycling to work • % staff using public transport to travel to work • % staff car sharing • % single occupancy car travel to work • % of staff working from home • Business mileage per annum
Adapting to Climate Change	• BREEAM excellent buildings • Air quality on Trust sites • Risk rating in Trust Assurance Framework
Our people as agents for change	• % of staff receiving sustainability induction • Social Value Calculator (TOMs) • Staff awareness of sustainability (annual staff survey) • % sickness absence • % staff recommending us as an employer

People Strategy

Being an Employer of Choice

DRAFT

Published: TBC

Version: Final draft 4 may 2022

Contents

Foreword

A very warm welcome to the People strategy Estates Excellence', the estates vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors and wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that a talented, motivated and valued workforce makes to the quality, safety, experience and outcomes of the care and services that we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' strategy sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of the talented staff in delivering safe, high quality services and our long-term goals cannot be overstated. This is set within the context of a workforce shortage in the NHS across the UK and global competition for talent.

This strategy sets out the workforce we require now, and in the future, and how we will work with our staff and partners to attract, retain, value and reward people for what they do in work.

Our People Strategy: Becoming an Employer of Choice

These are exciting times for Velindre University NHS Trust when we consider the opportunities ahead for Blood and Cancer Services in Wales.

Our People Strategy describes how we will create the workforce we need to deliver our vision 'Healthy People, Great Care, Inspirational Learning'.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys – it will be grounded in our values, to Be Accountable, Be Bold, Be Caring, Be Dynamic. We will ensure we are always aligned to our values.

Our People and the needs of our patients and donors are changing and so is the way we deliver care. Shortages of clinical staff nationally, an older workforce and population and changes to education pathways means our people profile is evolving.

As a Trust we value our staff and recognise they are all core to the success of our organisation. Our overall aim is to develop our staff, support career pathways, develop leadership, skills and the knowledge they need to deliver the care our patients and donors need now and in the future to support their wellbeing and to recognise and value their diversity as part of a bi-lingual culture.

The Strategy will build on a strong foundation as a good employer and is key to delivery of our service and clinical plans.

Our vision is to have a:

Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations.

Planned and Sustained People: having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Healthy and Engaged People: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity

This People Strategy will ensure that our Trust is best placed to continue to deliver world class services for our donors, patients and carers. This will only be possible if we have the right workforce in the right place with the right sills at the right time.

This People Strategy is the response to the Trust-wide strategy that has redefined our ambition for excellence by building on our strategic strengths and addressing our challenges. It is part of this Trust's ambition to be outstanding for donors, patients and carers, forward thinking for staff and a partner in delivering healthcare across the region. Ensuring that our staff are looked after and developed will be core pillars of success for this strategy.

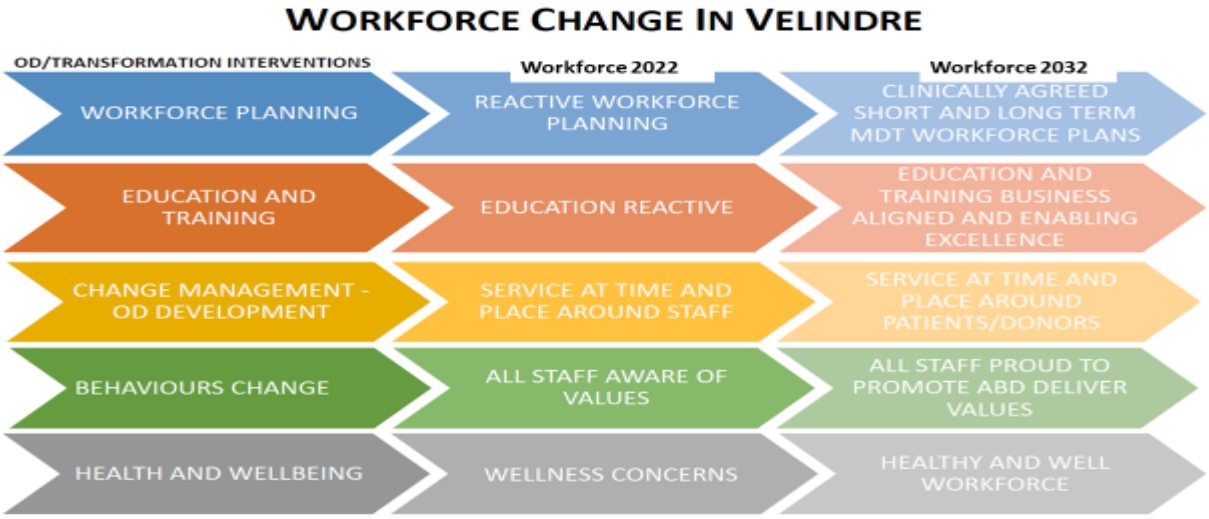
Our journey so far

Velindre is committed to being an employer of choice, offering an excellent working and development environment, with staff dedicated to providing outstanding care every time for our patient and donors and recognising that the key quality and strategic objectives can only be achieved through a combination of a well led, engaged and efficient people. We strive to behave in line with our values which we are always continuing to review.

The Trust is dedicated to providing opportunities for staff to engage and develop. It strives to provide opportunities for staff to learn and has strong relationships with academia through the Trust Academic Board. There is a range of health and wellbeing initiatives that are being made available to staff across our sites and on-line health and wellbeing resources that can be accessed at any time.

Models of care and service delivery need however to be constantly replaced and updated to support a changing NHS landscape and to meet the requirements of NHS Wales's service delivery strategy. Velindre University's NHS Trust is modernising in response to new healthcare options, the national Workforce Strategy, changing social expectation and expectations of patients and donors, rapid advances in technology and economic pressures. Additionally, the expectation that people have of their working lives and career pathways are evolving. The development of our people is key to transformation.

The graphic below summarises some of the key elements of our workforce change over time. A Healthy, Skilled and Planned workforce are integral parts of the transformation.



Our Workforce Response

We have developed a number of themes which will support us in attracting, developing and retaining a workforce fit-for-now and fit-for-the future.

Theme 1: Our People Wellbeing and Engagement

We will ensure our staff feel valued and supported.

Our objectives are to …

- Develop a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement
- Provide an Engagement Strategy to ensure staff are informed, involved, issues are raised and resolved, staff are rewarded and engagement can be measured
- Deliver an Equality, Diversity and Inclusion plans and Welsh Language Plan promoting a culture of true inclusivity, fairness and equity across the workforce. Our people are reflective of the Welsh population's diversity, Welsh language and cultural identity

We will …

- Demonstrate exemplar employment practices with a clear focus on equality, diversity and inclusion
- Support managers and staff to hold wellbeing and attendance conversations
- Provide effective work/life balance offers as we develop our agile and hybrid working arrangements
- Offer flexible career opportunities to meet changing needs
- Ensure our staff have access to appropriate support for mental and physical health concerns
- Deliver fair rewards and recognition, including addressing pay gaps across protected characteristics
- Continuously listening to staff and fostering a culture of care, compassion and inclusivity in line with our values

Theme 2: Our People Supply and Shape

We will have the right people with the right skills in the right place at the right time

Our objective is to …

- Develop effective people plans having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing

We will …

- Aligning to our Education Strategy, develop a Talent Management process that supports career pathways so staff have opportunities to grow professionally and internal and external pathways are visible to current and new staff

- Review our people plans to have the right skill mix of staff, maximising opportunities for new roles. This will include the implementation of delegation frameworks to support the development of Health Care Support Workers and further introduction of Advanced Practice and Physician Associate roles

- Maximise opportunities for all entry pathways including Apprenticeship, Graduate entry as well as Supported Recruitment to ensure an inclusivity in our supply routes
- Further embed our workforce planning process and develop our workforce information to maximise the opportunities for new ways of working

Theme 3: Skilled and Developed People

We will continually develop our staff to support them to achieve excellence in everything they do.

Our objectives are to…

- Develop a competent, capable and caring workforce
- Undertake a leading role with academic and national partners
- Provide high quality, technology enabled learning environments
- Develop new training pathways

We will …

- Develop a capable workforce including:
    - Meaningful Performance and Development Reviews that support, motivate and develop our staff
    - Assurance of safety through 85% compliance on Statutory and Mandatory Training
    - A Management and Leadership development offer that is flexible and supports 'just for me, just in time' development
- Working with our service improvement and research colleagues we will develop training and development pathways that respond to changing models of service delivery, delivering quality care
- Working with academic and service leaders in innovation technology we will development excellent learning environments for our staff building on the work already stared with virtual learning environments
- Through our Academic Board the Trust we will work with partners to achieve an academic profile showcasing its work on innovation and research

Theme 4: Leadership and Succession Planning

We will develop Compassionate Leaders and Managers which sustain our future requirements

Our objectives are to..

- Provide effective leadership development
- Promote a coaching culture at all levels to encourage compassionate leadership behaviour
- Establish a Talent Management process to spot and manage talent at all levels
- Embed team based working delivering high quality outcomes

We will …

- Enhance the Trust Inspire Leadership and Management Programme to continue its development of foundation and intermediate development programmes for leaders and managers supporting individuals through a bespoke offer of learning to deliver quality services
- Develop the talent management process ensuring it is systematic, equitable and inclusive across the Trust.
- Work with senior leaders in creating compassionate conditions in which all employees can thrive and work at their best.
- Build on our partnerships in academia and Health Education and Improvement Wales to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses

Theme 5: Digital Ready People

We will create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology

Our objectives are to.. …

- Create new Digital Leadership at all levels of the organisation
- Provide education to support a culture where utilising digital tools becomes second nature
- Work with partners in Academia to promote the digital vision of the Trust and attract talent

We will …

- Ensure our staff have the skills required to access to high quality information, to deliver high quality, safe services
- Support service transformation by including attracting and deploying digital talent within the transformation teams.
- Utilise the digital platforms to provide access to wellbeing resources for staff
- Encourage self-directed learning for all by developing digital literacy and utilising publicly available resources

Theme 6: Attracting and retaining the best talent

We will seek to identify the best talent locally and across the globe to work in our organisation.

Our objectives are to…

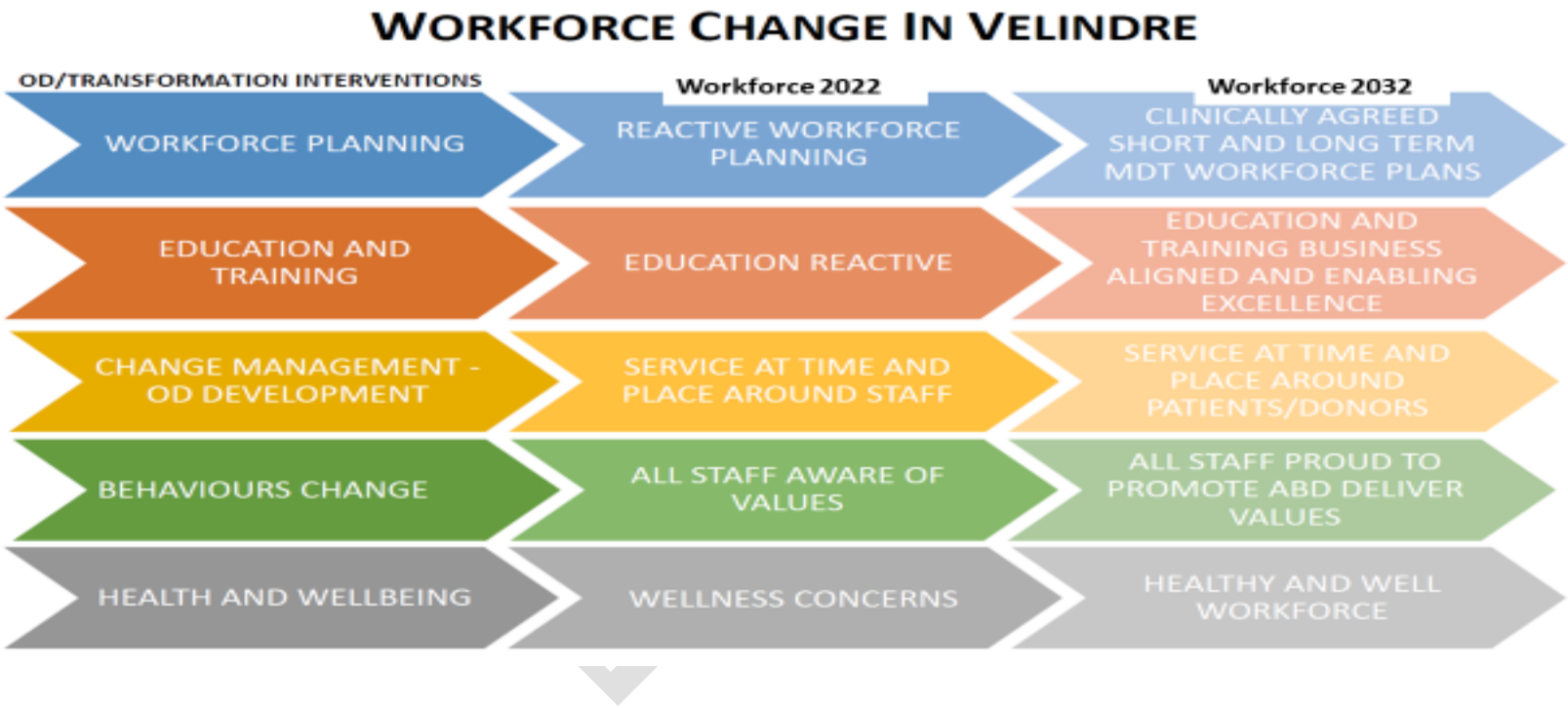
- Supply and retain appropriate trained and skilled staff
- Development of realistic and sustainable workforce plans
- Be a workplace that staff would proudly recommend to their friends, family and colleagues as a great place to work

We will …

- Create new approaches to recruitment marketing, targeting specific areas of shortage and using a range of communication channels to engage prospective staff
- Grow our Welsh speaking workforce by focussing on bi-lingual recruitment and developing language skills of staff
- Promote the Trust as a local employer of choice, working with our Academic colleagues to provide pathways into employment at all levels, ensuring inclusivity at all levels
- Ensure our recruitment processes are agile, assessing our time to hire regularly
- Develop wellbeing and engagement of all staff through listening, dialogue and involvement
- Recognise our staff for their achievements

Our Future People - Workforce 2032

With the successful implementation of the above themes the Trust will enable the transition of its people across all its key deliverable areas to create a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce



Measures for Success

People Wellbeing and Engagement

- Positive feedback from staff regarding wellbeing support
- % of staff recommending the organisation as a good employer in staff survey
- % sickness absence
- % of formal staff grievance cases

People Supply and Shape

- Number of Apprenticeships and Graduate Programmes offered/filled
- HCSW Delegation Framework in place
- Diversity of the workforce
    - Ethnicity
    - Gender
- % Welsh Language learners
- % Welsh Language speakers

Leadership and Succession Planning

- % of managers completing the Inspire Programme

Skilled and Developed People

- % Personal Development Reviews completed
- % Statutory and Mandatory training completed
- New Training pathways in place

A Digital Ready People

- Number of Digital Apprenticeships and Graduate trainees offered/filled

Employer of Choice – Attraction and Retention

- % Turnover rate
- % staff recommending the organisation as an Employer of Choice to family and friends

Digital Excellence

… Enabling Services of Tomorrow … Today

DRAFT

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Contents

Foreword

A very warm welcome to 'Digital Excellence', the digital vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors and wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that digital technology and insight can make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of digital technology, digital services and good information in delivering safe, hig quality services and our long-term goals cannot be overstated.

One of the most important components of our future success will be how well we embrace the opportunities that digital services offer. "Digital Excellence' sets out our strategy for the next five years and will help us use technology and insight to support our vision of excellence.

Digital Excellence: what does digital mean for you?

Digital can mean a variety of different things to a variety of different people. But was does it mean for our staff, donors, patients and carers …

Digital technology and services provide the opportunity to make a real shift in the relationship between health and care professionals and the people they serves, and the services healthcare organisations provide. Designing services in partnership with patients and donors will allow us to reimagine services and provide a more personal experience; enabled by digital technology.

It is important we understand what it means for each group. What does digital mean for a ……..

blood donor……..

- I can manage my donation appointments on the move
- I can view my donation history and understand where my donation has gone
- It allows me to keep my details up to date
- Helps me identify donation sessions close to my current location
- Signposts we to other services I may find usefu
- Let's me know what difference my donation is making
-

patient

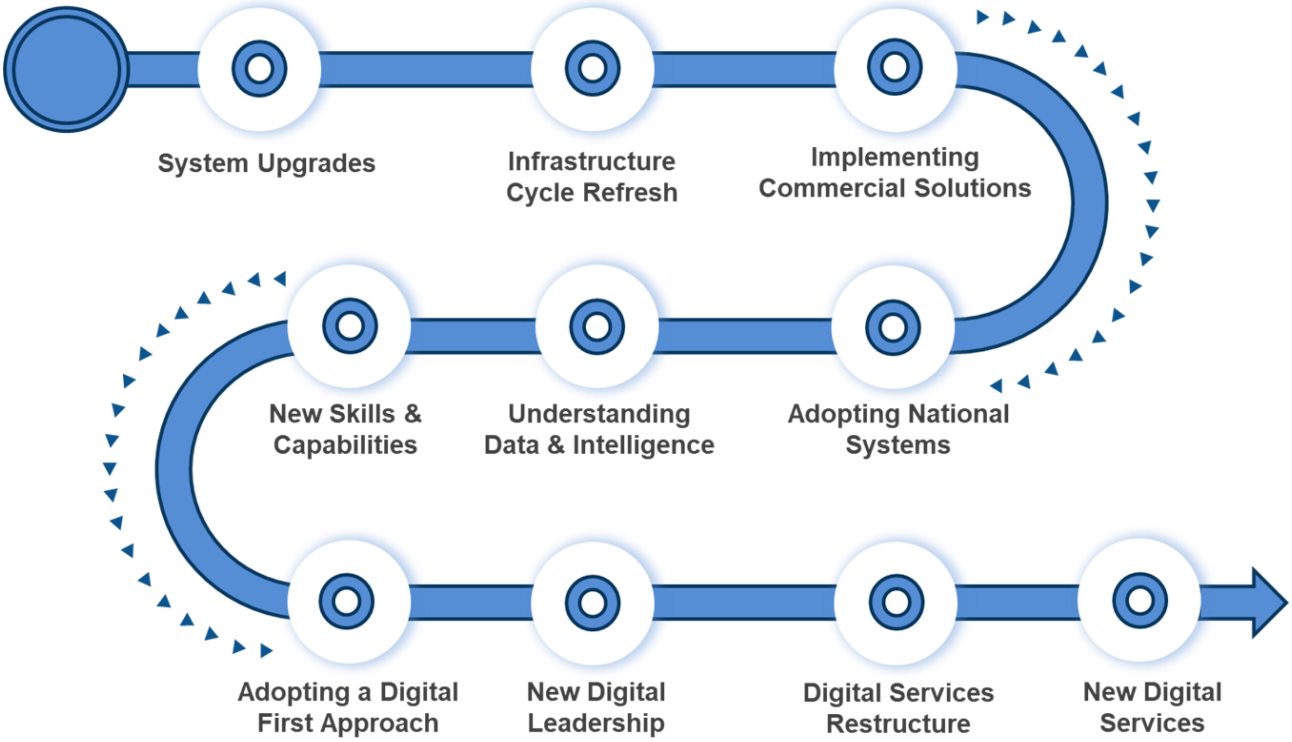
- Give me information about my health and care and supports me to make more informed decisions over what in need from the services you provide
- Gives me more choice about where/how I access the services I need
- Signposts we to other services I may find useful
- Information for carers to support patients recieiving care

member of staff and other healthcare partners…..

- Makes my role easier and more efficient
- Connects me to my team and my organisation
- Gives me flexibility in how and where I work
- Allows me to innovate and explore new ways of working
- Gives me the right information at the right time
- Allows the sharing of information across organisations to improve care

Our journey so far

Velindre University NHS Trust has built a proud history of significant developments in digital services which have made a difference to the quality, safety and experience of the services we provide …



These achievements over the last 5 years have put in place the foundations, skills and capabilities for the next stage of digital transformation.

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Looking to 2028: our digital transformation

Our vision: to ensure our patients, donors and staff experience of digital services is the same as our care…… outstanding

To deliver our vision, we have set out a number of themes which will support us in delivering a connected future that is people focused, personalised and supports a sustainable future.

Theme 1: Ensuring our Foundations

We will empower our staff to have access to high quality information, while equipped with the digital resources they require 24 hours a day 7 days a week, to deliver high quality, safe services.

Our objectives are to …

- Maintain resilient hardware and software across the organisation
- Develop and implement a suite of application services which maximise the benefits of an integrated all Wales systems approach
- Deliver digital systems and services which are designed with interoperability and integration as a core requirement
-

We will …

- Develop a 'fit-for-the future' infrastructure that is resilient with hybrid of cloud and data centre / on premise deployment
- Design all systems around the national principles (e.g. open; inter-operable;) to support integration across organisations
- Implement a range of national systems including Welsh Clinical Portal, Welsh Patient Administration System, WLIMs, ePrescribing
- Continually develop and maximise the benefits of our existing business systems including the Blood Establishment Computer System (eProgesa); Digital Health Care Record
- Implement local solutions relevant and appropriate to the needs of the population we serve
- Strengthen our prioritisation and governance arrangements to maximise the benefits of any investment in digital services and technology
- Design and implement a new strategy for the telephony services used across the Trust, to include the adoption of new digital telephony services, such as those available via Microsoft Teams

Theme 2: Connected and Inclusive Services

We will support people to become more digitally confident, included and connected.

Our objectives are to …

- Digitally connect our staff, donors, patients and carers to our services
- Place information which is uncomplicated and accessible into the hands of patients and donors
- Deliver the technology which supports the provision of more services at home, close to home as possible
- Provide our staff with the technology to work from a wide range of locations across Wales
- Reduce digital exclusion

We will …

- Create a new Integrated Platform for our digital patient and donor services, to include the delivery of a suite of mobile 'applications' for clinical and non-clinical services
- Work with patients/donors and third parties to explore opportunities to develop a suite of 'apps' that that can be plugged in or out easily which provide value
- Work with the local/national programmes to ensure staff have devices to use anytime/anywhere and access to mobile working e.g. .Gov.roam etc
- Fully implement Office 365 and realise the benefits of connected working
- Implement the digital requirements of the Transforming Cancer Services/Velindre Future and Welsh Blood and Transplant transformation programmes by 2025
- Hardwire the digital inclusion principles into our day-to-day activities and decision-making and:
    - Develop a digital inclusion programme to support patients, donors, volunteers and the public in accessing our services (including training; provision of tablets/devices etc)
    - Deliver our programme of work in the Digital Communities Initiative
    - Share with a and learn from best practice with *Digital Communities Wales* to co-ordinate our approach for maximum impact
- Build local and national partnerships to share ideas and co-ordinate activities with others in their area

Theme 3: Insight Driven

We will optimise the use of data and knowledge to help us make informed and insight driven decisions within the organisation and working with partners across organisational boundaries.

Our objectives are to.. …

- Develop a data-driven, insight led culture and evidenced-based decision making

We will …

- Continually improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols
- Work with the Digital Health and Care Wales (DHCW) to maximise the benefits of the National Data Resource (NDR) and integrate it with our data lake
- Develop the business intelligence service to :
    - democratize data, supporting frontline staff to own and analyse it;
    - provide a range of standard reports using PowerBI and other tools
    - provide expertise to undertake bespoke analysis

- Establish a programme of work which will seek to identify further opportunities in the following areas:
    - Operational and clinical intelligence
    - Tools and business insight
    - Robotic Processing Automation
    - Artificial intelligence
    - Knowledge and skills sharing and learning
    -
- Facilitate an open culture that encourages colleagues to challenge and question and use data to drive forward and measure improvement
- Provide staff with training and support in a range of areas on data standards; analysis; tools and techniques
- Building partnerships with academia to develop new methods of training and education in data science for all levels of the organisation
- Provide opportunities for research studies with local universities, offering MSc and PhD students the opportunity to use our data to provide us with insights
- Implement linked outcome reporting (for example Patient Reported Outcomes Measures (PROMS) / Patient Reported Experience Measures (PREMS)

4: Safe and Secure Systems

We will secure our data and information through an effective approach to cyber security. Working in collaboration with the Cyber Resilience Unit and the National Cyber Security Centre.

Our objectives are to..

- Maintain compliance with national policies and the Network and Information Systems (NIS) Regulations
- Increase awareness and training of cyber security principles

We will …

- Implement our strategic delivery plan for cyber security
- Develop and test cyber security business continuity / disaster recovery plans
- Conduct periodic exercises simulated on cyber attacks
- Ensure the Trust is fully compliant with the Network and Information Systems (NIS) regulations
- Implement the national Vulnerability Management Solution (VMS)
- Ensure all devices across the Trust to utilise automated patch management
- Develop new policies and procedures to support our security delivery plan
- Implement new controls for third party removable media scanning
- Enable further system protections and disable legacy communication protocols
- Develop and implement Microsoft InTune for enhanced Mobile Device Management (MDM)

Theme 5: A Digital Organisation

We will work with patients, donors, staff and partners to create a service culture that embraces the use of digital technology to get the best quality services from it

Our objectives are to.. …

- Create strong digital leadership at all levels of the organisation
- Build a highly skilled digital team that has the capacity to deliver the Trust's digital ambition
- Create a digitally literate workforce which embraces the use of technology to improve the services we provide
- Become a paperless organisation

We will …

- Strengthen our digital education and training programme from 'ward/lab to board' to improve knowledge and understanding
- Work with the Intensive Learning Academy and other partners to develop the core digital competence of the workforce aligned to their role
- Identify a range of digital leaders and support them in attaining digital/transformation qualifications e.g. MSc
- Build the capacity and capability of the Digital Directorate to support the delivery the digital transformation roadmap
- Create ways to share learning and knowledge through communities of practice; 'lunch and learns'; sandpit environments; and online resources staff can use to acquire skills and knowledge
- Actively promote digital as a profession within other clinical and non-clinical professions
- Operationalise the principle of 'Bring Your Own Device' to allow staff to access Trust digital services using the mobile technology of their choice
- Develop a plan to transition to a paperless organisation

Theme 6: Working in Partnership

We will work with partners to make Wales the area that innovators want to come to learn about digital excellence. Building a suite of partnerships covering all aspects of digital will be fundamental to the successful delivery of this strategy.

Our objectives are to…

- To build a network of partners and capabilities which enable us to maximise the benefits from research, development and innovation
- To become an exemplar within NHS Wales for digital innovation
- To develop our buildings that partners from across sectors use

We will …

- Develop a suite of technology partners to support all aspects of our digital transformation blueprint
- Develop agreed work programmes with local universities in stated areas of shared interest to drive the use and evaluation of digital technology in healthcare
- Recruit students and academic personnel to drive forward our research, development and innovation plans for digital technology
- Develop a Collaborative Centre for Learning, Technology & Innovation to be a physical and virtual point of contact for all partners and stakeholders to collaborate and innovate
- Establish partnerships which enable us to implement the concepts of SMART technology in our new infrastructure including the Welsh Blood Service, Llantrisant, the Radiotherapy Satellite Centre and the new Velindre Cancer Centre. This will allow us to share the knowledge, innovation and learning across Wales

How will digital technology make a difference for our patients and donors ?

Rachels's Story: a cancer patient

Rachel is referred to us by her Local Health Board after surgery for breast cancer. Rachel books her first appointment to see a consultant on-line using an app. She books her car parking on-line and emails her consultant on our platform with the questions she has in advance of her first appointment. She is able to access her medical records and information and uses our app to tell us how she is feeling in advance of her first outpatient appointment. This allows us to support her as she is feeling anxious and provide her with useful information and access to other services which can assist e.g. therapies; financial information etc.

Rachel arrives for her first consultant appointment and parks in her allocated space and checks in using the digital check-in desk. This immediately alerts us that she has arrived and helps us ensure that she is seen on-time. Rachel uses the Velindre app on her wearable device to access the wayfinding function which helps her easily find the cafeteria and outpatients department. Rachel's clinical information and the data she shared with us whilst waiting to see the consultant is all available to Dr Davies when she sits down with her for the consultation.

Rachel and Dr Davies agree a treatment plan which includes radiotherapy, systematic anti-cancer therapy together with mindfulness and support from the Maggie's. Rachel downloads our app onto her wearable watch device and Ipad and this allows her to monitor her health and share her data with us on a number of vital signs (bloods, temperature, heart rate) and her diet and sleep patterns. Our artificial intelligence systems monitor Rachel's health remotely 24/7 to ensure there are no concerns whilst she is waiting to start here treatment. If anything is of concern, an the remote monitoring triggers an automatic email to Dr Davies and the clinical team who review her situation and provide her with clinical guidance. Rachel also has video calling access to our teams to address any questions she has or any concerns she has during her time with us. She also has access via our platforms to the our Support Community which consists current and previous patients/families who provide support for each other through shared experiences.

Following her first appointment and treatment Rachel goes home and we keep in touch via the app. Rachel continues to monitor her vital signs and health information on the app and share her data with us for us to monitor. Unfortunately, Rachel begins to feel unwell at 3am and calls our 24/7 intelligent assistant for information which provides her with information and re-assures her that. It also books a virtual call with her Cancer Nurse Specialist the following day. Rachel discusses her concerns with our Cancer Nurse Specialist the next day and they agree that she needs to speak to an oncologist locally at the V@UHW facility for further examination. They book the appointment on-line and Rachel speaks to Dr Davies in the afternoon who prescribes some anti-biotics. Rachel continues to feel unwell and Dr Davies decides to admit Rachel to the Cancer Centre for further review. Rachel has her own room and uses the IPad or change the lighting and temperature in her room, order food and keep in touch with family and friends. She is still sharing her data with us (blood pressure, sleeping hours) and Dr Davies visits her with all her information available immediately on Dr Davies IPad in real time. This allows the cause of the problem to be quickly diagnosed with no unnecessary delays and the infection to be treated quickly. Rachel returns home and continues to monitor her health on her wearable/IPad device which we monitor remotely. Rachel continued to talk to the clinical team and ask any questions she has whilst receiving her treatment.

Her treatment was successful and she continues to monitor her vital signs using our app and share her data with us whilst she continues her recovery. Our clinical team will continue to monitor Rachel's recovery using the data she provides via her wearable device and Ipad using our artificial intelligence systems. This will alert us immediately to any concerns. She is also a regular contributor to the Support Community accesses a range of other local services through the signposting on our platform such as the local gym, choir and walking routes.

Maliks's story: a blood donor

Malik lives in West Wales and is in his first year of University. He has never donated blood but a friend mentioned it to him whilst talking over lunch. Malik searched for blood donation on his phone and clicked on the Blood and Transplant Services link. Malik was taken to our platform which provided him with a wide range of information and videos about why he should consider donating, the blood journey and the way in which it changes people's lives. Malik wanted further information so clicked on the 'send me more info' button and received an automatically generated email and offer to speak with an intelligent assistant 24/7 or have a virtual chat with one of our recruitment team. Malik goes onto our platform and selects a time/date which suits him to speak to our recruitment team to discuss the opportunity further.

Malik calls Tracey, in our recruitment team via Facetime, and they discuss a range of issues which Malik had identified in an email he had sent Tracey in advance. Malik decides he wants to become a blood donor but donating needs to work around his busy life. He sets up his user-ID online and logs into the donation app and completes the donor application form on-line in 5 minutes sends it off. We undertake all the necessary checks to ensure it is safe for Malik to be a donor and email Malik back. Tracey follows-up with a Facetime call to thank Malik for becoming a donor. Tracey also mentions that our platform offers a wider range of information and signposts to a range of other local services that Malik may find of use such as information of health living, local clubs and amenities such as gyms, libraries, local transport etc.

Malik books his blood donation appointment on-line using his watch. He books his appointment at a location which suits him in 2 weeks' time after using our platform to access the local bus times to ensure he can attend the donation clinic easily. Malik receives information about his appointment and a few days before receives an email asking for some information to allow us to undertake the donor screening process in advance of him arriving for his appointment.
On the day of his first donation, Malik gets an automated reminder text message to his watch with a personal thank you message from one of the people who has received blood – this reminds Malik of why he is donating.

Malik arrives at the donation venue and checks in digitally and waits for his appointment. The donation is a local sports club and he is able to use the free public Wi-Fi that we have worked in partnership with the local community to provide. The Wi-Fi has enabled the sports club to allow local children to use it as a community facility in normal hours and transformed the opportunities for some of the local children who didn't have Wi-Fi access at home.

Malik donates his first pint of blood and is thanked by our staff and returns home. Malik receives an email from us which offers him the opportunity to 'follow his bloods' journey – showing him how it's processed and where it's going to. In two months, Malik receives his automated reminder that he is now able to book his next appointment. When he arrives he tells our staff that he's been using our platform to access information about healthier lifestyles and has joined the local yoga class and volunteers with a local charity in his spare time; all as a result of the signposting available on our platform.

Measuring Our Success

Ensuring our Foundations
• % User Satisfaction with Digital Service Desk
• % of critical IT system service availability / uptime against agreed targets
• % of Incidents responded to within agreed targets
• % of Service Requests completed within agreed targets
• % of critical IT systems that support single sign-on (SSO)

Connected & Inclusive Services
• % of patients/donors who believe health and well-being improved due to online services
• % of patients/donors seeking health/service information on-line
• % of patients using applications to monitoring their health digitally
• % of consultations performed virtually
• % donors booking on-line
• % of patients / donors notified with via their communication preference of choice (SMS, email, other approved comms channels etc.)
• Mobile 'app' usage / interactions
• % buildings with free public wi-fi

Insight Driven
• % data quality (accuracy and timeliness)
• % of staff using local business analysis tools and standard reports
• % of data validation / corrections performed

Safe & Secure Services
• % compliance against NCSC '10 Steps to Cyber Security' standards

• Number of incidents reportable under NIS Directive
• Number of IT Business Continuity Incidents
• % compliance with cyber security statutory and mandatory training
• % staff clicking on phishing campaigns/awareness

A Digital Organisation
• % of Trust expenditure (revenue & capital) invested in digital
• hours / £££s saved through digitisation / automation of paper-based manual processes
• Number of 'Digital Champions' within the Trust
• % of staff achieving required digital skills/capability required of their job competencies
• % of clinical/nursing/clinical sessions identified for digital leadership/development
• % of staff with formal digital qualification e.g. BCS; degree; MSc
• % of staff with a mobile device
• Number of Digital Apprenticeships

Working in Partnership
• Participation in national / regional groups – e.g. AOS
• No. of academic establishments with whom we actively collaborate (e.g. PhD students, university placements)

For more information about this Strategy and understanding the detail of our Digital Roadmap please visit our Digital Services Portal:

vunhst.wales/digitalservices

(Access for NHS Wales staff only)

Estates Excellence: Our strategy 2022-2032

Supporting wellbeing through creation of a high quality, flexible, safe estate for today, and for future generations

WORKING DRAFT

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Contents

Foreword

A very warm welcome to 'Estates Excellence', the estates vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors and wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that a safe, high quality, accessible and sustainable estate can make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

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These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of the estate in delivering safe, high quality services and our long-term goals cannot be overstated.

The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients and donors, the services we provide and the broader needs of the communities we live and operate in. The estate is an important components of our future success will be how well we embrace the opportunities that the estate, sustainability and wider opportunities to create social value in the communities we serve offer. "Estates Excellence' sets out our strategy for the next five years and will help us maximise the opportunities.

This strategy sets out what estate we require now, and in the future, and how we will work with our patients, donors, staff and communities to ensure they have a safe and enjoyable experience which helps to improve their overall health and well-being. It also sets out how we can use our estate and facilities to make a wider contribution to communities and society.

Why do we need a new strategy

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. Our buildings, facilities and green spaces are a vital part of patient, donor and staff experience, are pivotal in improving mental health and well-being and will play an important role in developing thriving and resilient communities.

A Healthier Wales sets out a clear path to move from ill-health to well-being. Reducing the environmental and health impact of our estate is a priority for NHS Wales.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to

We need to reduce carbon emissions, drive energy efficiency, reduce plastics and waste, improve air quality and use resources more efficiently to move from ill-health to well-being

Technology, the 4th Industrial revolution, provides healthcare with the opportunity to transform the way we deliver services, increasing the value for patients, donors and our partners in a more sustainable way.

Where Are We Now?

Our Estate

Our services cover the whole of Wales and are delivered through a 'hub and spoke' model with services being delivered within the home, locally with communities, and at a number of fixed locations we own. These are:

Headquarters (HQ)

The headquarters building located in Nantgarw houses the executive and corporate functions.

Non-surgical tertiary oncology services

We deliver these services from a number of locations:-

Velindre Cancer Centre

Velindre Cancer Centre is based at Velindre Hospital in Cardiff and provides specialist non-surgical cancer services to approximately 1.5 million people living in South East Wales. The Centre was constructed in 1966 and has been subject to various extensions through each decade since opening, the last major construction being in the 2000's. The hospital occupies a footprint of 14,718m2, with 70% of buildings being 40 years of age.

Velindre@ facilities

We provide services across South East Wales from buildings and facilities across our partner Health Board sites.

Blood and Transplant Services

We have a number of locations including:-

Talbot Green, Llantrisant: constructed in 2003/4 and was extended in 2017-2019 to provide a Clinical Services and Hospital Lab Area. The building occupies a footprint of 6,981m2 with 80% of the site being 18 years of age.

Dafen: situated in Llanelli and is the primary base for the collection teams in West Wales. The building occupies a footprint of 356m2, and houses all consumables required to support collections. This building is leased which runs until 2022

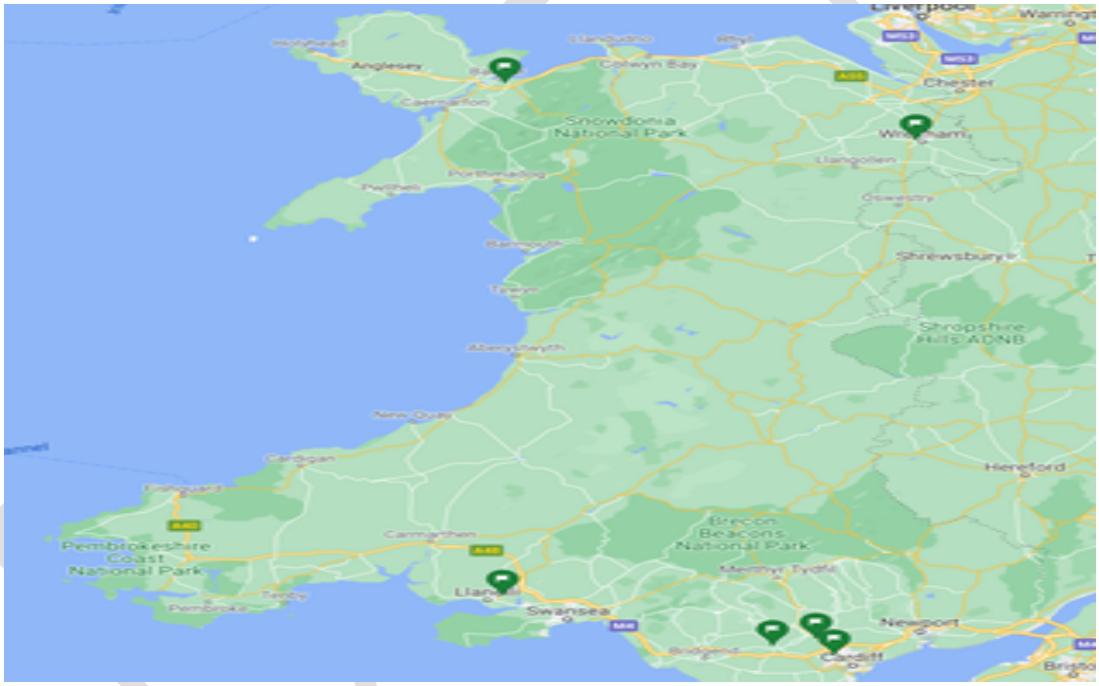
Bangor

This is the primary base for the collection teams in North Wales. The building occupies a footprint of 520m2, and houses all consumables required to support collections. This building is leased which runs until 2024.

Wrexham (Pembroke House)

Pembroke House occupies a floor area of 465m2 in size is subject to a lease agreement which is due to expire in 2025. The main purpose of this building is to act as a stock holding unit provide north wales hospitals with blood products together with the main base of operations for the collections team in the north east region of Wales.

VUNHST Estate



We will also provide services from various buildings across Wales which are owned by our as part of our 'hub and spoke' model of service delivery. These include buildings within local communities and at local hospital sites.

Condition

The Trust manages the condition of the estate through the strategic investment and operational maintenance plans to maintain suitable facilities, for staff and patients, continually benchmarking the condition of our estates to ensure facilities are maintained to the required standards and to inform strategic investment. The condition of our main sites are set out in the tables below;

Velindre Cancer Centre				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
63	70% >40 years	64	100	80
Welsh Blood service HQ				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
8595	18 years	100	95	95
Dafen				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
95	15 years	100	100	95
Pembroke House				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
100	25	99	100	99
Bangor				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
90	20	100	100	99

Estates Excellence: transforming our Estate

Our vision:

A sustainable estate which provides a great experience for all

Delivering the transformation

We have developed four themes to develop our estate

Theme 1: A safe and high quality estate which provides a great experience

Theme 2: Healthy buildings and healthier people

Theme 3: Minimising our impact

Theme 4: Using our estate to deliver the maximum benefit and social value to the community

Theme 1: A safe and high quality estate which provides a great experience

Our Objectives are to:

- Develop an estate which supports delivery of excellent frontline services
- Provide a first class experience for our staff and the people who use our buildings and facilities
- Achieve all statutory obligations regarding the estate and buildings while reducing operating costs
- Design in excellence adopting a sustainability first approach to all new buildings

We will achieve this by:

- Designing the estate around the hub and spoke clinical models used by the blood and cancer services
- Continuously engaging with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Investing our resources wisely to ensure we comply with all statutory legislation and infection prevention control requirements
- Getting the basics in place with all buildings having comfortable surroundings, car parking, Wi-FI and easy access to and from then on public transport
- Investing in our estate through the capital programme to ensure all of our facilities always achieve a minimum of Category B standard
- Improving the information we have on the performance of the estate to enable an effective risk-based approach to its management and prioritisation of resources
- Designing to BREEAM excellent as a minimum standard in all of our new buildings in the major capital programme, together with the requirement for them to be developed on the circular economy principles
- Investing in a range of building and facilities which are designed with sustainability at their heart, will reduce our carbon footprint and achieve BREEAM Excellent. These include:
    - major refurbishment and infrastructure upgrade at Welsh Blood Service Head Quarters in 2022/2024
    - construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
    - construction of a new Velindre Cancer Centre by 2025

- Work with contractors to take a whiole life cycle costing approach to all major capital projects, building refurbishments and new buildings

Theme 2: Healthy buildings and healthier people

Our Objectives are to:

- Provide buildings and places that help improve the health and well-being of patients, donors and staff
- Use our buildings as a resource to support improved health and well-being within the local communities we serve
- Raise awareness, and promote the benefits of natural capital for physical and mental health and well-being amongst our staff, patients and donors

We will achieve this by:

- Integrating formal carbon reduction and sustainability requirements into project briefs, tender documents and contracts to ensure that our current and future estate is refurbished, designed and constructed to have a low carbon impact
- Designing our buildings to promote sustainable behaviours and to be adaptable and resilient against climate change, supporting our journey towards low carbon patient and donor pathways. This will include:
    - Providing staff, patients and donors with better access to amenities, with all having access to rest areas, food and beverages and outdoor spaces of curiosity and enjoyment
    - Creating flexible working spaces that allow individual control of lighting and environmental conditions to promote multifunction use of space that may be tailored to meet individual requirements
    - Prioritising access to natural light, ventilation, greenspace and active travel infrastructure in the refurbishment and development of the Trust estate
    - Focussing on interior and exterior design to include selection of materials that soften the internal space and make the setting pleasant to work in
    - Maximising the opportunity to redesign our buildings and workspaces to offer more flexible working through the use of digital technology

- Working with our staff, local communities, the voluntary sector and business to identify how we can make our land, buildings and facilities work better for people to support health and well-being. This will include:
    - plans which creates green spaces that people can use to find calm in their busy day such as repurposing unused areas of roof space and walls and increasing bio-diversity
    - use of our estate daily for activities which create joy such as walking, gardening schemes, bee-keeping, local food growing
    - creating space to provide the potential for food growing schemes

Theme 3: Minimising our impact

Our objectives are to:

- Reduce our use of energy to run the estate by (being finalised %)
- Reduce our operational carbon emissions by 100%
- Develop a multi-skilled and knowledgeable workforce to support the transformation of our estate

We will achieve this by:

- Improving our monitoring, management of energy used to run the estate through the introduction of SMART technology and the Internet of Things
- Implementing our decarbonisation plan to reduce and eradicate carbon from the estate
- Establishing an ambitious programme of carbon, energy and finite resource reduction projects to drive down use of energy and transition to 100% renewables including:
    - Improving our metering and monitoring of energy across our estate
    - Responding quickly to any preventable energy inefficiency such as overheating or leaks through effective monitoring and leak detection systems
    - retrofit our existing buildings to improve efficient use of energy
    - Improving the utilisation of clinical space to improve efficiency and maximise the use of our assets for excellent clinical care, experience and outcomes
    - Improving the efficiency and productivity of our long-term assets through disposal and rationalisation in accordance with the hub and clinical models of the Welsh Blood and Velindre Cancer Services
    - Reviewing the potential for reducing the new for the current Headquarters building
    - upgrading our existing buildings, plant and equipment to reduce consumption and use energy more efficiently
    - greening our estates procurement activities and decarbonising our supply chain
    - specifying renewable energy when we enter into new purchasing arrangements for electricity reduction and lifecycle costing
- Seeking ways to improve the air quality at our sites
- Developing an education and action programme to promote sustainable behaviours amongst our staff and people who use our buildings
- Developing useful information for our staff, patients, donors and partners which can support behaviour changes that reduce our energy consumption
- Working with staff to Implement our agile working policy to reduce the need for staff travel and use of buildings
- Identifying opportunities for sharing facilities with partner organisations to reduce our collective estates footprint
- Develop a workforce which has the skills and competence to support a green and sustainable estate.

Theme 4: Using our estate to deliver the maximum benefit and social value to the community

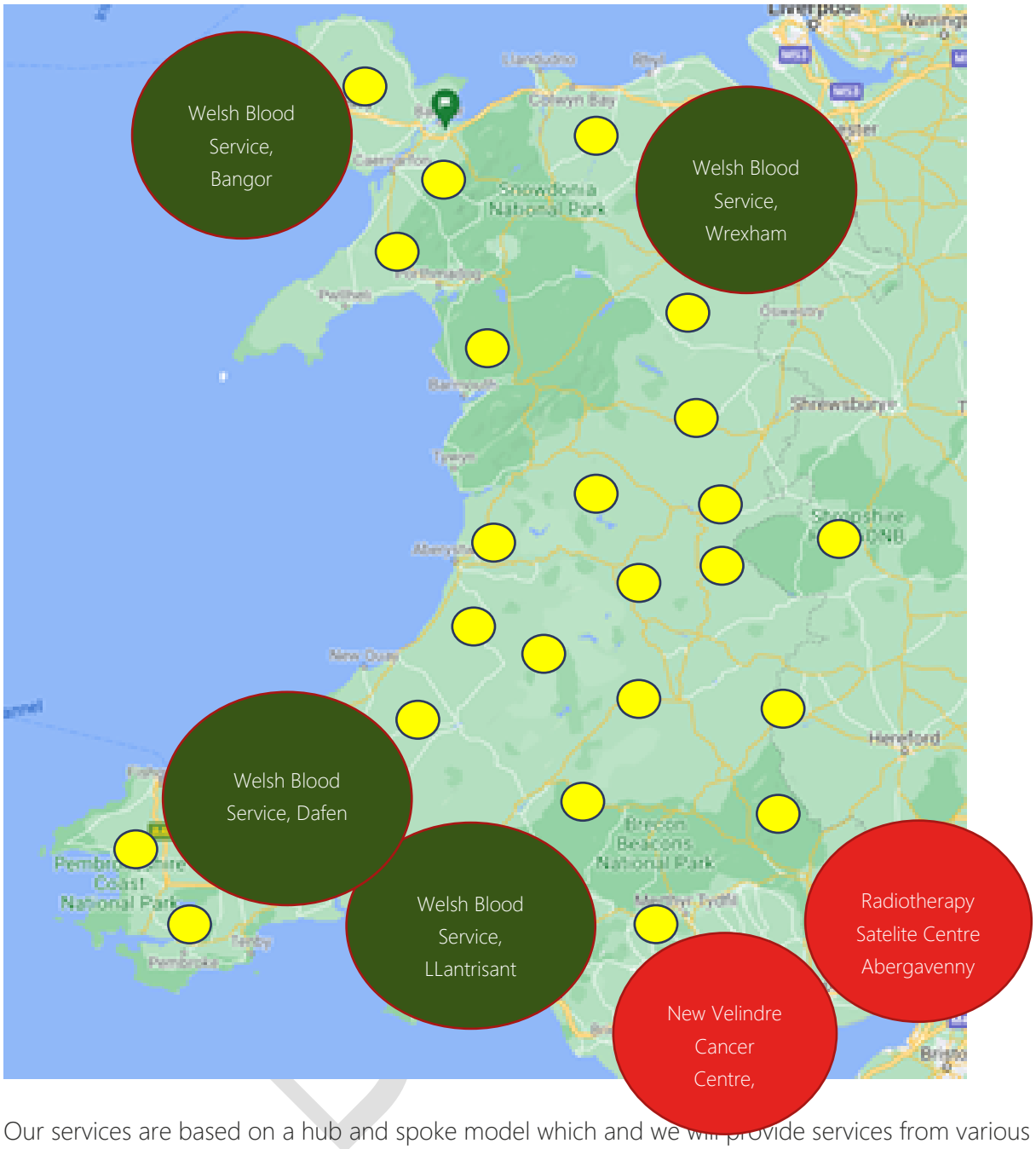
Our objectives are to:

- Use our buildings and facilities as community assets to increase the value our local communities can generate from our services
- Use our estate to help reduce inequalities in Wales and maximise the benefit to people, local communities and Wales

We will achieve this by:

- Working collaboratively with community partners to maximise the use of our buildings and grounds for the people we serve. We will:
    - engage with stakeholders to plan and deliver buildings and facilities across Wales which are strategically connected to our partners plans to maximise the improve access to services
    - Identify opportunities to share buildings and assets with partners to make it easier for people to meet their needs in 'one stop'
- Developing training, work placements, apprenticeships and employment opportunities for local people, learners and students.
- Seeking to re-use, re-purpose and bring back to life buildings is local communities which support community resilience
- Working with partners and the local community to identify ways in which local groups can use our buildings and estates as a community resource to generate health, wealth, prosperity and joy locally. For example, use of our facilities for local schools, charity group meetings, film screenings or arts programmes
- Identifying a range of offers we could make across our estate which makes a difference locally such as the provision of broadband Wi-Fi in the local buildings we use which can be routinely used by the community
- Sourcing and procuring goods and services to run the estate locally where possible to increase wealth and prosperity

What will our estate look like in 2032 ?



Our services are based on a hub and spoke model which and we will provide services from various buildings across Wales some owned by us and some by a wide range of partners.

Key

- Blood and Transplant Service buildings owned by the Trust
- Cancer Service buildings owned by the Trust
- Illustration of the multiple venues across Wales we will collect blood and blood products from

Measuring Our Success

A safe high quality estate which provides a great environment for visitors and staff	• Annual backlog maintenance • % Planned preventative maintenance undertaken on time • % of estate Cat B standard • BREEAM excellent buildings • Compliance with statutory requirements • Security incidents • Accidents/incidents/near misses
Health Buildings, Healthy People	• % patients and donors rating the environment as excellent • % of staff rating their working environment as excellent • Compliance with equality, diversity and disability legislation
An efficient estate which minimises the Trusts energy use and carbon footprint	• Annual EFPMS return • % utilisation of the estate • CO2 emissions • Overall carbon footprint of the estate • Water consumption • Energy consumption • Gas consumption • % of energy from renewable sources • % of waste reduction overall • % of waste to landfill • Overall waste created (i). % recycled (ii). % landfilled • Operating costs as % of budget • % staff awareness of sustainability activities across the Trust

Using our estate to deliver the maximum benefit and social value to the community	• % of building assets available for use by local community stakeholders (i) % availability to local community utilised • % biodiversity net gain on estate • % staff travelling to work by (i). walking (ii) bike (iii). public transport (iv) car (v). single occupancy car journeys

STRATEGIC DEVELOPMENT COMMITTEE

PERFORMANCE MANAGEMENT FRAMEWORK (PMF)

PROPOSED NEW FORMAT PMF REPORTING STRUCTURE

DATE OF MEETING	16/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Draft Status - Final Version will be Published in Public Domain

PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT	9 March 2022	**ENDORSED**
VCC SLT	22 March 2022	**ENDORSED**
PMF Project Group	5 April 2022	**ENDORSED**
South Glam Community Heath Council	26 April 2022	**DISCUSSED**
Executive Management Board	9 May 2022	**ENDORSED**

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee

EMB	Executive Management Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
IMTP	Integrated Medium Term Plan
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts

1. SITUATION AND BACKGROUND

1.1 The Welsh Government's publication 'A Healthier Future for Wales' (2018 to 2030), signaled the introduction of quality statements as part of the enhanced focus on quality in healthcare delivery. In May 2021, the Strategic Development Committee approved the plan for a phased approach to the development of an improved Trust-wide performance management methodology and reporting framework.

1.2 The Performance Management Framework (PMF) Project Group was established, with representation from WBS, VCC and Support Services functions, to explore alternative dashboard reporting styles and methodologies, in order to improve both the presentation of management information and to better understand variations in performance.

1.3 Due to operational pressures, caused by the resurgence of COVID-19 pandemic infections during 2021, the work of the PMF Project Group has not progressed as quickly as planned. However, this paper now contains proposals for a new style of performance reporting, based on a hierarchy of PMF Scorecards, mainly using existing Key Performance Indicators (KPIs), supported by enhanced data analysis.

1.4 This paper describes the process and timescales for completing Phase 1 of the PMF Development Project. Phase 2 will then continue to develop the range of our KPI metrics, looking to automate collection as far as possible, as well as exploring opportunities to benchmark against comparable organisations.

1.5 The Scorecards, KPIs and Data Analysis Templates proposed have been considered and endorsed by both VCC and WBS SLTs held in March, the PMF Project Group on 5th April and 10th May and the Executive Management Board on 9th May 2022

1.6 This report also describes, under 2.27, how the new style PMF Performance Report structure will evolve further, during 2022/23, in consultation with VCC, WBS service leads and further engagement with Independent Members and local CHC representatives.

2. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Integrated Medium Term Plan (IMTP) for 2022/25, approved by the Trust Board on 31 March 2022, focuses on the future, and how our strategic goals will be achieved over the next three years, whilst the PMF concentrates on how well services are performing and being delivered for patients and donors today. However, the PMF also includes measures demonstrating how well we have made progress towards our strategic ambitions.

2.2 The development of the proposed new Performance Management Framework for the Trust has drawn upon best practice principles, and seeks to address a number of issues previously identified, in discussion with Independent Members and CHC representatives, relating to our current performance reports.

2.3 In particular, the proposed PMF seeks to introduce the following improvements:

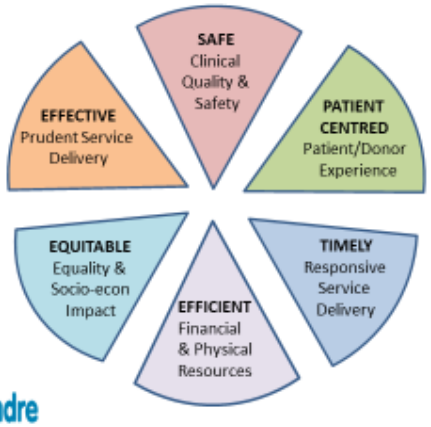
- **Better ownership of KPIs** – developing appropriate reporting hierarchies for strategic, tactical and operational measures so we are reporting the right things at the right level
- **Wider range of KPIs** – enhancing patient and donor outcome measures, facilitating triangulation across KPIs, to better understand the relationship between cause and effect from input > throughput > output > outcome.
- **Stronger linkage with IMTP Strategic Goals** – including PMF measures demonstrating how we have made progress towards our strategic ambitions
- **Exception Reporting** – developing robust assurance protocols and parameters, to escalate matters of concern, that Independent Members and the Executive Team can place reliance upon
- **Performance against Targets** – looking to gain a better understanding of current performance and future trends and the difference between immediate v. long-term actions to address any issues
- **Business Information and Data Quality** – recognizing the need to automate as far as possible the collection and presentation of performance data and balancing the cost v. benefit of producing the information
- **Enhanced narrative and explanation** – improving the supporting information and more insightful analysis of performance to understand why something is happening, and what we are doing about it.
- **More accessible language** – addressing the challenge of presenting in public documents, what can be quite often be complex issues, in a language that is both understandable and clinically robust.

However, we recognize that not all the above areas will be fully addressed straight away, and that the proposed PMF model will continue to be enhanced and will evolve through 2022/23 and beyond.

2.4 Proposed PMF Scorecard Reporting Structure

As part of the Welsh Government's focus on healthcare quality, safety and the patient and donor experience, a Quality and Safety Framework (QSF) was introduced, covering 'six QSF domains' of safe, effective, patient/donor experience, timely, efficient and equitable care, illustrated by **Figure 1** below.

Figure 1: The Quality Safety Framework



Canolfan Ganser Felindre Velindre Cancer Centre

Welsh Blood Service

2.5 A number of alternative 'dashboard or scorecard' formats were considered e.g. the classic four quadrant 'balanced scorecard' (Performance & Delivery, Safety & Quality, People & Wellbeing and Finance & Resources). However, on balance the QSF format above, was considered to be the most appropriate basis for the new VUNHST Performance Management Framework (PMF) reporting structure. This format has been supported by the VCC and WBS Senior Leadership Teams and agreed at the PMF Project Group.

2.6 The QSF scorecard structures proposed for the Trust Board, Quality Safety and Performance (QSP) Committee, Executive Management Board (EMB) and VCC and WBS Senior Leadership Teams (SLT) are all based on the 'six QSF domains' and populated with appropriate KPIs to ensure consistency throughout the different levels of the organization.

2.7 PMF scorecards have also been developed for Support Services, including Estates, Health & Safety, Digital, Workforce and Finance (as a single scorecard or separated).The Support Services scorecards incorporate KPIs that provide a 'snapshot' across the whole Trust. For example, energy consumption is shown for the Trust, VCC and WBS divisions and HQ, however, divisional energy consumption is also included within VCC and WBS scorecards in line with delegated budgetary control arrangements.

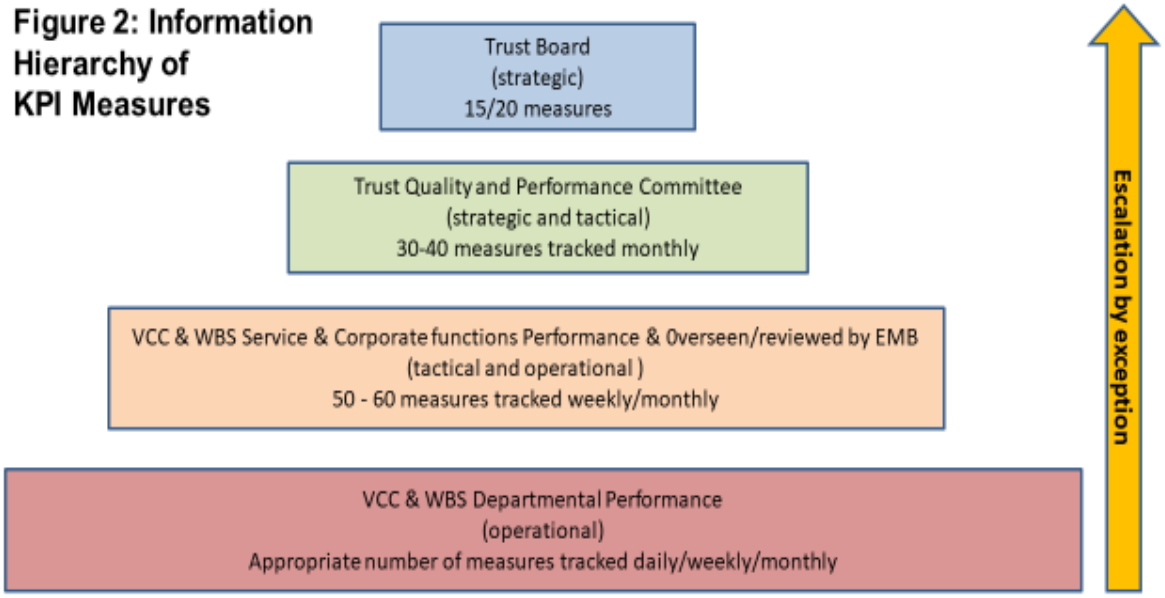
2.8 The PMF Scorecards recommended for the Trust Board, QSP Committee, EMB and VCC & WBS SLTs and Support Services (consolidated and separated formats) are given in **Appendix 1.**

2.9 Proposed PMF Reporting Hierarchies

The recommended 'balanced scorecard' or 'dashboard' PMF approach seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources. However, the information needs at the Trust Board level (strategic) will be very different from those at the VCC and WBS Divisional and Department levels (operational).

2.10 Therefore, a hierarchical structure is proposed, illustrated by **Figure 2** below, to provide a 'pyramid' of performance measures and metrics. This structure enables more detailed operational measures to be used to manage performance at the divisional or departmental level, to feed more appropriate, higher level strategic indicators at the Committee and Trust Board level.

Figure 2: Information Hierarchy of KPI Measures



2.11 This hierarchical scorecard structure will result in more manageable volumes and focused analysis of performance data for Committees and Trust Board, allowing a better understanding of the cause and effect of actions and service changes. The parameters for escalation through the hierarchy, and reporting matters by exception to Trust Board, are being developed.

2.12 The hierarchical approach proposed relies upon the Trust Board taking assurance from the detailed performance review and challenge carried out by the QSP Committee, Executive Management Board and Divisional (VCC & WBS) SLT/SMTs, and having necessary confidence that any matters of significant concern will be reported by exception to the Trust Board.

2.13 Trust-wide PMF (organizational level) and VCC and WBS PMF (service level) Scorecard reporting structures have been developed and discussed with Divisions and

Trust-wide functions and are again reflected by the Trust Board, QSP Committee, EMB and VCC & WBS SLTs and Corporate Services scorecards given in **Appendix 1.**

2.14 It should be noted that a number of key KPIs, relating to quality and safe service delivery, patient/donor experience, workforce wellbeing and financial balance, feature in all Scorecard levels from VCC & WBS SLTs to Trust Board, as discussed in the following section.

2.15 Proposed Key Performance Indicators (KPIs)

Many of the existing range of KPI measures reported throughout the Trust are statutory or 'Tier 1' reporting requirements mandated by Welsh Government, and must be included in any new style PMF performance reporting structures. This is particularly the case with cancer services e.g. radiotherapy and SACT waiting times. However, this is not the case for blood services which rely upon key measures based upon recognized standards of best practice.

2.16 Similarly, Trust-wide or Support Services functions have a range of mandatory performance reporting measures in the areas of workforce e.g. staff sickness and mandatory training, health and safety e.g. RIDDOR reportable events and finance e.g. financial returns and agency spending.

2.17 Therefore, the KPIs that populate the hierarchy of scorecards, for the VCC and WBS divisions and Support Services, have built upon our current range of performance measures (which remain in the majority), retaining statutory measures as required and recommending enhancements.

2.18 The greatest proposed KPI change relates to WBS services. The division has sought to enhance the current range of indicators, taking note of metrics used by the NHS England Blood and Transplant Service and in response have developed some revised and/or additional measures. The proposed revisions to the range of VCC and WBS KPIs and the rationale supporting any KPIs that are 'new, changed or retired', is provided in **Appendix 2.** This table will be maintained as an 'audit log', and will record any further approved KPI changes.

2.19 Support Services have also proposed an enhanced the range of KPIs for reporting to Trust Board, in particular, estates, health & safety, digital and sustainability. In addition, a number of new Ministerial measures have been announced for 2022/23, around staff wellbeing, bank and agency spending, decarbonisation.

2.20 Each QSF domain in the PMF scorecards is populated with Key Performance Indicators (KPIs) plus a range of KPIs for Support Service functions. Performance against individual KPIs is no longer 'RAG rated' in the traditional way. Performance is now assessed as either 'within standard' ✓ or 'outside standard' ✘ against any particular target or best practice measure for the current month, plus an assessment of the year to date trend seen , as either 'improving' ↑ or 'stable' → or 'declining' ↓

2.21 The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis. A baseline will also be set for each KPI to reflect our current average performance at the beginning of the financial year.

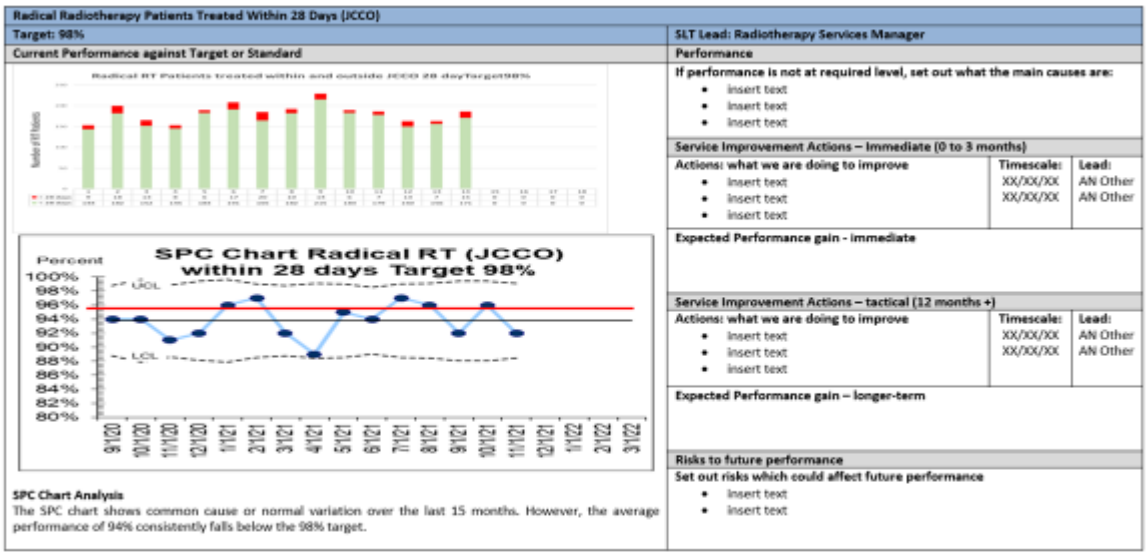
2.22 Each KPI is supported by data that explains the current performance, using wherever possible Statistical Process Control (SPC) Charts to enable the distinction to be made between 'natural variations' in activity, and 'special cause' trends or performance requiring investigation, The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

2.23 Proposed KPI Supporting Data Templates and SPC Charts

Operational decisions made based on traditional 'run charts' and RAG rated performance data, (where there is limited understanding of the 'process' and its variation), can result in trends being identified where no trend exists, and the natural variations in the data being interpreted as special events leading to incorrect or wasteful management actions.

2.24 Therefore, the proposed KPI Supporting Data Templates incorporate wherever possible, Statistical Process Control (SPC) charts to help understand what is 'different' and what 'is the norm'. By using these charts, we can then understand where the focus of work needs to be concentrated to make a difference, illustrated by **Figure 3.**

Figure 3: KPI Template Radiotherapy



2.25 Examples of the KPI Supporting Data Templates are given in **Appendix 3.** The Templates follow a consistent format, providing analysis of in month and year to date performance against target, with supporting narrative to explain the underlying reasons for any 'special cause' variations or trends, proposed remedial actions and associated risks to delivery and will help in the escalation/exception reporting process.

2.26 The target performance level or threshold set by individual KPIs is represented on the SPC charts by the straight red line. It should be noted that certain thresholds should be achieved or exceeded e.g. 98% RT patients received treatment within 28 days, whilst other threshold target should not be exceeded e.g. staff sickness at 3.54% or blood platelet wastage no greater than 10%.

2.27 PMF Project Plan for 2022/23 – 'Go Live' and Future PMF Development
The Strategic Development Committee is asked to discuss and endorse the Scorecard structures, revised KPIs and Data Templates developed in this report, for presentation to the June Trust Board Development meeting.

2.28 It is further proposed, subject to SDC approval and Trust Board Development discussions, to 'go live' with the new style PMF performance reports for the reporting cycle to the Trust Board to be held on 29th September 2022, as shown below:

Meeting	Date
Strategic Development Committee – discussion	16th May 2022
Trust Board Development Session – discussion and orientation	28th June 2022
EMB Shape – trial run of new approach	18th July 2022
EMB Shape – approval	15th August 2022
EMB Run – receive first set of PMF reports in new format	1st September 2022
Quality Safety & Performance Committee – receive first PMF reports in new format	15th September 2022
Trust Board – receive first PMF reports in new format	29th September 2022

2.29 This timescale will allow time to refine a number of targets, finalize the measurement basis for some KPIs and for further engagement with our Independent Members and local CHC representatives on the new style PMF Performance Report.

2.30 During 2022/23, the PMF Development Project Group will look to evaluate potential BI solutions that automate KPI collection, analysis and reporting, agree escalation parameters for exception reporting and approach potential benchmarking partners for both tertiary cancer services and blood services.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
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)
	VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

4. RECOMMENDATIONS

4.1 The Strategic Development Committee is asked to:

- discuss the paper.
- support the direction of travel.
- note the remaining activities and timeline to complete Phase 1.

APPENDIX 1

Proposed Scorecards for Trust Board, EMB, and VCC, WBS Divisions & Support Services

Trust Board Scorecard (based on Six Quality Safety Framework QSF domains)

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	85%	85%	86%	✓	➔	KPC.19
	Number of Serious Untoward Incidents recorded and investigated with negative outcome	Local	Monthly		TBA		✓	➔	KPV.29
	Number of Staff RIDDOR Incidents, injuries and work-related accidents	Local	Monthly	5	0	0	✓	➔	KPC.13
	Number of Never Events (definition specific to cancer services)	Local	Monthly	0	0	0	✓	➔	KPV.30
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp. bacteraemia	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	➔	KPV.04
	Antibiotic usage within the WHO Access category of total antibiotic consumption	National	Monthly	0	≥55%	0	✓	➔	KPV.04
	Compliance with the principles of 'Start Smart then Focus'.	National	Monthly	0	TBA	0	✓	➔	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	Local	Monthly	4	0	0	✓	➔	KPV.01
	Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines Healthcare products Regulation Agency (MHRA)	Local	Monthly	1	0	0	✓	➔	KPI.30
	% carbon emissions	National	Quarterly		-16%		✓	➔	KPC.06

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	SACT 30 Day Mortality –Professional NHS Standard	Prof. Std.	Quarterly		TBA		✓	➔	KPV.06
	Patient Reported Outcome Measures (PROMS)	Local	Quarterly		TBA		✓	➔	KPV.08
	Research published with actual impact on service	Local	Quarterly		TBA		✓	➔	KPV.09
	Number of Health and Care Research Wales portfolio & commercially sponsored studies	Local	Annually		TBA		✓	➔	KPV.31
	Number of patients recruited to Health and Care Research Wales research portfolio & commercially sponsored studies	Local	Annually		TBA		✓	➔	KPV.33
	Red Blood Cell % of hospital demand met for manufactured bags with no imported blood required – best practice/benchmark	Best practice	Monthly	112%	100%	111%	✓	➔	KPI.04
	Time expired adult Red Blood Cell bags as % of total RBC bags manufactured in month	Local	Monthly	0.10%	Max 1%	0.05%	✓	➔	KPI.26
	Time expired adult Platelet bags as % of total platelets manufactured in month	Local	Monthly	12%	Max 10%	15%	✗	➔	KPI.25
	WBMDR Number of Stem Cell transplants supported 80 per annum	National	Monthly	50	70	39	✗	➔	KPI.13
	% Staff sickness levels 12 month reduction trend measured against rolling average target	National	Monthly	5.5%	3.54%	5.66%	✗	➔	KPC.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors	National	Monthly	65%	85%	69%	✗	➔	KPC.36
	Delivering wider social value (Sustainable Development Assessment Tool (SDAT)	Local	Quarterly		TBA		✓	➔	KPC.25

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as excellent	Local	Monthly	70%	80%		✓	→	KPV.11
	% of Donors Who Rate Experience at WBS as excellent	Local	Monthly	95%	90%	96%	✓	→	KPI.09
	Number VCC formal complaints received under Putting Things Right within 30 days	Local	Monthly		TBA		✓	→	KPV.12
	% WBS 'formal' concerns that have received a final reply within 30 working days under Regulation 24 'Putting Things Right	Local	Monthly	90%	90%	88%	✗	→	KPI.11
	% staff who rate us as a good employer in Annual Staff Survey	National	Annually		Annual Improv e		✓	→	KPV.13
Timeliness	%Patients Radiotherapy treatment JCCO Radical within 28 days	National	Monthly	94%	98%	92%	✗	→	KPV.14
	Palliative within 14 days	National	Monthly	98%	98%	98%	✓	→	KPV.15
	Emergency within 2 days	National	Monthly	100%	98%	100%	✓	→	KPV.16
	% Patients Begin SACT Non-Emergency within 21 days	National	Monthly	95%	98%	94%	✗	↑	KPV.20
	Emergency within 2 days	National	Monthly	100%	100%	100%	✓	↑	KPV.21
	% of Routine Antenatal Patient testing results provided to hospitals within 3 working days – Best practice/benchmark	Best practice	Monthly	90%	90%	92%	✓	→	KPI.17
	H & I turnaround service response times from sample receipt to reporting within 5 working days – Best practice/benchmark	Best practice	Quarterly	90%	90%		✓	→	KPI.21
	Donor Appointments Percentage of on the day or pre planned session donor deferrals	Local	Monthly	15%	Max 10%		✓	→	KPI.07

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	Financial Balance – % achievement of forecast in line with revenue expenditure profile to achieve financial balance	National	Monthly	0%	0%	0%	✓	➔	KPC.71
	% achievement of capital expenditure in line with forecast profile to achieve annual Cash Resource Limit	National	Monthly	£10.1m	£10.1m	£10.1m	✓	➔	KPC.73
	Overtime Bank and Agency staff % of overall workforce pay bill, taken from Financial Monitoring Returns	National	Monthly		Annual reduced	Annual reduced	✓	➔	KPC.72
	Cost Improvement Programme: % achievement of annual forecast in line with savings profile	National	Monthly	£1.1m	£1.1m	£1.1m	✓	➔	KPC.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	93%	✗	➔	KPC.60
	Energy: gas consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	➔	KPC.62
	Energy: electric consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	➔	KPC.63
	Delivery of IMTP 2022/23 Quarterly Action plans % of actions implemented	Local	Quarterly	100%	100%	100%	✓	➔	KPC.70
Equitable	% Welsh Speakers in Trust	National	Quarterly		TBA		✓	➔	KPC.81
	Diversity of Workforce (Gender) - % females in workforce - % females in senior leadership/Board roles - Gender Pay differentials	Local	Quarterly		TBA		✓	➔	KPC.78
	Diversity of Workforce (ethnicity) - % BME in workforce - % black ethnic minority staff in senior leadership & Board roles	Local	Quarterly		TBA		✓	➔	KPC.79
	Diversity of Workforce (disability) - % registered disabled in workforce	Local	Quarterly		TBA		✓	➔	KPC.80
	Equity agreed measures to be developed proxy Equality Impact Assessments	Local	Quarterly		TBA		✓	➔	KPC.77

Symbols Key: In Month Performance = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓

Cancer Services Scorecard

QSF Domain	Cancer Services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	Local	Monthly		0	0	✓	→	KPV.01
	Number of VCC Inpatient Falls per month Target 0 Avoidable	Local	Monthly		0	2	✗	→	KPV.02
	% Sepsis NEWS score >or= 3 receiving all 6 elements within 1 hour – Professional NHS Standard	Prof. Std.	Monthly		100%	100%	✓	→	KPV.03
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly		0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly		0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa	National	Monthly		0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp.	National	Monthly		0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly		0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly		0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly		0	0	✓	→	KPV.04
	Antibiotic usage within the WHO Access category of total antibiotic consumption	National	Monthly		≥55%	0	✓	→	KPV.04
	Compliance with the principles of 'Start Smart then Focus'.	National	Monthly		TBA	0	✓	→	KPV.04
	Serious Untoward Incidents recorded and investigated with a negative outcome ***	Local	Monthly		0		✓	→	KPV.29
	Number of Never Events (definition specific to cancer services) ***	Local	Monthly		0	0	✓	→	KPV.30
	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competences ***	National	Monthly		85%	85%	✓	↑	KPC.19
	Number of Staff RIDDOR Incidents, injuries and work-related accidents ***	Local	Monthly		0		✗	→	KPC.13
	% staff compliant Level 1 (Essential) Fire Safety, Manual Handling, Violence & Aggression & Mental Health training ***	Local	Quarterly		95%		✗	→	KPC.04

	% of fire drills completed in accordance with schedule ***	Local	Quarterly		TBA		✓	→	KPC.17
	% actions implemented of fire action plan number completed ***	Local	Monthly		TBA		✓	→	KPC.15
	% carbon emissions	National	Quarterly		16% reduction		✓	→	KPC.07
	% of Asbestos risk assessments completed against plan ***	Local	Quarterly		TBA		✓	→	KPC.08
	% of legionella risk assessments completed against plan ***	Local	Quarterly		TBA		✓	→	KPC.09
	Digital Infrastructure total major incidents logged per month ***	Local	Monthly		0		✓	→	KPC.21
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in Corporate Services Scorecard									

QSF Domain	Cancer Services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly		0	1	✓	→	KPV.05
	SACT 30 Day Mortality – Professional NHS Standard	Prof. Std.	Quarterly		TBA		✓	→	KPV.06
	NICE Guidance compliance with relevant standards – Professional NHS Standard	Prof. Std.	Quarterly		TBA		✓	→	KPV.07
	Patient Reported Outcome Measures (PROMS) – Professional NHS Standard	Prof. Std.	Quarterly		TBA		✓	→	KPV.08
	Research published with actual impact on service	Local	Quarterly		TBA		✓	→	KPV.09
	Number of Health and Care Research Wales portfolio studies	Local	Annually		TBA		✓	→	KPV.31
	Number of Health and Care Research Wales commercially sponsored studies	Local	Annually		TBA		✓	→	KPV.32
	Number of patients recruited to Health and Care Research Wales research portfolio studies	Local	Annually		TBA		✓	→	KPV.33
	Number of patients recruited to Health and Care Research Wales commercially sponsored studies	Local	Annually		TBA		✓	→	KPV.34

	Number of lead investigators	**Local**	**Quarterly**		**TBA**		✓	➔	KPV.10
	% staff overall compliance with Level 1 (Essential) Fire safety training	**Local**	**Monthly**		**85%**		✓	➔	KPC.26
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors ***	**National**	**Monthly**		**85%**	**65%**	✗	➔	KPC.36
	% Staff sickness levels 12 month reduction trend – measured against rolling average ***	**National**	**Monthly**		**3.54%**	**5.58%**	✗	➘	KPC.37
	% Medical Appraisal & successful Revalidation, recorded on MARS system – Professional NHS Standard***	**Prof. Std.**	**Monthly**		**100%**		✗	➔	KPC.35
	Sustainable Development Assessment Tool (SDAT) ***	**Local**	**Annually**		**TBA**		✓	➔	KPC.25
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘ **(***) KPIs also appear in Corporate Services Scorecard**									

QSF Domain	**Cancer Services Scorecard**			**Performance as at Month 10 (Jan)**			**Compliance against Target or Standard**		**Data Link**
	KPI Measure	**Target**	**Reported**	**Baseline**	**Target**	**Actual**	**In Month Position**	**Year to date trend**	
Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as excellent (PREMS) – Professional NHS Standard	**Prof. Std.**	**Monthly**		**80%**		✓	➔	KPV.11
	% of 'formal' concerns received and treated within 30 working days	**Local**	**Monthly**		**TBA**		✓	➔	KPV.12
	% staff who rate VCC as a good employer in Annual Staff Survey	**National**	**Annually**		**TBA**		✓	➔	KPV.13
	% Staff Grievances upheld of total headcount & resolved ***	**Local**	**Annually**		**TBA**		✓	➔	KPC.50
	Staff health & Well-being – % staff reporting positive interest shown by line manager in health & wellbeing NHS staff Survey***	**National**	**Annually**		**Annual Improve**		✓	➔	KPC.48
	Overall staff engagement NHS Staff Survey score***	**National**	**Annually**		**TBA**		✓	➔	KPC.49
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘ **(***) KPIs also appear in Corporate Services Scorecard**									

QSF Domain	Cancer Services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	Patients Begin Radical Radiotherapy Within 28 days (JCCO)	National	Monthly		98%	92%	✗	➔	KPV.14
	Patients Begin Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly		98%	98%	✗	➔	KPV.15
	Patients Begin Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly		98%	100%	✗	➔	KPV.16
	Scheduled Patients beginning RT within 21 days (COSC reported internally only)	TBA	Monthly		80%	34%	✗	➔	KPV.17
	Urgent Scheduled Patients begin RT within 7 days (COSC reported internally only)	TBA	Monthly		80%	37%	✗	➔	KPV.18
	Emergency Patients beginning RT within 1 day (COSC reported internally only)	TBA	Monthly		100%	90%	✗	➔	KPV.19
	Patients Beginning Non-Emergency SACT within 21 days	National	Monthly		98%	94%	✓	➔	KPV.20
	Patients Beginning Emergency SACT within 2 days	National	Monthly		100%	100%	✗	➔	KPV.21
	Outpatient Appointments seen within 30 minutes of the scheduled times	Local	Monthly		100%	paused	✗	➔	KPV.22
	Equitable & Timely access to Therapy Services	Local	Monthly		100%	100%	✓	➔	KPV.23
	Estates % planned preventative maintenance completed 95%	Local	Monthly		95%		✗	➔	KPC.52
	Digital % requests responded to within agreed timescale	Local	Monthly		TBA		✓	➔	KPC.58
	Incidents of violence and aggression open greater than 30 days ***	Local	Monthly		TBA		✓	➔	KPC.55
	% of COSHH assessments completed in agreed timescales ***	Local	Monthly		TBA		✓	➔	KPC.56
	% of Site visits completed on time against HSG65 schedule ***	Local	Monthly		TBA		✓	➔	KPC.57

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➔ stable ➔ deteriorating ➔
(***) KPIs also appear in Corporate Services Scorecard

QSF Domain	Cancer Services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	Outpatient Did not attend (DNA) rates	National	Monthly		5%	3%	✓	➔	KPV.24
	Value-based Healthcare embedded in strategic plans and decisions – Professional NHS Standard	Prof. Std.	Monthly		Evidence		✓	➔	KPV.25
	Electricity performance consumption -3% on 2020/21 ***	National	Annual reduction		-3%		✓	➔	KPC.63
	Gas performance consumption -3% on 2020/21 ***	National	Annual reduction		-3%		✓	➔	KPC.62
	Water performance consumption on 2020/21 ***	Local	Annual reduction		TBA		✓	➔	KPC.64
	Waste Recycling performance consumption on 2020/21 ***	Local	Annual		TBA		✓	➔	KPC.65
	Landfill performance consumption on 2020/21 ***	Local	Annual		TBA		✓	➔	KPC.66
	Delivery of IMTP 2022/23 VCC Quarterly Action plans - % of actions implemented	Local	Quarterly		100%		✓	➔	KPC.70
	Financial Balance % achievement of VCC forecast in line with revenue expenditure profile to achieve financial balance ***	National	Monthly		0	0	✓	➔	KPC.71
	Overtime VCC Bank and Agency staff % of overall workforce pay bill, taken from Financial Monitoring Returns ***	National	Annual		Annual Reduce	Annual Reduce	✓	➔	KPC.72
	% achievement of VCC capital schemes in line with forecast profile to achieve annual Cash Resource Limits ***	National	Monthly		7.2m	7.2m	✓	➔	KPC.73
	Cost Improvement Programme: % achievement of annual forecast in line with VCC savings profile ***	National	Monthly		413	413	✓	➔	KPC.74
	Digital Cyber Security % of employees clicking on internal phishing campaigns / exercises ***	Local	Quarterly		TBA		✓	➔	KPC.69

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➔ stable ➔ deteriorating ➔
(***) KPIs also appear in Corporate Services Scorecard

QSF Domain	Cancer Services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	Equality Impact assessments completed by department	Local	Quarterly		TBA		✗	➔	KPV.26
	Digital awareness/literacy of staff	Local	Quarterly		TBA		✗	➔	KPV.27
	Digital inclusion/access for patients	Local	Quarterly		TBA		✗	➔	KPV.28
	Diversity of Workforce % women in senior leadership positions & roles ***	Local	Quarterly		TBA		✗	➔	KPC.78
	Diversity of Workforce % BAME in senior leadership roles ***	Local	Quarterly		TBA		✗	➔	KPC.79
	Diversity of Workforce % registered disabled ***	Local	Quarterly				✗	➔	KPC.80
	% Welsh Speakers in Trust ***	National	Quarterly		TBA		✗	➔	KPC.81
	Foundation Economy – delivery across health & social care initiatives	National	Quarterly		Evidence		✗	➔	KPC.76

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘
(***) KPIs also appear in Corporate Services Scorecard

Blood and Transplant Scorecard

QSF Domain	Blood and Transplant Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	Number of Health & Safety Incidents recorded	Local	Monthly		0		✓	→	KPI.01
	Health & Safety Incidents responded to within agreed response times	Local	Monthly		95%	100%	✓	→	KPI.02
	H&S Requests responded to within agreed response times	Local	Monthly		95%	100%	✓	→	KPI.03
	Total number of Quality Incidents reported	Local	Monthly		TBA		✓	→	KPI.27
	Total number of incidents due for closure within the reporting period (month) that were not closed on time	Local	Monthly		95%	100%	✓	→	KPI.28
	Total number of overdue incidents that remain open at the end of the reporting period	Local	Monthly		0	0	✓	→	KPI.29
	Total number of serious incidents reported to regulators in the reporting period	Local	Monthly		0	0	✓	→	KPI.30
	% Audits completed as scheduled in the reporting period	Local	Monthly		100%		✓	→	KPI.31
	Total number of Critical/Significant Audit observations within the reporting period – Best practice/benchmark	Best practice	Monthly		0	0	✓	→	KPI.32
	Major/ Critical/Significant findings from External Audits in the reporting period – Best practice/benchmark	Best practice	Monthly		0	0	✓	→	KPI.33
	Serious Untoward Incidents recorded and investigated with a negative outcome ***	Local	Monthly		0	0	✓	→	KPI.39
	Number of Never Events (definition specific to blood and transplant services) – Best practice/benchmark ***	Best practice	Monthly		0	0	✓	→	KPI.40
	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competences ***	National	Monthly		85%		✓	↑	KPC.19
	Number of Staff RIDDOR Incidents, injuries and work-related accidents ***	Local	Monthly		0	0	✗	→	KPC.13
	% staff compliant with Level 1 (Essential) Fire Safety, Manual Handling, Violence & Aggression & Mental Health training ***	Local	Quarterly		95%		✗	→	KPC.04
	% of fire drills completed in accordance with schedule ***	Local	Quarterly		TBA		✓	→	KPC.17

	% actions implemented of fire action plan number completed ***	Local	Monthly		TBA		✓	➔	KPC.15
	% carbon emissions ***	National	Quarterly		16% reduce		✓	➔	KPC.07
	% of Asbestos risk assessments completed against plan ***	Local	Quarterly		TBA		✓	➔	KPC.08
	% of legionella risk assessments completed against plan ***	Local	Quarterly		TBA		✓	➔	KPC.09
	Digital Infrastructure total major incidents logged	Local	Monthly		TBA		✓	➔	KPC.21
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘ (***) KPIs also appear in Corporate Services Scorecard									

QSF Domain	Blood and Transplant Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	% S&M compliance against target Statutory Training	National	Monthly		85%	94%	✓	➔	KPI.14
	Number of Clinical Audits completed	Local	Monthly		TBA		✓	➔	KPI.15
	New Whole Blood Donors recruited to the donor panel	Local	Quarterly		2750		✓	➔	KPI.
	Demand for red blood cells met and with no 'mutual aid' required. – Best practice/benchmark	Best practice	Monthly		100%	111%	✓	➔	KPI.04
	Number of new Apheresis Donors recruited to the donor panel	Local	Quarterly		14		✓	➔	KPI.
	Number of new bone marrow donors aged 17-30 recruited to the WBMDR) - Just Blood 4000 annual trajectory	National	Monthly		3330	2096	✗	➔	KPI.13
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors***	National	Monthly		85%	84%	✗	➔	KPC.36
	% Staff sickness levels 12 month reduction trend – measured against rolling average target***	National	Monthly		3.54%	6.45%	✗	➘	KPC.37

	Sustainable Development Assessment Tool (SDAT) ***	**Local**	**Annually**		**TBA**		✓	➔	KPC.25
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓ (***) KPIs also appear in Corporate Services Scorecard									

QSF Domain	**Blood and Transplant Scorecard**			**Performance as at Month 10 (Jan)**			**Compliance against Target or Standard**		**Data Link**
	KPI Measure	**Target**	**Reported**	**Baseline**	**Target**	**Actual**	**In Month Position**	**Year to date trend**	
Donor/ Staff Experience	Measure from needle to viable donation (recording failed venipuncture/part bags)	**Best practice**	**Monthly**		**95%**		✓	➔	KPI.07
	% donors that scored being totally satisfied) with their overall donation experience after they have been registered on clinic to donate. Taken via an eSurvey	**Local**	**Monthly**		**93%**	**96%**	✓	➔	KPI.09
	Number of formal concerns	**Local**	**Monthly**		**Annual improve**	**6**	✓	➔	KPI.10
	Number incidents reported per month & closed within 30 days (%)	**Local**	**Monthly**		**90%**	**88%**	✓	➔	KPI.11
	Number of QA incidents reported per month & closed within 30 days (%)	**Local**	**Monthly**		**90%**	**90%**	✓	➔	KPI.12
	% Staff Grievances upheld of total headcount & resolved ***	**Local**	**Annually**		**TBA**		✓	➔	KPC.50
	Staff health & Well-being – % staff reporting positive interest shown by line manager in health & wellbeing NHS staff Survey ***	**National**	**Annually**		**TBA**		✓	➔	KPC.48
	Overall staff engagement – NHS Staff Survey score ***	**National**	**Annually**		**TBA**		✗	➔	KPC.49
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓ (***) KPIs also appear in Corporate Services Scorecard									

QSF Domain	**Blood and Transplant Scorecard**	**Performance as at Month 10 (Jan)**	**Compliance against Target or Standard**	**Data**

	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	Link
Timeliness	% antenatal -d & -c quantitation results provided to customer hospitals within 5 working days – Best practice/benchmark	**Best practice**	**Monthly**		**90%**		✓	➔	KPI.17
	% routine antenatal patient results provided to customer hospitals within 3 working days – Best practice/benchmark	**Best practice**	**Monthly**		**90%**	**92%**	✗	➔	KPI.18
	Annual Stem Cell transplants figure reported against monthly – Best practice/benchmark	**Best practice**	**Monthly**		**No.**		✓	➔	KPI.19
	H & I Service response times from sample receipt to reporting – within **10 days** – Best practice/benchmark	**Best practice**	**Quarterly**		**90%**		✓	➔	KPI.20
	H & I Service response times from sample receipt to reporting – within **5 days** – Best practice/benchmark	**Best practice**	**Quarterly**		**90%**		✓	➔	KPI.21
	Number of RCI samples referred for specialist testing, results available to customer hospitals within 5 working days – Best practice/benchmark	**Best practice**	**Monthly**		**90%**		✓	➔	KPI.22
	Number of discrepant deceased donor HLA types reported to NHSBT-ODT – Best practice/benchmark	**Best practice**	**Quarterly**		**0.5%**		✓	➔	KPI.23
	% deceased donor typing reported within 4 hours – Best practice/benchmark	**Best practice**	**Quarterly**		**80%**		✓	➔	KPI.24
	% of the total number of platelets manufactured (Time Expired Platelets)	**Local**	**Monthly**		**Max 10% month**	**15%**	✓	➔	KPI.25
	Number of red blood cells, excluding pediatric bags, which have time expired, as a % of the total number of red blood cell bags manufactured in the month	**Local**	**Monthly**		**Max 1% month**	**0.05%**	✓	➔	KPI.26
	Incidents of violence and aggression open greater than 30 days ***	**Local**	**Monthly**		**TBA**		✓	➚	KPC.55
	% of COSHH assessments completed on time in agreed timescales ***	**Local**	**Monthly**		**TBA**		✓	➔	KPC.56
	% of Site visits completed on time against HSG65 schedule ***	**Local**	**Monthly**		**TBA**		✓	➚	KPC.57

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘
(***) KPIs also appear in Corporate Services Scorecard

QSF Domain	Blood and Transplant Scorecard	Performance as at Month 10 (Jan)	Compliance against Target or Standard	Data

	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	Link
Efficient	Whole Blood Productivity number of blood components (weighted) collected per Standardised FTE	**Best practice**	**Monthly**		**1.25 WTE**		✓	➔	KPI 0.08
	Electricity performance consumption -3% on 2020/21 ***	**Local**	**Annual reduction**		**-3%**		✓	➔	KPC.63
	Gas performance consumption -3% on 2020/21 ***	**Local**	**Annual reduction**		**-3%**		✓	➔	KPC.62
	Water performance consumption -3% on 2020/21 ***	**Local**	**Annual reduction**		**TBA**		✓	➔	KPC.64
	Waste Recycling performance consumption -3% on 2020/21 ***	**Local**	**Annual improved**		**TBA**		✓	➔	KPC.65
	Landfill performance consumption -3% on 2020/21 ***	**Local**	**Annual improved**		**TBA**		✓	➔	KPC.66
	Delivery of IMTP 2022/23 WBS Quarterly Action plans - % of actions implemented	**Local**	**Quarterly**		**TBA**		✓	➔	KPC.70
	Financial Balance – % achievement of VCC forecast in line with revenue expenditure profile to achieve financial balance***	**National**	**Monthly**		**0**		✓	➔	KPC.71
	Overtime VCC Bank and Agency staff % of overall workforce pay bill, taken from Financial Monitoring Returns ***	**National**	**Annual**		**Annual Reduction**		✓	➔	KPC.72
	% achievement of WBS capital schemes in line with forecast profile to achieve annual Cash Resource Limits ***	**National**	**Monthly**				✓	➔	KPC.73
	Cost Improvement Programme: % achievement of annual forecast in line with WBS savings profile ***	**National**	**Monthly**				✓	➔	KPC.74
	Digital Cyber Security % of employees clicking on internal phishing campaigns / exercises ***	**Local**	**Quarterly**		**TBA**		✓	➔	KPC.69

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓
(***) KPIs also appear in Corporate Services Scorecard

QSF Domain	Blood and Transplant Scorecard	Performance as at Month 10 (Jan)	Compliance against Target Standard	Data

	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	Link
Equitable	Diversity of Workforce % women in senior leadership positions & roles ***	Local	Quarterly		TBA		✗	➔	KPC.78
	Diversity of Workforce % BAME in senior leadership & roles ***	Local	Quarterly		TBA		✗	➔	KPC.79
	Diversity of Workforce % registered disabled t***	Local	Quarterly		TBA		✗	➔	KPC.80
	% Welsh Speakers in Trust ***	National	Quarterly		TBA		✗	➔	KPC.81
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➔ stable ➔ deteriorating ➔ **(***) KPIs also appear in Corporate Services Scorecard**									

Support Services Scorecard (Consolidated version)

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	Staff Vaccination Rates (incl. COVID, Flu % staff vaccinated) – Professional NHS Standard	**Prof. Std.**	**Quarterly**		**TBA**				KPC.01
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Estates % Statutory Compliance with Fire; H&S; Waste, etc. ***	**Local**	**Quarterly**		**85%**				KPC.04
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Annual backlog maintenance % completion 85%		**Annually**		**85%**				KPC.05
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Reduction in CO2 emissions Welsh Public Sector Net Zero Carbon % target reduction from current baseline 2020/21***	**National**	**Quarterly**		**16 % reduction**				KPC.06
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% Carbon Footprint/Emissions Statutory Regulations reduction by 2025 against 2021/22 baseline – measure carbon parts per million by volume	**National**	**Annually**		**Actual number**				KPC.07
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% of Asbestos risk assessments completed against plan high risk/priority actions following risk assessments ***	**Local**	**Quarterly**		**100%**				KPC.08
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	% of legionella risk assessments completed against plan high risk/priority actions following risk assessments ***	Local	Quarterly		100%				KPC.09
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Air quality / emissions	Local	Annually		TBA				KPC.10
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% of security incidents per 1000 patient and donor visits	Local	Quarterly		TBA				KPC.11
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% Accidents/incidents/near misses per 1000 patient / donor visits	Local	Quarterly		TBA				KPC.12
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% RIDDOR reportable incidents of workforce ***	Local	Quarterly		TBA				KPC.13
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% actions implemented of fire action plan number completed (nominator) / total number in plan (denominator) x % ***	Local	Monthly		TBA				KPC.14
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% fire risk assessments undertaken high risk/priority actions following risk assessments	Local	Monthly		TBA				KPC.15

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Health and safety incidents (accidents that did or may result in personal injury relative to staff number) ***	**Local**	**Monthly**		**TBA**				KPC.16
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% of fire drills completed in accordance with schedule – desk top – number completed (nominator) / total number in plan (denominator) x %***	**Local**	**Quarterly**		**TBA**				KPC.17
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% of fire drills completed in accordance with schedule – live exercise– number completed (nominator) / total number in plan (denominator) x % ***	**Local**	**Quarterly**		**TBA**				KPC.18
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% compliance of level for the Core Skills and Training Framework taken from Electronic Staff Record (data source) ***	**National**	**Monthly**		**85%**				KPC.19
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Cyber Security NCSC "10 Steps to Cyber Security" % compliance against best practice standards	**Local**	**Annually**		**TBA**				KPC.20
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	Digital Service % uptime of critical systems which may have direct clinical or business implications – % availability by service (excl. planned maintenance windows)	Local	Monthly		TBA				KPC.21
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)									

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	% estate functionally suitable – as per EFPMS definition for Cancer Centre, WBS Labs, VHQ	Local	Annually		95%				KPC.22
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% of staff with required certification – authorized persons – number of APs certified (nominator) / number of APs required (denominator) x %	Local	Quarterly		TBA				KPC.23
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% of staff with required certification — number of CPs certified (nominator) / number of CPs required (denominator) x %	Local	Quarterly		TBA				KPC.24
	Trust-wide						✓	↑	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	VCC						✗	→	
	WBS						✓	→	
	Sustainable Development Assessment Tool (SDAT) ***	Local			TBA				KPC.25
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% staff overall compliance with Level 1 (Essential) Fire safety training ***	Local	Monthly		85%				KPC.26
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% staff compliant with Level 2 (Fire Warden) Fire safety training	Local	Monthly		TBA				KPC.27
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% compliance manual handling training (level 1)	Local	Monthly		TBA				KPC.28
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% compliance manual handling training (level 2)	Local	Monthly		TBA				KPC.29
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Health and Safety % Compliance with Statutory Training	Local	Monthly		TBA				KPC.30
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Violence and Aggression (% compliance Module A)	Local	Monthly		TBA				KPC.31
	Trust-wide						✓	↑	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	VCC						✗	→	
	WBS						✓	→	
	Violence and Aggression (% compliance Module B)	**Local**	**Monthly**		**TBA**				KPC.32
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Mental Health First Aid Training - % compliance	**Local**	**Monthly**		**TBA**				KPC.33
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% medics having PADR/medical appraisal in the previous 12 months & recorded on ESR – Professional NHS Standard***	**Prof. Std.**	**Monthly**		**85%**				KPC.34
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% medics successful Revalidation on MARS System – Professional NHS Standard***	**Prof. Std.**	**Monthly**		**100%**				KPC.35
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors ***	**National**	**Monthly**		**85%**				KPC.36
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% of sickness absence rate of staff (rolling average %) taken from Electronic Staff Record ***	**National**	**Monthly**		**12 month reduction to 3.54%**				KPC.37
	Trust-wide						✓	↑	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	VCC						✗	➔	
	WBS						✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)									

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	% of estate Cat B standard –need to highlight any critical risk areas by exception	Local	Quarterly		85 %				KPC.38
	Trust-wide						✓	↑	
	VCC						✗	➔	
	WBS						✓	➔	
	BREEAM excellent buildings - as above	Local	Annually		TBA				KPC.39
	Trust-wide						✓	↑	
	VCC						✗	➔	
	WBS						✓	➔	
	% patients and donors rating the environment as excellent – survey based and link with wider Patient / Donor Survey	Local	6 Monthly		TBA				KPC.40
	Trust-wide						✓	↑	
	VCC						✗	➔	
	WBS						✓	➔	
	% of staff rating their working environment as excellent – survey based and link with wider Staff Survey	Local	6 Monthly		TBA				KPC.41
	Trust-wide						✓	↑	
	VCC						✗	➔	
	WBS						✓	➔	
	Occupational health referrals relative to staff number ***	Local	Monthly		TBA				KPC.42
	Trust-wide						✓	↑	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	VCC						✗	→	
	WBS						✓	→	
	Incidents of violence and aggression to staff ***	**Local**	**Monthly**		**TBA**				KPC.43
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Staff satisfaction with training % Fire – link to staff survey	**Local**	**Quarterly**		**TBA**				KPC.44
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Staff satisfaction with training - % H&S link to staff survey	**Local**	**Quarterly**		**TBA**				KPC.45
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Staff satisfaction with training - Violence & Aggression	**Local**	**Quarterly**		**TBA**				KPC.46
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Staff satisfaction with training - Manual Handling link to staff survey	**Local**	**Quarterly**		**TBA**				KPC.47
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Staff health & Well-being – % staff reporting positive interest shown by line manager in health and wellbeing (NHS Staff Survey) ***	**National**			**Annual Improve**				KPC.48
	Trust-wide						✓	↑	
	VCC						✗	→	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	WBS						✓	➔	
	Overall staff engagement – NHS Staff Survey score ***	National			Annually				KPC.49
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
	% Staff Grievances upheld of total headcount + if grievance resolved ***	Local			TBA				KPC.50
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
	Digital Service Desk % User Satisfaction with Digital Service Desk	Local	Quarterly		TBA				KPC.51
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘ (***) KPIs also appear in VCC & WBS Scorecards)									

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timelin ess	% PPM undertaken completed against plan– –need to highlight any critical risk areas by exception	Local	Quarterly		85%				KPC.52
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	Help Desk - % cat 1 / 2 estates issues closed within xxx days / hours – need to agree response times	**Local**	**Quarterly**		**TBA**				KPC.53
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Help Desk - % reactive maintenance achieved within xx days/hours – need to agree response times	**Local**	**Quarterly**		**TBA**				KPC.54
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Incidents of violence and aggression open greater than 30 days ***	**Local**	**Monthly**		**TBA**				KPC.55
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% of COSHH assessments completed on time in agreed timescales***	**Local**	**Monthly**		**TBA**				KPC.56
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% of Site visits completed on time against HSG65 schedule***	**Local**	**Monthly**		**TBA**				KPC.57
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	Digital % requests responded to within agreed response times	**Local**	**Monthly**		**95%**				KPC.58
	Trust-wide						✓	🡅	
	VCC						✗	🡆	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	WBS						✓	➔	
	Digital % incidents responded to within agreed timescale	**Local**	**Monthly**		**95%**				KPC.59
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
	Public Sector Payment Performance (invoices paid within 30 days)	**National**	**Monthly**		**95%**				KPC.60
	Trust-wide					**93%**	✗	➔	
	VCC						✗	➔	
	WBS						✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ➚ stable ➔ deteriorating ➘ **(***) KPIs also appear in VCC & WBS Scorecards)**									

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	% utilization of the estate measure = current functional suitability (nominator) / optimum utilization (denominator)	**Local**	**Monthly**		**TBA**				KPC.61
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
	% gas consumption***	**Local**	**Monthly**		**TBA**				KPC.62
	Trust-wide						✓	➚	
	VCC						✗	➔	
	WBS						✓	➔	
	% electricity consumption ***	**Local**	**Monthly**		**TBA**				KPC.63
	Trust-wide						✓	➚	
	VCC						✗	➔	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	WBS						✓	→	
	% water consumption ***	Local	Monthly		TBA				KPC.64
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% waste recycled ***	Local	Monthly		TBA				KPC.65
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% waste landfill ***	Local	Monthly		TBA				KPC.66
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	% recycling ***	Local	Monthly		TBA				KPC.67
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Total count of IT Business Continuity Incidents logged	Local	Monthly		0				KPC.68
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises ***	Local	Quarterly		TBA				KPC.69
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Delivery of IMTP 2022/23 CORP Quarterly Action plans - % of actions implemented	Local	Quarterly		TBA				KPC.70
	Trust-wide						✓	↑	
	VCC						✗	→	

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
	WBS						✓	➔	
	Financial Balance revenue position Target net zero trajectory ***	National	Monthly		Balance				KPC.71
	Trust-wide					Balance	✓	➔	
	VCC					Balance	✓	➔	
	WBS					Balance	✓	➔	
	Minister's New 2022/23 National Target Agency spend as % of total pay bill taken from Financial Monitoring Returns ***	National	Monthly		Annual Reduce				KPC.72
	Trust-wide						✓	↑	
	VCC						✓	➔	
	WBS						✓	➔	
	Financial Capital spend position against forecast expenditure profile ***	National	Monthly		£10.2M	£10.2M			KPC.73
	Trust-wide						✓	➔	
	VCC				£7.2M	£7.2M	✓	➔	
	WBS						✓	➔	
	Cost Improvement programme delivery against saving profile***	National	Monthly		£1.1M	£1.1M			KPC.74
	Trust-wide						✓	↑	
	VCC				£413k	£413k	✓	➔	
	WBS						✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)									

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	Qualitative Monitoring Return detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organization's plan	**National**	**Annually**		**Evidence improved**				KPC.75
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme	**National**	**Annually**		**Delivery and/or evidence of improvements**				KPC.76
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Equality Impact assessments completed	**Local**	**Annually**		**Annual Improve**				KPC.77
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Diversity of Workforce % women in senior leadership positions ***	**Local**	**Annually**		**Annual Improve**				KPC.78
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Diversity of Workforce % BAME in senior leadership ***	**Local**	**Annually**		**Annual Improve**				KPC.79
	Trust-wide						✓	↑	
	VCC						✗	→	
	WBS						✓	→	
	Diversity of Workforce % registered disabled ***	**Local**	**Annually**		**Annual**				KPC.80

QSF Domain	Support services Scorecard			Performance as at Month 10 (Jan)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
					Improve				
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
	% Welsh Speakers in Trust ***	National	Annually		Annual Improve				KPC.81
	Trust-wide						✓	🡅	
	VCC						✗	🡆	
	WBS						✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)									

Support Services Scorecards (Separated version)

Estates Support Services

QSF Domain	Estates Support Services Scorecard		Performance as at Month 10 (Jan)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	Estates % Statutory Compliance with Fire; H&S; Waste, etc. – Local Target	**Quarterly**		**85%**				KPC.04
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	Annual backlog maintenance % completion 85% – Local Target	**Annually**		**85%**				KPC.05
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	Reduction in CO2 emissions Welsh Public Sector Net Zero Carbon % target reduction from current baseline 2020/21 – National Target	**Quarterly**		**16 % reduction**				KPC.06
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% Carbon Footprint/Emissions Statutory Regulations reduction by 2025 against 2021/22 baseline – measure carbon parts per million by volume	**Annually**		**Actual number**				KPC.07
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% of Asbestos risk assessments completed against plan high risk/priority actions following risk assessments – Local Target	**Quarterly**		**100%**				KPC.08
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	

	% of legionella risk assessments completed against plan high risk/priority actions following risk assessments – Local Target	**Quarterly**		**100%**				KPC.09
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Air quality / emissions – Local Target	**Annually**		**TBA**				KPC.10
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	**Estates Support Services Scorecard**		**Performance as at Month 11 (Feb)**			**Compliance against Target or Standard**		**Supporting Data Link**
	KPI Measure	**Reported**	**Baseline**	**Target**	**Actual**	**In Month Position**	**Year to date trend**	
Effectiveness	% estate functionally suitable – as per EFPMS definition for Cancer Centre, WBS Labs, VHQ – Local Target	**Annually**		**95%**				KPC.22
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	% of staff with required certification – authorized persons – number of APs certified (nominator) / number of APs required (denominator) x % – Local Target	**Quarterly**		**TBA**				KPC.23
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	% of staff with required certification –– number of CPs certified (nominator) / number of CPs required (denominator) x % – Local Target	**Quarterly**		**TBA**				KPC.24
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	

	Sustainable Development Assessment Tool (SDAT) – Local Target			TBA				KPC.25
	Trust-wide					✓	↑	
	VCC					✖	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Estates Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	% of estate Cat B standard –need to highlight any critical risk areas by exception – Local Target	**Quarterly**		**85 %**				KPC.38
	Trust-wide					✓	↑	
	VCC					✖	→	
	WBS					✓	→	
	BREEAM excellent buildings - as above – Local Target	**Annually**		TBA				KPC.39
	Trust-wide					✓	↑	
	VCC					✖	→	
	WBS					✓	→	
	% patients and donors rating the environment as excellent – survey based and link with wider Patient / Donor Survey – Local Target	**6 Monthly**		TBA				KPC.40
	Trust-wide					✓	↑	
	VCC					✖	→	
	WBS					✓	→	
	% of staff rating their working environment as excellent – survey based and link with wider Staff Survey – Local Target	**6 Monthly**		TBA				KPC.41
	Trust-wide					✓	↑	
	VCC					✖	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Estates Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	Trust-wide & Divisional Indicators	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	% PPM undertaken completed against plan– –need to highlight any critical risk areas by exception – Local Target	Quarterly		85%				KPC.52
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Help Desk - % cat 1 / 2 estates issues closed within xxx days / hours – need to agree response times – Local Target	Quarterly		TBA				KPC.53
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Help Desk - % reactive maintenance achieved within xx days/hours – need to agree response times – Local Target	Quarterly		TBA				KPC.54
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable → deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Estates Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	% utilization of the estate measure = current functional suitability (nominator) / optimum utilization (denominator) – Local Target	Monthly		TBA				KPC.61
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	% gas consumption – Local Target	Monthly		TBA				KPC.62
	Trust-wide					✓	🡅	

	VCC					✗	→	
	WBS					✓	→	
	% electricity consumption – Local Target	**Monthly**		**TBA**				KPC.63
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% water consumption – Local Target	**Monthly**		**TBA**				KPC.64
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% waste recycled – Local Target	**Monthly**		**TBA**				KPC.65
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% waste landfill – Local Target	**Monthly**		**TBA**				KPC.66
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% recycling – Local Target	**Monthly**		**TBA**				KPC.67
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ **(***) KPIs also appear in VCC & WBS Scorecards)**								

QSF Domain	Estates Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	Qualitative Monitoring Return detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organization's plan – National Target	**Annually**		**Evidence improved**				KPC.75
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme – National Target	**Annually**		**Delivery and/or evidence improved**				KPC.76
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable → deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

Health & Safety Support Services

QSF Domain	Health & Safety Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	% of security incidents per 1000 patient and donor visits – Local Target	Quarterly		TBA				KPC.11
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% Accidents/incidents/near misses per 1000 patient / donor visits– Local Target	Quarterly		TBA				KPC.12
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% RIDDOR reportable incidents of workforce– Local Target	Quarterly		TBA				KPC.13
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% actions implemented of fire action plan number completed (nominator) / total number in plan (denominator) x % – Local Target	Monthly		TBA				KPC.14
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% fire risk assessments undertaken high risk/priority actions following risk assessments – Local Target	Monthly		TBA				KPC.15
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	Health and safety incidents (accidents that did or may result in personal injury relative to staff number) – Local Target	Monthly		TBA				KPC.16
	Trust-wide					✓	↑	
	VCC					✗	→	

	WBS					✓	→	
	% of fire drills completed in accordance with schedule – desk top – number completed (nominator) / total number in plan (denominator) x %– Local Target	**Quarterly**		**TBA**				KPC.17
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% of fire drills completed in accordance with schedule – live exercise– number completed (nominator) / total number in plan (denominator) x % – Local Target	**Quarterly**		**TBA**				KPC.18
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	**Health & Safety Support Services Scorecard**		**Performance as at Month 11 (Feb)**			**Compliance against Target or Standard**		**Supporting Data Link**
	KPI Measure	**Reported**	**Baseline**	**Target**	**Actual**	**In Month Position**	**Year to date trend**	
Effectiveness	% staff overall compliance with Level 1 (Essential) Fire safety training – Local Target	**Monthly**		**85%**				KPC.26
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% staff compliant with Level 2 (Fire Warden) Fire safety training – Local Target	**Monthly**		**TBA**				KPC.27
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% compliance manual handling training (level 1) – Local Target	**Monthly**		**TBA**				KPC.28
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	

	% compliance manual handling training (level 2) – Local Target	**Monthly**		**TBA**				KPC.29
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Health and Safety % Compliance with Statutory Training – Local Target	**Monthly**		**TBA**				KPC.30
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Violence and Aggression (% compliance Module A) – Local Target	**Monthly**		**TBA**				KPC.31
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Violence and Aggression (% compliance Module B) – Local Target	**Monthly**		**TBA**				KPC.32
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Mental Health First Aid Training - % compliance – Local Target	**Monthly**		**TBA**				KPC.33
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable → deteriorating 🡇 **(***) KPIs also appear in VCC & WBS Scorecards)**								

QSF Domain	Health & Safety Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	Occupational health referrals relative to staff number – Local Target	**Monthly**		**TBA**				KPC.42
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Incidents of violence and aggression to staff – Local Target	**Monthly**		**TBA**				KPC.43
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Staff satisfaction with training % Fire – link to staff survey – Local Target	**Quarterly**		**TBA**				KPC.44
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Staff satisfaction with training - % H&S link to staff survey – Local Target	**Quarterly**		**TBA**				KPC.45
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Staff satisfaction with training - Violence & Aggression – Local Target	**Quarterly**		**TBA**				KPC.46
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	
	Staff satisfaction with training - Manual Handling link to staff survey – Local Target	**Quarterly**		**TBA**				KPC.47
	Trust-wide					✓	🡅	
	VCC					✗	→	
	WBS					✓	→	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable → deteriorating 🡇
(***) KPIs also appear in VCC & WBS Scorecards)

QSF Domain	Health & Safety Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	Incidents of violence and aggression open greater than 30 days – Local Target	Monthly		TBA				KPC.55
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	% of COSHH assessments completed on time in agreed timescales – Local Target	Monthly		TBA				KPC.56
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	% of Site visits completed on time against HSG65 schedule – Local Target	Monthly		TBA				KPC.57
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 **(***) KPIs also appear in VCC & WBS Scorecards)**								

QSF Domain	Health & Safety Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	No Health & Safety Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Health & Safety Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	No Health & Safety Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

Workforce Support Services

QSF Domain	Workforce Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	% compliance of level for the Core Skills and Training Framework taken from Electronic Staff Record (data source) – National Target	Monthly		85%				KPC.19
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Workforce Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	% medics having PADR/medical appraisal in the previous 12 months & recorded on ESR – Professional NHS Standard	Monthly		85%				KPC.34
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% medics successful Revalidation on MARS System – Professional NHS Standard	Monthly		100%				KPC.35
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors – National Target	Monthly		85%				KPC.36

	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% of sickness absence rate of staff (rolling average %) taken from Electronic Staff Record – National Target	**Monthly**		**12 month reduction to 3.54%**				KPC.37
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	**Workforce Support Services Scorecard**		**Performance as at Month 11 (Feb)**			**Compliance against Target or Standard**		**Supporting Data Link**
	KPI Measure	**Reported**	**Baseline**	**Target**	**Actual**	**In Month Position**	**Year to date trend**	
Patient/Donor/ Staff Experience	Staff health & Well-being – % staff reporting positive interest shown by line manager in health and wellbeing (NHS Staff Survey) – National Target			**Annual Improve**				KPC.48
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	Overall staff engagement – NHS Staff Survey score – National Target			**Annually**				KPC.49
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	% Staff Grievances upheld of total headcount + if grievance resolved – Local Target			**TBA**				KPC.50
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Workforce Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	No Workforce Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Workforce Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	No Workforce Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Workforce Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	Equality Impact assessments completed – Local Target	**Annually**		**Annual Improve**				KPC.77
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Diversity of Workforce % women in senior leadership positions – Local Target	**Annually**		**Annual Improve**				KPC.78
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Diversity of Workforce % BAME in senior leadership – Local Target	**Annually**		**Annual Improve**				KPC.79
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Diversity of Workforce % registered disabled – Local Target	**Annually**		**Annual Improve**				KPC.80
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	% Welsh Speakers in Trust – National Target	**Annually**		**Annual Improve**				KPC.81
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇
(***) KPIs also appear in VCC & WBS Scorecards)

Digital Support Services.

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	Cyber Security NCSC "10 Steps to Cyber Security" % compliance against best practice standards – Local Target	Annually		TBA				KPC.20
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Digital Service % uptime of critical systems which may have direct clinical or business implications – % availability by service (excl. planned maintenance windows) – Local Target	Monthly		TBA				KPC.21
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇								

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	No Digital Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	Digital Service Desk % User Satisfaction with Digital Service Desk – Local Target	Quarterly		TBA				KPC.51
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	Digital % requests responded to within agreed response times – Local Target	Monthly		95%				KPC.58
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
	Digital % incidents responded to within agreed timescale – Local Target	Monthly		95%				KPC.59
	Trust-wide					✓	↑	
	VCC					✗	→	
	WBS					✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable → deteriorating ↓ (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	Total count of IT Business Continuity Incidents logged – Local Target	Monthly		0				KPC.68
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – Local Target	Quarterly		TBA				KPC.69
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Digital Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	No Digital Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

Finance Support Services

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Safety	No Finance Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Effectiveness	No Finance Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Patient/Donor/ Staff Experience	No Finance Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Timeliness	Public Sector Payment Performance (invoices paid within 30 days) – National Target	Monthly		95%				KPC.60
	Trust-wide				93%	✗	🡆	
	VCC					✗	🡆	
	WBS					✓	🡆	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Efficient	Delivery of IMTP 2022/23 CORP Quarterly Action plans - % of actions implemented – Local Target	Quarterly		TBA				KPC.70
	Trust-wide					✓	🡅	
	VCC					✗	🡆	
	WBS					✓	🡆	
	Financial Balance revenue position Target net zero trajectory – National Target	Monthly		Balance				KPC.71
	Trust-wide				Balance	✓	🡆	
	VCC				Balance	✓	🡆	
	WBS				Balance	✓	🡆	
	Minister's New 2022/23 National Target Agency spend as % of total pay bill taken from Financial Monitoring Returns – National Target	Monthly		Annual Reduce				KPC.72
	Trust-wide					✓	🡅	
	VCC					✓	🡆	
	WBS					✓	🡆	
	Financial Capital spend position against forecast expenditure profile – National Target	Monthly		£10.2M	£10.2M			KPC.73
	Trust-wide					✓	🡆	
	VCC			£7.2M	£7.2M	✓	🡆	
	WBS					✓	🡆	
	Cost Improvement programme delivery against saving profile – National Target	Monthly		£1.1M	£1.1M			KPC.74
	Trust-wide					✓	🡅	
	VCC			£413k	£413k	✓	🡆	
	WBS					✓	🡆	

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇
(***) KPIs also appear in VCC & WBS Scorecards)

QSF Domain	Finance Support Services Scorecard		Performance as at Month 11 (Feb)			Compliance against Target or Standard		Supporting Data Link
	KPI Measure	Reported	Baseline	Target	Actual	In Month Position	Year to date trend	
Equitable	No Finance Indicators currently in this QSF domain							
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Year to date trend = Improving 🡅 stable 🡆 deteriorating 🡇 (***) KPIs also appear in VCC & WBS Scorecards)								

APPENDIX 2

Proposed Changes to Key Performance Indicators (KPIs) for VCC, WBS and Support Services

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
Velindre Cancer Centre KPI Amendments						
Scheduled Radiotherapy for Patients (COSC) measure	**Change**	% of Scheduled patients beginning RT within 21 days	80%	Monthly	Inconsistent interpretation and reporting	Whilst discussions are being held with Welsh Gov.t, this measure will be reported internally only
Urgent Scheduled Radiotherapy for Patients (COSC) measure	**Change**	% of Urgent Scheduled patients beginning RT within 7 days	80%	Monthly	Inconsistent interpretation and reporting	Whilst discussions are being held with Welsh Gov.t, this measure will be reported internally only
Emergency Radiotherapy for Patients (COSC) measure	**Change**	% of Emergency patients beginning RT within 1 day	100%	Monthly	Inconsistent interpretation and reporting	Whilst discussions are being held with Welsh Gov.t, this measure will be reported internally only
Outpatient Scheduled Appointments	**Retired**	% of Outpatient Appointments seen within 30 minutes of scheduled time	100%	Monthly	No	The data capture and recording is currently being reviewed to improve the accuracy of data
Welsh Blood Service KPI Amendments						
Demand for Red Cells	**Retired**	% appointment filled (against available capacity) – Best practice/benchmark	90%	monthly		There are a number of factors being considered and currently reviewing NHSBT definition for clarity. Removed to Tier 2 for the time being. Will be reviewed again.

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
Meeting demand for Red blood Cells	**Retired**	Donors who did not attend pre-arranged appointments (DNA rate)	16%	Monthly		KPI0.06 Covered in other measures
Meeting demand for Red blood Cells	**Retired**	Percentage of on the day or pre planned session donor deferrals – Best practice/benchmark	10%	monthly		KPI 0.07 Covered in other measures
O, D- issued as a percentage of total red blood cell issues	**Retired**	Percentage of OD issued as a % of total RBC– Best practice/benchmark	12%	monthly		KPI 0.16 Covered in other measures
WBMDR Swab Recruitment	**Change**	Number of Swab donors recruited	TBC	monthly	No	Captured in revised **KPI 0.13** of new bone marrow donors aged 17-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)
Number of whole blood donations that are collected on session which are below the minimum viable volume	**Change**	whole blood donations which are below the minimum viable volume as a % of the total number of whole blood donations collected	3% Max.	Monthly	No	captured in new measure **KPI 0.07** 'needle to viable donation'

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag	**Change**	the % of the number of donors who have reached the donation chair (but despite an attempt to venepuncture the donor, no blood enters the bag as a % of the number of donors who have reached the donation chair	2% Max.	Monthly	No	captured in new measure **KPI 0.08** 'needle to viable donation' (Failed Venepuncture / Part Bags)
Harm An unplanned event which resulted in injury or ill health to a person and/or property damage. Incident rate for accidents and near misses monthly number divided by total number of staff by 1000	**Change**	Number of incidents	zero	monthly	UK benchmarking	captured in revised **KPI 0.33** as number of reported critical or major findings/non-conformities through external audits or inspection
Near miss Unplanned event which could have resulted in injury or ill health to a person and/or property damage but was avoided by good luck	**Change**	Number of incidents	zero	monthly	UK benchmarking	Captured in KPIs for serious incidents and Health and safety incidents, **KPI 0.01**

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
SABRE proposal to expand this measure to include serious adverse reactions and events reported to HTA, HTA - adverse reaction to Tissues and Cells - see below	**Change**	Number of incidents reported to the regulators or licensing authorities	zero	monthly	UK benchmarking	captured in revised **KPI 0.33**, as 'number of reported critical or major findings/non-conformities through external audits or inspection'
SAEAR	**Change**	Number of incidents reported to the regulators or licensing authorities	zero		UK benchmarking	captured in revised **KPI 0.33**: number of reported critical or major findings/non-conformities through external audits or inspection
Processing productivity	**Retired**	Number of components manufactured per Standardised FTE. (Manufacturing Efficiency)	392	annual	UK benchmarking	Does not inform workforce profile does not form utilisation accuracy of ESR
Newly opened risks above the threshold for risk before mitigation	**Change**	New or updated Risks scoring above the threshold appetite for risk before mitigation	n/a	Monthly		KPI0.34
Newly opened risks above the threshold for risk after mitigation	**Change**	Risks remaining above the threshold appetite for risk after mitigation	n/a	Monthly		KPI0.35

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
No. stem cell collections made in the month	**Change**		n/a	Monthly		Captured in revised **KPI 0.19 '** No. stem cell transplants supported'
H&I service activity YTD	**Retired**	total activity	number	Monthly	UK benchmarking	There is not a commissioned level of activity for WTAIL. therefore this is currently not a measureable KPI and does not add value
RCI activity YTD	**Retired**	total activity	number	Monthly	UK benchmarking	There is not a commissioned level of activity for RCI. therefore this is currently not a measureable KPI and does not add value
Number of Deceased Donor Typing / Cross Matching reported	**Change**		80% or greater RAG (up/down/	quarterly	UK benchmarking	to be replaced by two new measures - **KPI 0.23 '** No. of discrepant HLA types for deceased donors' and 'Turnaround time for deceased donors HLA type' **KPI 0.24**
Age of issued of red cell units, % age issued within 21 days	**Change**		%	Monthly		Captured in revised **KPI 0.26** - KPI 'time expired adult red cells available for issue'
Number of bags of platelets manufactured	**Retired**	Number of bags of platelets manufactured as a % of the number of issues to hospitals (% platelet demand met).	zero	monthly		This measure does not provide performance data to support any decision making

KPI Measure	New or Change or Retired	Narrative	Proposed Target	Reporting Frequency	Alignment with other Services	Rationale for Change
% Red Cell Supply Demand Met -	**Change**	The number of bags of RBCs manufactured as a % of the number of issues to hospitals	100%	monthly		Captured in **KPI 0.04** Demand for red blood cells met including no. Import required'.

APPENDIX 3

Examples of Proposed KPI Supporting Data Templates (VCC, WBS & Corporate), incorporating SPC Charting

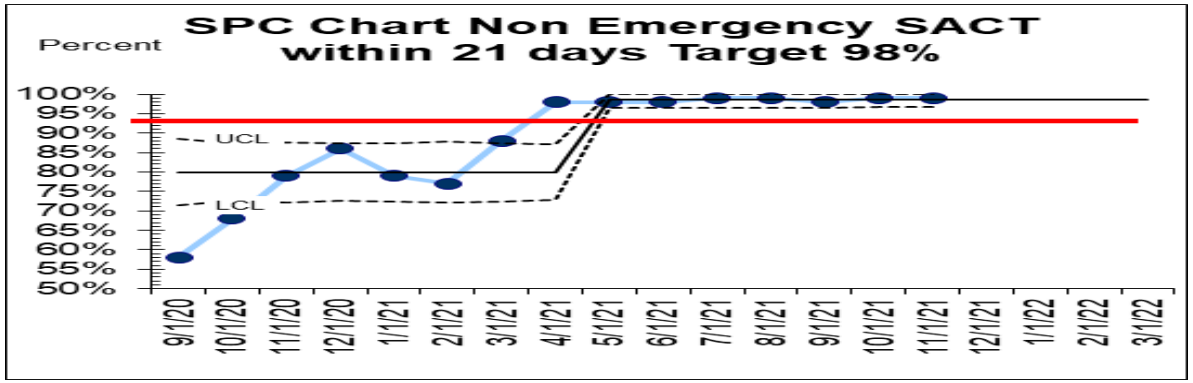
Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance against Target or Standard

	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	58	68	79	86	79	77	88	98	98	98	99	99	98	99	99
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 28 days	84	83	50	36	54	54	32	6	5	6	3	3	6	4	5
Within 28 days	116	177	190	224	201	181	224	274	265	274	282	287	295	350	367



SPC Chart Analysis

The system improvements have continued for 8 months, and are considered to be sustainable. Therefore, we have introduced a 'new SPC phase' from November 21 onwards with adjusted Upper and Lower Control Limits, reflecting the parameters of this improved performance.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

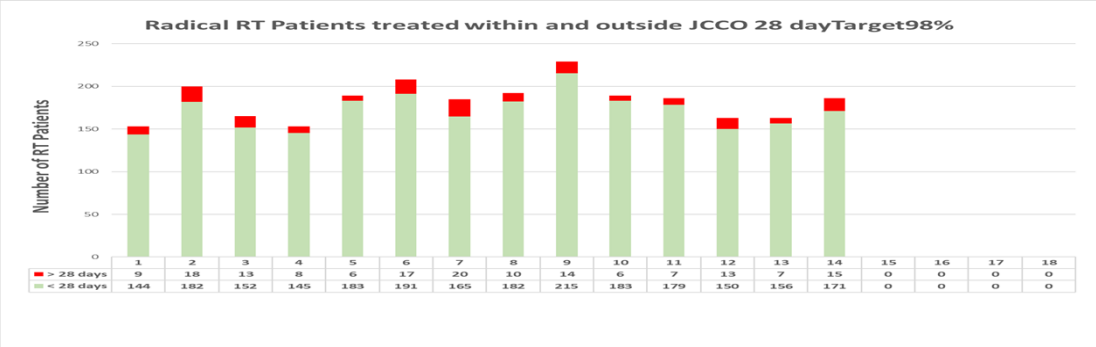
- insert text
- insert text

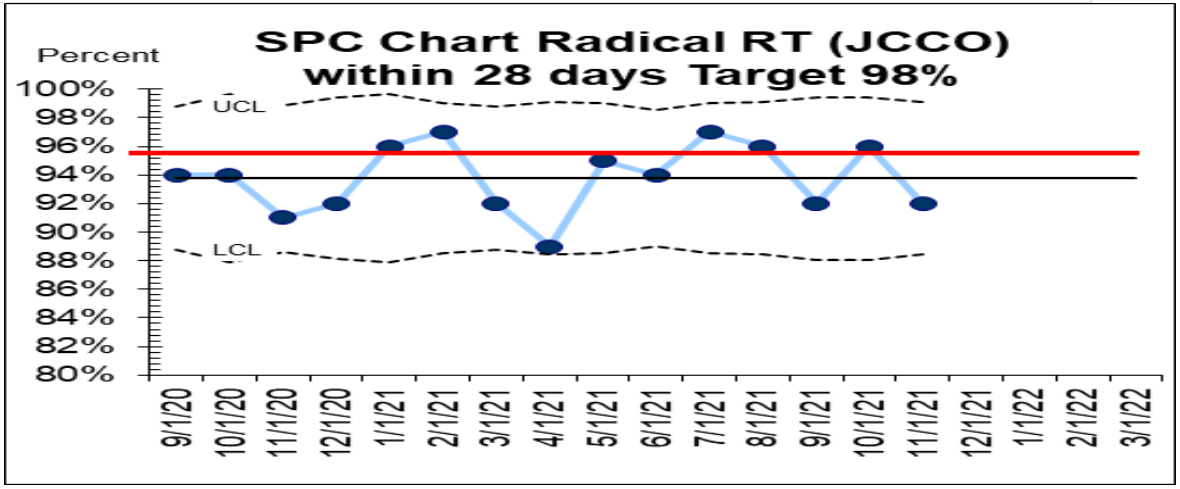
Radical Radiotherapy Patients Treated Within 28 Days (JCCO)

Target: 98%

SLT Lead: Radiotherapy Services Manager

Current Performance against Target or Standard





SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months. However, the average performance of 94% consistently falls below the 98% target.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

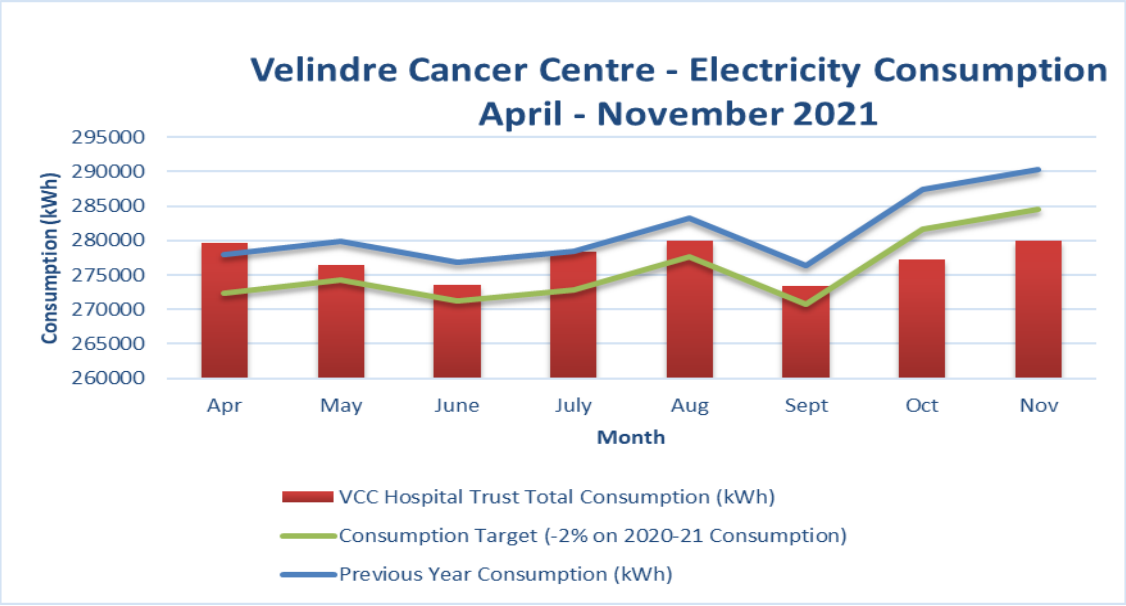
VCC - Energy (Gas & Elect) performance consumption -3% on 2020/21

Target: -3% 0 2020/21 Consumption

SLT Lead: Operations Director

Current Performance against Target or Standard

Trust Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual Number															
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%



Performance

If performance is not at required level, set out what the main causes are:

- Ongoing LED lighting upgrades across the site (both internal and external lighting) has continued to be undertaken the financial year.
- The Trust has obtained funding for a BMS upgrade, which will be delivered before the end of the financial year this will provide further controls and reduction in usage will follow.
- There was an increase in usage - increased heating in the building - due to the temperature.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Building Management System installed (tender completed) • Ongoing monitoring	April 2022 April 2022	Estates Manager Environ Manager

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Metering strategy development	2022/23	Estates Manager

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

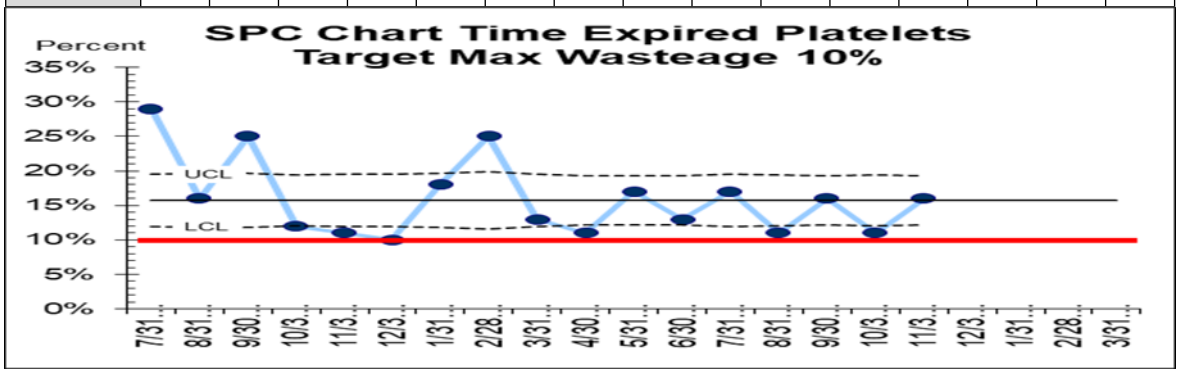
Time Epired Platelets as a Percentage of Total Platelet Production

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	**29**	**16**	**25**	**12**	**11**	**10**	**18**	**25**	**13**	**11**	**17**	**13**	**17**	**11**	**16**
Target Max 10%	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
Wastage	**24 4**	**12 5**	**19 5**	**10 4**	**90**	**81**	**14 0**	**17 2**	**10 6**	**10 4**	**15 6**	**12 1**	**14 4**	**98**	**14 8**
Total Platelets	**84 1**	**78 0**	**78 0**	**86 6**	**82 0**	**81 1**	**77 7**	**68 7**	**81 7**	**94 4**	**91 9**	**93 2**	**84 7**	**89 4**	**92 2**



SPC Chart Analysis

The SPC chart above, shows common cause or normal variation for the period April to September 2021. However, the maximum 10% wastage is routinely exceeded.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text • insert text • insert text	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text • insert text • insert text	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

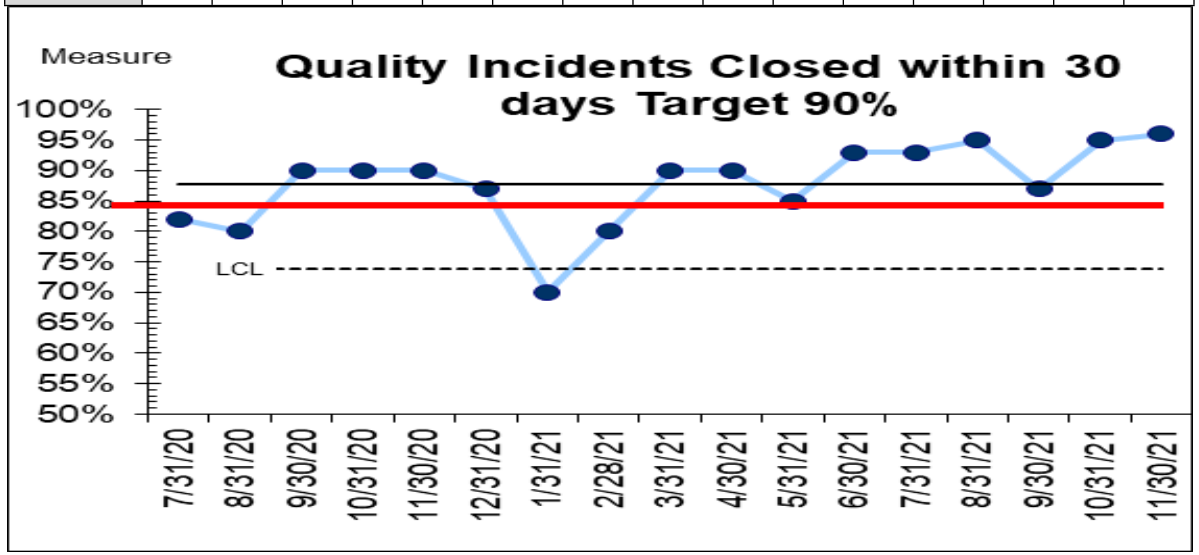
% Quality Incidents closed within 30 days

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	**90**	**90**	**90**	**87**	**70**	**80**	**90**	**90**	**85**	**93**	**93**	**95**	**87**	**95**	**96**
Target 85%	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**	**90**



SPC Chart Analysis

The SPC chart above, shows common cause or normal variation for the period January to September 2021

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

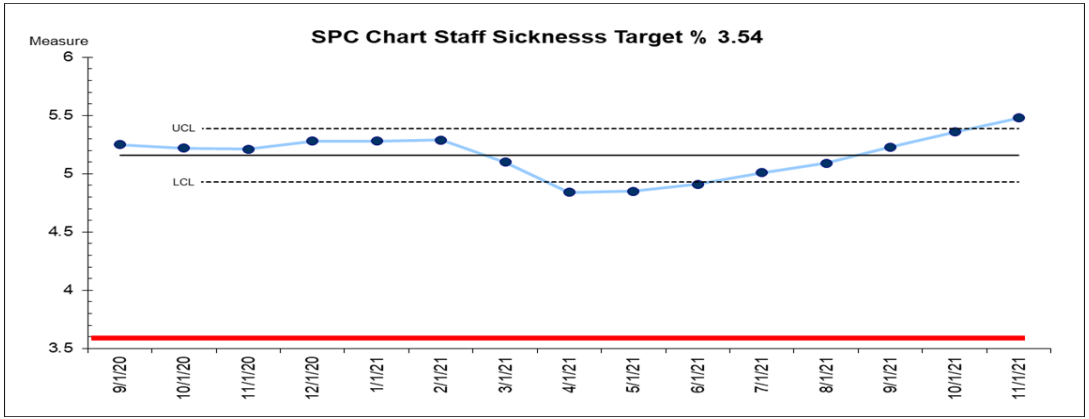
Staff Sickness levels against Target

Target: 3.54%

Trust Lead: Director of Workforce

Current Performance against Target or Standard

Trust Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	5.25	5.22	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 8 months with the overall average 5.2% sickness level remains higher than the 3.54% target

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

Staff Sickness levels against Target

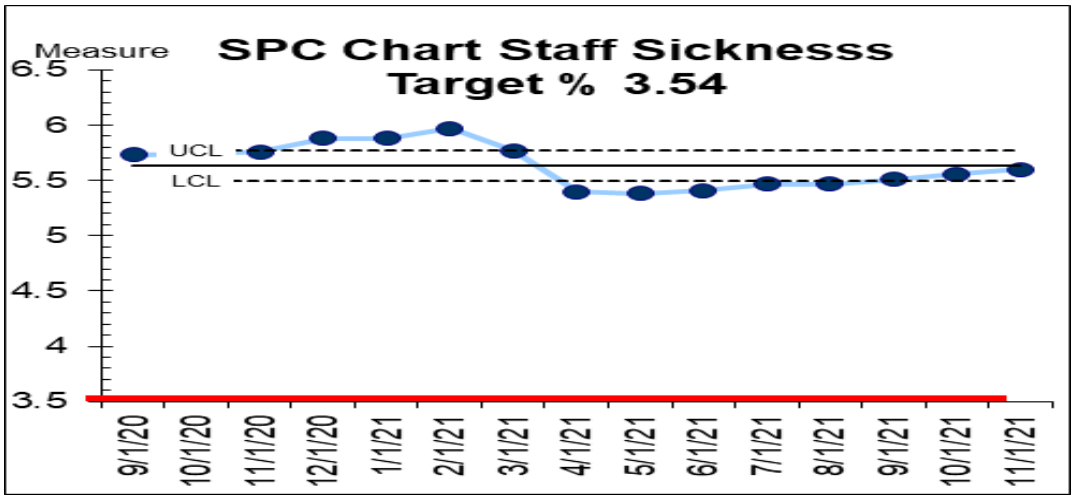
Target: 3.54%

SLT Lead: VCC Director

Current Performance against Target or Standard

Performance

VCC Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	**5.73**	5.74	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	**5.56**	**5.60**
Target 3.54%	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**



SPC Chart Analysis

The SPC chart shows a consistent deterioration over the last 8 months, with the average 5.6% sickness level remaining higher than the 3.54% target

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

Staff Sickness levels against Target

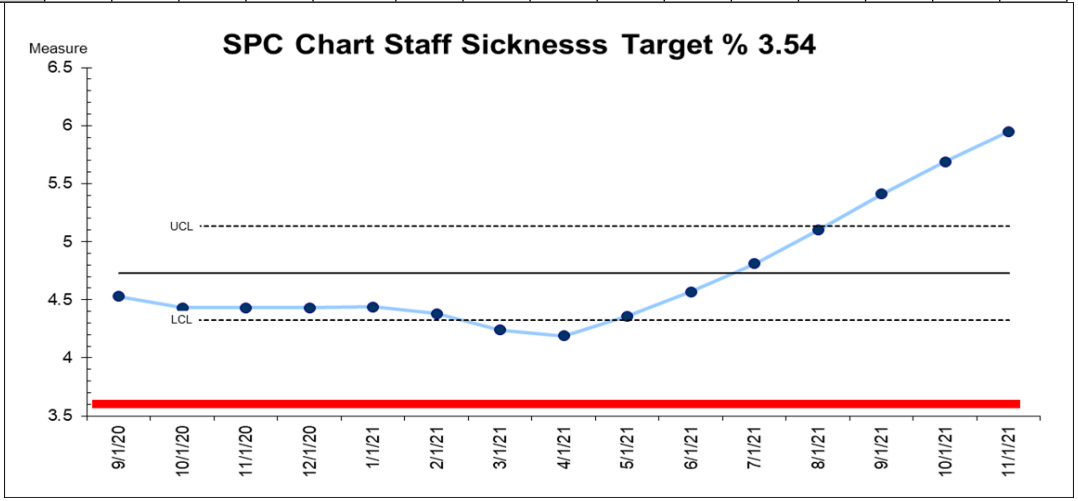
Target: 3.54%

SLT Lead: WBS Director

Current Performance against Target or Standard

Performance

WBS Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	4.53	4.43	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	**5.41**	**5.69**	**5.95**
Target 3.54%	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**	**3.54**



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 8 months with the overall average 4.54% sickness level remains higher than the 3.54% target

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

STRATEGIC DEVELOPMENT COMMITTEE

PATIENT ENGAGEMENT STRATEGY

DATE OF MEETING	16.5.22

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Non Gwilym, Assistant Director of Communications Cath O'Brien, Chief Operating Officer
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB SHAPE	21.3.22	IN SUPPORT

ACRONYMS	
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team

PEG	Patient Engagement Group

1. SITUATION/BACKGROUND

Velindre University NHS Trust has identified a need for a new patient engagement strategy and in February 2021, agreed that the first phase of the strategy's development should focus on patient engagement relating to the delivery of its cancer services.

Over the past 12 months, and with the support of CWMPAS (formerly known as the Wales Cooperative Centre), a core group of staff and patient representatives have shaped the development of a new strategy learning from organisations in Wales and further afield.

A Patient Engagement Steering Group was established to shaped the goals and 'what good looks like' which included representatives from organisations such as Community Health Councils, health boards and the third sector.

The two phases of work focused on a review of the current patient engagement approach and practice at Velindre and learning from others with direct experience of both delivering and receiving patient engagement. This work has resulted in the production of a Patient Engagement Strategy which is available to you as Appendix 1. The document sets out an ambition for what we want to deliver in terms of patient engagement with seven specific goals in support.

Initial feedback and emerging themes were shared with the Velindre Cancer Centre (VCC) Senior Leadership Team, Patient and Carer Liaison Group for feedback in autumn 2021. A draft strategy was shared for comment with Executive Management Board in December 2021 and a final strategy agreed in March 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

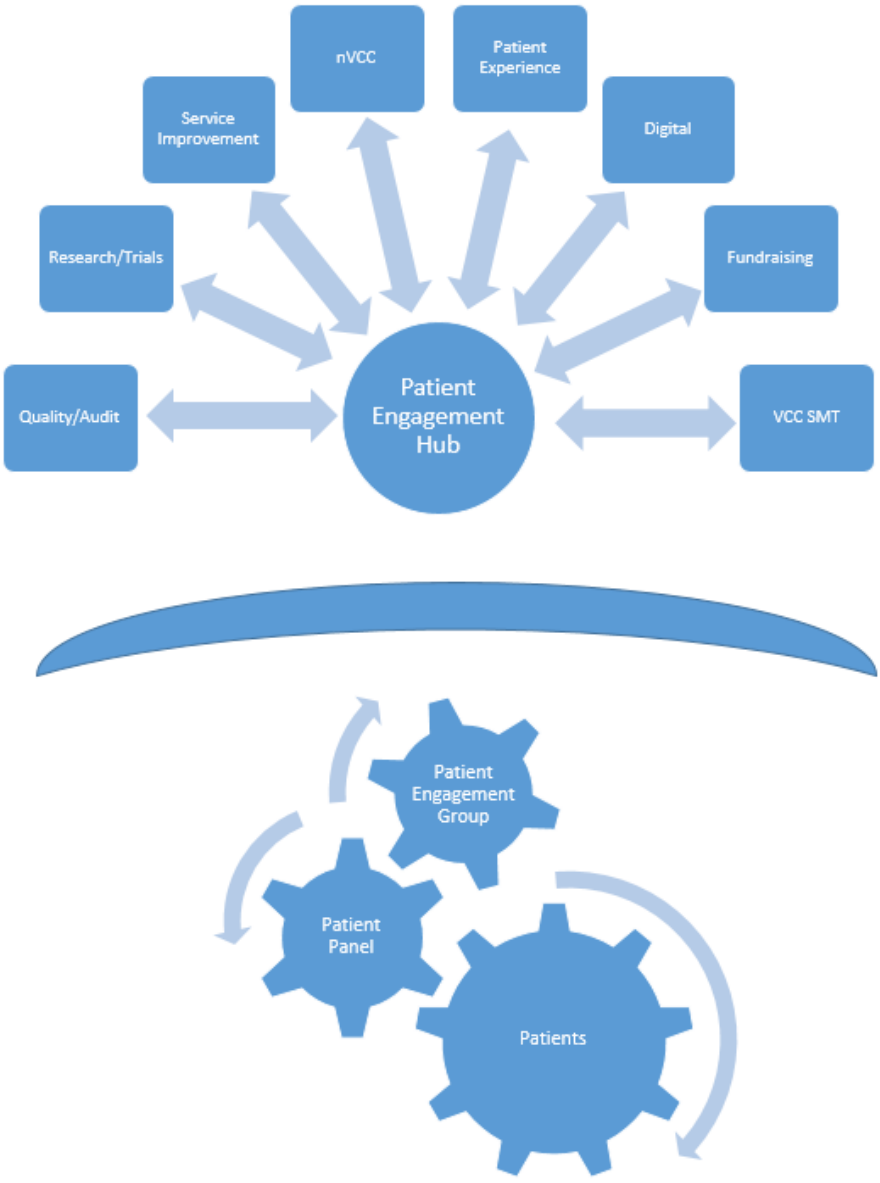
The strategy sets out a new ambition for Velindre Cancer Services through a series of goals that focus on patient engagement in a number of key areas:

Individual treatment and care
Service delivery, performance, quality and assurance
Service design, improvement, transformation and innovation
Research
Strategy and Future Planning
Statutory obligations of patient experience, citizen engagement, equality and Welsh Language

Our ambition is to deliver patient engagement or Velindre Cancer Services that puts patient's experience, needs and ideas at the heart of how we plan and deliver our services now and for the future.

1. **Delivering our Patient Engagement Strategy - establishing a new Patient Engagement Hub**

   We are pursuing plans to establish a Patient Engagement Hub at VCC that acts as a point of co-ordination, signposting and advice for our patient engagement activity. Hub staff will be responsible for the implementation and development of the Patient Engagement Strategy, the management of a new patient engagement forum and provide secretariat support for a refreshed Patient and Carer Group. The hub will provide a link between VCC operational teams, Velindre Futures and the Transforming Cancer Services (TCS) programmes and to the Executive (EMB) team for their functions. The Hub will sit within the VCC planning function and align with the Programme Management Office to ensure it is at the heart of all VCC activity.



For the provision of Patient Information, the current service and information produced is currently being reviewed and developed through the Velindre Futures Development and Delivery Group e.g. how we are covering patient and carer information needs from the first contact to the end of treatment. Aligning this work and the new Patient Engagement Hub will be key if both services are to succeed in the future.

The Hub team will report against a set of performance metrics to EMB through a governance pathway that will include the role of the Patient Engagement Group.

2. **Delivering our Patient Engagement Strategy – staffing the Patient Engagement Hub**

The only staff resource dedicated to aspects of patient engagement currently is a Band 6 Patient Experience Co-ordinator whose role is a composite of patient experience and engagement including the secretariat for the Patient and Carer Liaison Group.The post-holder is consistently considered as the lead for all VCC patient engagement including the delivery of patient engagement activity linked to the new Velindre Cancer Centre and TCS projects.

To establish an effective Patient Engagement Hub we will need to invest in two additional roles. They are:

A new ***Head of Patient Engagement (8A***) with responsibility for:

- oversight of the delivery of the Patient Engagement Framework and its development
- oversight of all systems relating to the delivery of the Patient Engagement Framework, including the Information Governance requirements;
- main liaison point for department leads regarding patient engagement asks e.g. input into focus groups, feedback, testing, clinical trials etc.
- oversight of an integrated communications and engagement plan to deliver the Patient Engagement Framework
- management of the Patient Leadership Group and its development, among other responsibilities.

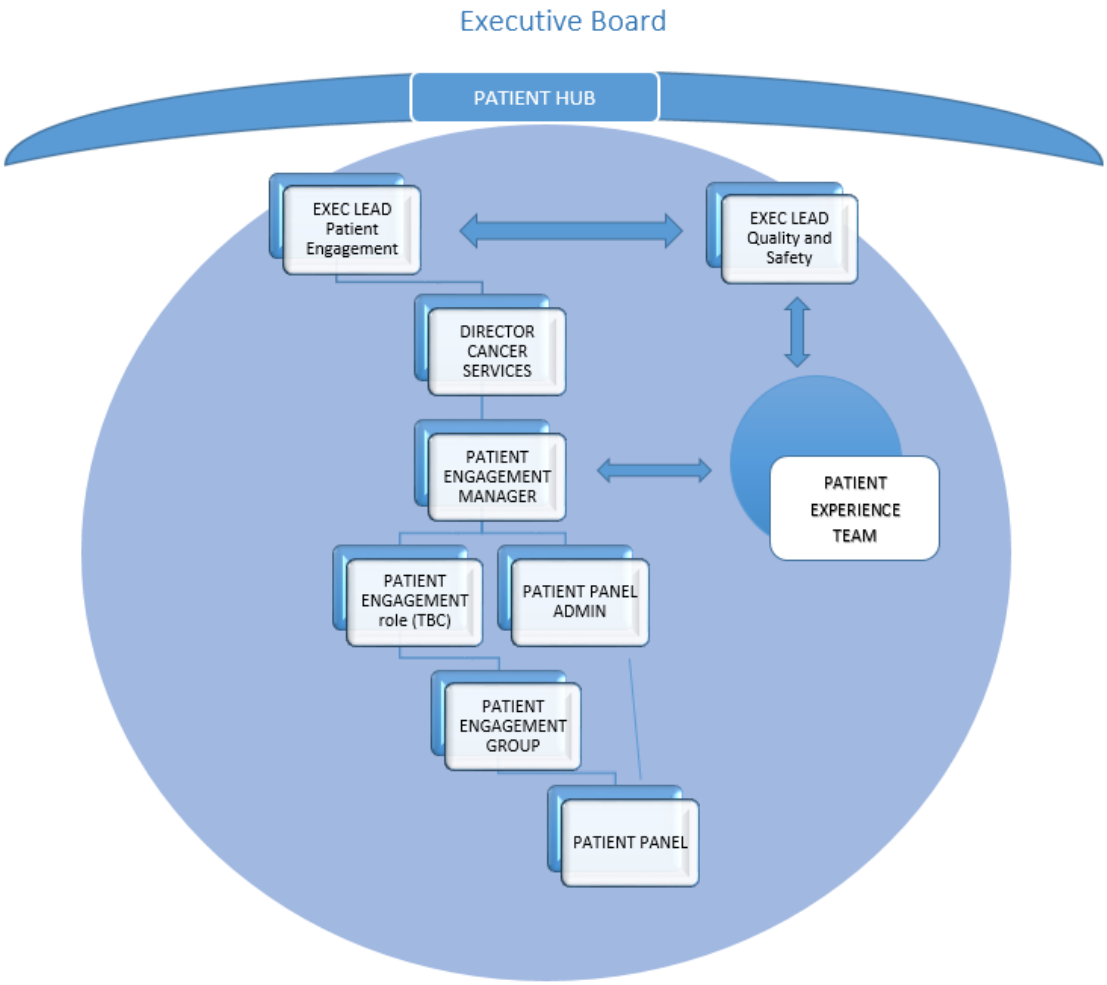
A new ***new Patient Engagement Coordinator (B5)*** *to support.*

We propose to fund these two posts through a bid to Velindre Fundraising charitable funds. This will be for an initial 24 months with a view to review and ongoing funding.

3. **Delivering our Patient Engagement strategy - Executive Leadership**

It is clear from the list of areas above that these areas map to the responsibilities of each of the members of the Executive team and our ways of working have to create a way of supporting the various engagement activities to support all of these areas of work.

However, we propose that the executive lead for this work is the Director of the Cancer Centre reporting to the Chief Operating Officer. This aligns with the approach at WBS where the executive lead for Donor Engagement is the Director of WBS.



4. Priorities: establishing a new patient forum – Velindre Voices

We need to develop a means for making, maintaining and optimising our contact and engagement with the broad range of patients we support to deliver the strategic goals set out in the strategy. To do this, our initial task is to establish a means, compliant with all GDPR and Information Governance requirements, of allowing our patients to opt-in to a system that effectively maintains their contact details, areas of interest etc and allows us to communicate and engage with those who have opted into the system and potentially for patients to engage with each other.

5. Priorities: establishing a new Patient Leadership Group

The terms of reference of the Patient and Carer Liaison Group places them as the voice of the patient directly through the Patient Experience Coordinator. There is an opportunity to be more ambitious in terms of the representation of the Velindre patient community with the establishment a new patient forum and a refreshed Patient Engagement Group (PEG). There is appetite both within the VCC staff and the membership of the PLG for evolution and change within the current set up. A detailed transition plan is in development based on good practice elsewhere and the PLG's experience and ambition.

Among the key principles guiding the refresh are:

- Members of the PEG acting as the 'conscience' of patients ensuring that the patients' needs are at the forefront of any change or discussions.
- Group members to serve for a defined period rather than until they decide to stand down
- Members acing as the recruitment champions for the Patient Forum
- Provision of training and support for PEG members, building on work already undertaken in partnership with the Kings Fund and drawing on external expertise.
- Nominated members' continued attendance at Trust Board and specific committees.

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	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

4. RECOMMENDATION

4.1 Strategic Development Committee is asked to **ENDORSE FOR BOARD APPROVAL** the Patient Engagement strategy for Trust on 26th May 2022.

Appendix 1

Patient Engagement Strategy

Velindre University NHS Trust - Velindre Cancer Services

Gweithio gyda'n gilydd/ How we work together:

Our new patient, family and carer engagement strategy for Velindre Cancer Services.

March 2022

Velindre University NHS Trust has a proud, well-established history of providing cancer services, treatment and care for the patient population of south east Wales. We deliver our services at Velindre Cancer Centre in Whitchurch, Cardiff and other hospitals in the region. Over time, the services we deliver, the national and international healthcare landscape and cancer care network have changed significantly. In parallel, access to communications and technology with considerable potential to connect patients to clinicians and each other during their cancer journey continues to evolve.

Our new Velindre Cancer Centre patient engagement strategy has been developed to reflect these changes with one clear outcome in mind – to provide a strategy that that will allow us to embed an honest, trusting, respectful partnership with our patients at the heart of everything we do.

Introduction

Our patient engagement strategy has been developed working in conjunction with Velindre Cancer Centre patients, our volunteers, our staff, cancer charities and the Community Health Councils. It outlines how we will engage with our patients, their families, and carers in the future to ensure that their voices are at the heart of how we plan and deliver our services.

Why have we done this?

Velindre Cancer Centre is undergoing a period of unprecedented change. We are undertaking an exciting, ambitious programme of work to improve the cancer services we deliver for our patient population, building on our past achievements and learning from our experiences.

We are working from strong foundations, but our future success will be dependent on the strength of our partnerships with our patients, public and healthcare colleagues across South East Wales.

The focus of this strategy are the actions that we will take to achieve a step change in our partnership with our patients to improve what we do today and plan what we need for the future. Specifically, how we make sure that patient voices are threaded through our work from the outset and by adopting an accessible, innovative approach, guided by the Welsh Government's ambitions.[1]

Who is this Strategy for?

This strategy has been written for Velindre Cancer Centre patients, their families and carers, our staff, volunteers and other organisations that work with us to deliver cancer services. These organisations may be other NHS organisations, charities, other third sector organisations or healthcare providers.

In recognising that the focus of this strategy is patient, family and carer engagement, we will also align it with our emerging public involvement strategy and the Welsh Blood Service's (WBS) donor strategy. The donor strategy will include the way in which we recruit and engage, with the engagement aspect aligning with this document.

[1] The relevant Welsh Government documentation at time of publication is available as Annex A

Throughout this document, for simplicity we will refer to patients, however this should be read as patients, their families and carers. It considers engagement with patients, their families and carers as individuals and also as a group.

The context – national, regional and at Velindre Cancer Centre

Velindre University NHS Trust (the Trust) has a 10-year organisational strategy which outlines an ambition for the cancer services it delivers through the Velindre Cancer Centre and our partners. The strategy meets the aspiration of Welsh Government strategies and policies.

This patient engagement strategy outlines how we will empower the patient voice into the delivery of this aspiration and support the Trust's Purpose, Vision and Vales in its new ten year strategy.

Trust's Purpose:	To improve lives
Trust Vision:	Excellent care, Inspirational Learning, Healthier People
Trust Values:	Accountable, Bold, Caring, Dynamic

We will also ensure that this work aligns with our Strategic Equality Objectives to enhance our ability to meet the differing needs of all our communities and to ensure that the strategy aligns with our core objectives creating a culture of fairness and inclusion.

How was this strategy developed?

This Strategy was developed in partnership. We explored ideas from other organisations and reflected on their suitability for our work. We also undertook focus groups, individual meetings, drop-in sessions, and offered opportunities for staff to respond to a questionnaire to find out what we are doing well, what we could improve and to share ideas for consideration. We spoke to and heard from a wide range of voices including:

- Our patients, their families, and carers
- Our staff
- Our volunteers
- Our wider stakeholders

Our work has also been supported by a Steering Group, made up of patients, staff, and wider stakeholders with an excellent track record of either delivering cancer services, public engagement or in some instances, both. Crucially, patients from across the region shared their experiences with us. The group included representatives from our Patient Liaison Group, Community Health Councils, Wales Cancer Alliance, Wales Cancer Network, Diverse Cymru and Wales Cancer Research Centre. It also included members of our Digital Team. The steering group was chaired by an Independent Member of the Trust Board. The work was facilitated by the Wales Co-operative Centre.

What do our patients, their families and carers expect from us?

When we asked our patients, their families, and carers about their expectations they told us:

- Patients want to be seen, heard and recognised.
- Patients want to be treated as individuals, with respect and receive personalised care
- Patients want conversations about their treatments in language they understand.
- Patients expect our services to be accountable and transparent and provide treatment and care that they can trust.
- Patients want to be involved (volunteering, Patient Liaison Group, Focus Groups, Fundraising).
- Patients want to know about and be part of research opportunities.
- Patients wants modern digital ways of keeping in touch and updated.
- Patients want the right information, at the right time.
- Patients want to know about additional support after their treatment has been completed.
- Patients want to influence the services for others in the future

When we asked staff about their expectations they told us:

- Staff want patient engagement to be integrated across the departments, projects and service changes.
- Staff want an organised process about how to engage with patients.
- Staff want to use digital technology to record patient details.
- Staff want a large patient panel that they can ask for input on a wide range of activities
- Staff want patients to feel empowered to feedback.

What do we mean by patient engagement?

The terms patient engagement, patient experience and patient involvement are often used interchangeably in healthcare and can lead to confusion, both within and outside organisations. In delivering this Strategy we wanted to clarify what each of the terms means to us at Velindre:

Patient engagement

Patient engagement is the umbrella term we use to describe the wide range of activities and interactions we have with our patients and those who care for them. How we do this will differ, depending on our responsibilities, but we have a common aim - to benefit the treatment, care and well-being of our patients today and those we will engage with in future.

The spectrum of activities we include when we talk about patient engagement include:

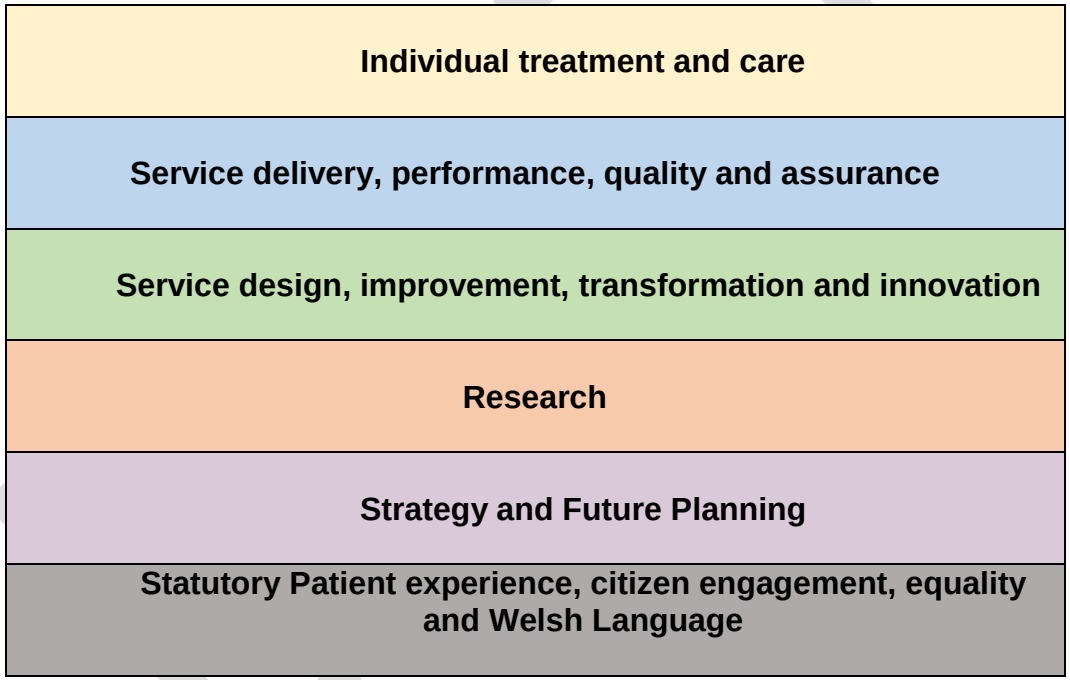
What we do	What it means
Informing	Sharing information effectively with our patients and providing the means for them to ask questions and feedback e.g., providing updates on our digital platforms or corresponding directly with individual patients.
Continuous Engagement	Gathering feedback on activity planned by Velindre and seeing the impact it had e.g., developing a new Velindre Cancer strategy and asking our patients what they think of the content.
Experience	Looking at and understanding what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care. It is about all of our cancer services, delivered across all of our healthcare settings. Ensuring that feedback

	from patients on their experience is acted upon and services improved.
Involving	Working directly with the patients on our future plans to ensure that their concerns and suggestions are understood and considered and demonstrating clearly how we responded e.g., inviting patients to focus groups to provide feedback on our future services.
Supporting	Providing wellbeing and welfare support for patients, their family and carers throughout their cancer journey e.g., signposting patients to our work with cancer charities, to financial services to support them along their journey or providing counselling services.
Collaborating	Contributing ideas and suggestions for improvements and in each aspect of the decision-making process, including developing alternatives and identifying the preferred solution e.g., patient forums or juries that enable us to work with patients to identify priority areas for improvement.
Empowering	Decision making power is in the hands of our patients, with the support of their family and carers e.g., creating the means for patients to make decisions on service priorities.

Which areas of Velindre Cancer Centre does the patient engagement strategy cover?

Velindre provides care for patients at the Velindre Cancer Centre, sometimes at other hospitals or mobile units in the south east Wales area. Everyone working at Velindre will play a part in the successful delivery of this Strategy.

There are six key areas of how we work that dependent on its success:



Our Ambition for Patient Engagement

We have developed our ambition in partnership with our patients, our staff, our volunteers and our partners.

We want to make sure that patient voices are threaded through Velindre Cancer Centre's work from the outset and partner with our patients to improve what we do today and plan what we need for the future.

Our Goals

Following the feedback from patients, staff and partners, we developed seven goals for our Strategy:

1. We will ensure that patient voices, both as individuals and as a group, are heard, listened to and have a visible impact.
2. We will ensure that all patients are enabled and empowered to engage with Velindre, including the voices of those that find it harder to be heard and those of our younger patients.
3. We will ensure that patient engagement is embedded into the way we work and at the heart of our organisational culture.
4. We will ensure that the reach of our engagement activities are maximised by implementing a range of tools and techniques, driven by evidence of our patients' preferences and choices.
5. We will signpost our patients, their families and carers to the right information, at the right time.
6. We will increase the opportunities for patients, their families and carers to take part in research and raise awareness of these opportunities.
7. We will excel in our statutory obligations including engagement with the Community Health Councils (and future successor organisations) and delivery of the NHS Strategy for Assuring Service User Experience and the Health and Care Standards (Wales Quality Standards).

By delivering these goals, we want our patients to:

- have the confidence and means to ask questions, make suggestions, collaborate and contribute to how we work together.
- feel listened to and valued as they progress on the patient pathway, and
- be empowered to contribute to Velindre' success today and help develop future services.

What will underpin our Goals?

Goal 1 – We will ensure that patient voices, both as individuals and as a group, are heard, listened to and have a visible impact

To achieve this we will:

- Outline our intentions and develop our approach and ways of working. This will include undertaking regular reviews and capturing feedback about how well we are doing and how we can keep improving. We will look at how we interact with each patient in providing them with information and an ability to feed back their experience, but also how we bring people together to share their views and ideas.
- Support patients to make shared decisions on their care with their care team.
- Create ways of working across the organisation, from front line service delivery to our strategic planning, to make sure that the patient voice is heard and that we work effectively in partnership, drawing on the experience of others and finding champions for our Patient Engagement Strategy from staff and patients.
- Create pathways to identify and recruit patients to join our patient voice groups.
- Work with Health Boards, to enable us to listen to the patient voice across the care pathway; recognising that people are often seen and treated in a number of different locations.
- Develop and use a range of training, information and tools to help patients work confidently with the service to provide their views, their experience and their thoughts and ideas in a range of ways recognising that people may want to have different opportunities and provide this information in a way that is easy to find and use.
- Work effectively with the third sector, Health and Care Research Wales and the Community Health Councils (and future successor organisations) to make the most of voices, skills and resources.

Goal 2 - We will ensure that all patients are enabled and empowered to engage with Velindre, including the voices of those that find it harder to be heard and those of our younger patients.

To achieve this we will:

- Make sure that the voices that we are hearing and people we are working with represent our patients in terms of their characteristics, where they live and the services and care that they receive. We will regularly review that we are achieving this.
- Set up a Patient Panel where we patients can be involved and input their feedback and thoughts
- Ensure patients are supported and signpost our services for well-being and after-care.
- Provide support for patients who help us by providing guidance and training. being

Goal 3 - We will ensure that patient engagement is embedded into the way we work and at the heart of our organisational culture.

To achieve this we will:

- Provide our staff with appropriate levels of patient engagement skills, training and information, starting at induction, so that they fully understand the importance and benefit of patient engagement and what we all need to do.
- Embed the patient voice in the ways we work throughout the organisation, across the spectrum of what we do; from strategic planning to service improvement.
- We will establish a patient engagement hub for the cancer service that provides a focal point for patients, staff and stakeholders to contact us and work with us.
- Ensure that our commitments are clearly visible to patients, staff and visitors.

Goal 4 - We will signpost or provide our patients, their families and carers to the right information, at the right time.

To achieve this we will:

- Review and revise the information that we currently provide to patients at the different stages of their treatment and recovery.
- Provide or signpost patients to relevant information at the start of their contact with us and this will include their treatment plan. We will make sure that patients, their families and carers know who they can speak to if, or when, they have any questions.
- Support patients, their families and carers to be able to ask us a question, raise a concern or provide us with feedback.

Goal 5 - We will ensure that the reach of our engagement activities are maximised by implementing a range of tools and techniques, driven by evidence of our patients' preferences and choices.

To achieve this we will:

- Make information, tools and resources available at the right time and in accessible ways.
- Continue to develop how we use our digital tools for patient experience feedback and provide more opportunities for feedback to be captured.
- Test and measure how effective we are at engaging and take any action, if needed, to improve. We will regularly review good practice examples and update our tools and techniques as necessary.

- Ensure that our ways of working include different ways of contributing, including making the most of what digital technology can offer for communicating, getting in touch, sharing feedback or ideas.

Goal 6 - We will raise awareness of and increase the opportunities for patients, their families and carers to take part in research.

To achieve this we will:

- Increase opportunities to take part in a wide range of research including treatments, support services, and how we work as an organisation.
- Ensure that research and research opportunities are accessible and explained in clear language.
- Provide patient and family signposting on the organisational research and innovation opportunities available, including general information on research
- Seek appropriate patient /carer involvement in our research and innovation activities
- Ensure the patient voice is present (patient, public representative) in appropriate research governance and leadership groups that shape, drive and manage the Research &Innovation agenda of the organisation.
- Provide appropriate support and mentorship to patients and carers, facilitating engagement and/or involvement in Research and innovation.
- Better understand the patient/ carer experience surrounding research participation, engagement and involvement to improve our research service
- Communicate the impact of our research and innovation, recognising the input of patients and carers.
- Build on our strong relationships with organisations that undertake or commission research, such as our partner Academic Institutions, Health and Care Research Wales, National Institute for Health Research, CRUK, Macmillan, Tenovus and NICE.

Goal 7 - We will excel in our statutory obligations including engagement with the Community Health Councils (and future successor organisations) and delivery of the NHS Strategy for Assuring Service User Experience and the Health and Care Standards.

- We will make sure that we continue to be actively engaged with the Community Health Councils in the areas where we provide our patient services and grow and develop this where we can.

- We will support the work of Welsh Government to develop the Citizen Voice as introduced in the Health and Social Care (Quality and Engagement) Act 2020. The Citizen Voice will replace Community Health Councils in April 2023
- We will articulate and plan our ambition in delivering the Strategy for Assuring Service User Experience and integrate it into our ways of working, meeting the requirements set out in the Health and Care Standards.

How are we going to achieve these goals?

Culture, Process, People

We know that we have work to do if we are going to achieve our ambition and the goals we have set ourselves. We plan to adopt a phased approach to the implementation of this Strategy and will develop a detailed and dynamic action plan that will sit alongside it. We will monitor our achievements against this action plan and share what we achieve.

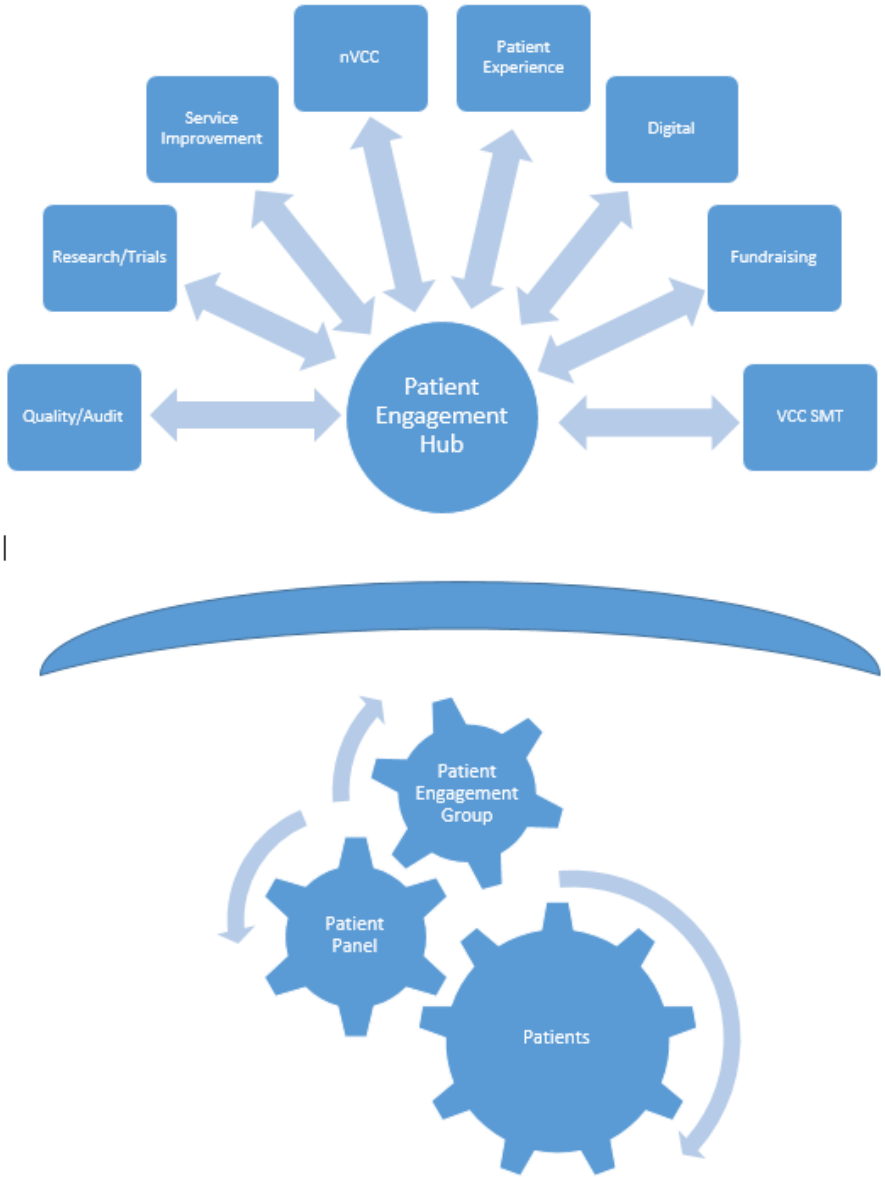
If we are going to deliver the goals outlined in this Strategy, in addition to our patients, our staff are key to our success. We must continue to keep them involved in the Strategy's implementation and keep them informed, involved and updated on progress made and how it develops in future. We need to work with them to develop a culture where engagement is embedded in our everyday activities. For many of our staff this is already the way that they work, and we need to give them the tools and techniques to build on the good practice that already exists. Our consultation with staff has also highlighted that many of our non-patient facing staff want to be able to engage with patients as they look to improve and develop functions, such as the information that they provide or the services that they offer. Again, we need to provide them with the tools and opportunities to be able to do this.

Co-ordinating and managing the work and the right tools and techniques

Engagement has to be an integral part of how we work so it needs to be embedded within the service. We will establish a patient engagement hub for the cancer service that provides a focal point for patients, staff and stakeholders to contact us and work with us. Together the Patient Hub will work with patients, colleagues, senior managers, the Executive team and Board to help us deliver our aspirations. It will work in collaboration with staff responsible for activities such as Communications, Clinical Audit and Patient Experience ensuring that the messages we hear and the lessons we learn things we learn are incorporated into the changes we plan and make their way through our work planning and programme office.

Sharing how we have listened and the difference the patient voice has made will be essential. Links with all of our communication channels will be used to provide ongoing feedback and share successes but we will also undertake periodic reviews of progress that will be reviewed by the Patient Engagement Group and provided to the Board as part of their assurance role.

PATIENT ENGAGEMENT HUB VISUAL



The Patient Experience function reaches out to gather details on experience, as outlined in the NHS Strategy for Assuring Service User Experience, which together with the work of the Trust Quality and Safety team in dealing with “concerns” under the *Putting Things Right* regulations i.e. how we manage complaints, provide two important sources of information and feedback. The patient engagement strategy will be aligned with these existing mechanisms.

How will the Strategy work?

Each of the members of our Executive Team increasingly require insight on the voice of our patients to fulfil their role. We know that we need to ‘join up’ how the work that happens. Our aim is that the Patient Engagement Hub acts as a single point of contact to drive and coordinate our engagement activities. This function will also have a key role in supporting our drive for equality in access to services, to participation and ultimately reducing health inequalities.

We also know that we will require new ways of identifying patients, reaching out and holding on to them in a range of ways that are accessible to them and efficient for us to manage. This will require some investment and increased training in new digital tools. The Patient Hub will lead on the development of a toolkit summarising the purpose, benefit and requirements of innovative ways of collating, analysing and sharing patients’ views and ideas working and learning with external partners, including Audit Wales’ Best Practice Unit.

To achieve our ambition we need to make changes to the way the organisation works – how we coordinate our activities and the tools, techniques and technology available to us to improve how we connect with our patients. The details on how we do this will be include in our delivery plan.

Oversight of the Strategy’s delivery

In summary:-

- The Strategy is owned by the Trust.

- Assurance for its delivery will be a matter for the Trust Board and Committees and they will be supported by patient representatives.

- Accountability and management of the Strategy's delivery will be shared by the Trust Executive Leadership, the Senior Management Team and the Velindre Cancer Centre Patient Engagement Team

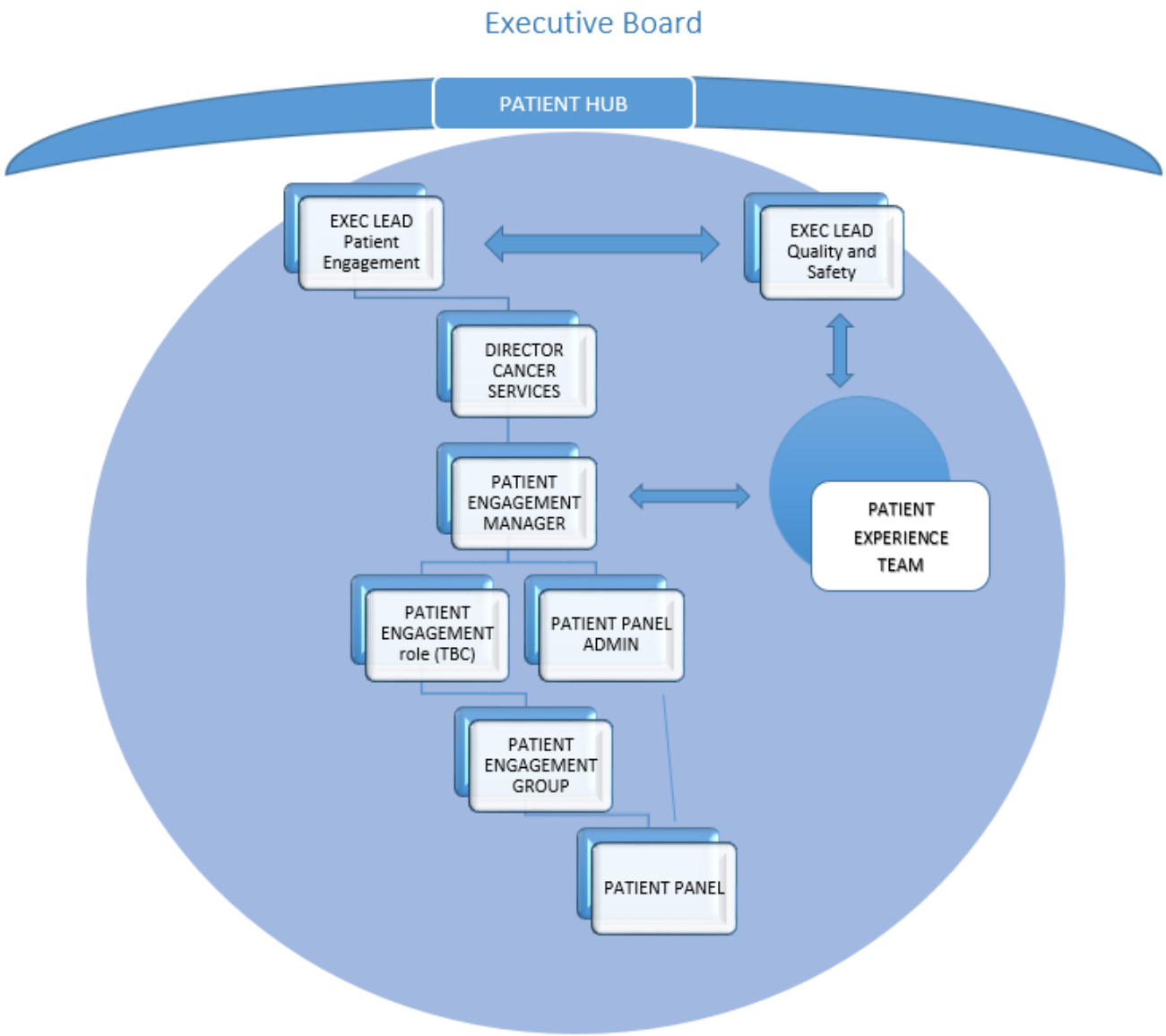
- Operational responsibility for the Strategy will be the Director of Velindre Cancer Services supported by the Chief Operating Officer

- The Executive Lead for ensuring the delivery of the Patient Engagement Strategy will be the Chief Operating Officer

- In addition, a newly reformed Patient Engagement Group (formally Patient Liaison Group) will also consider the role it will play in ensuring the delivery of the Strategy's goals, working with staff to support delivery and as patient engagement champions, and helping us review our progress and achievements.

- A new Patient Panel (a list of volunteers) will be set up, consisting of people who wish to share their views so that they can be involved in service changes, feedback, surveys etc.

- A new Patient Engagement Hub will be set up to support the coordination and alignment of current patient engagement with our patient experience duties, volunteers, Fundraising activity and involvement activities across the cancer centre.


Executive Board
PATIENT HUB
EXEC LEAD Patient Engagement
EXEC LEAD Quality and Safety
DIRECTOR CANCER SERVICES
PATIENT ENGAGEMENT MANAGER
PATIENT EXPERIENCE TEAM
PATIENT ENGAGEMENT role (TBC)
PATIENT PANEL ADMIN
PATIENT ENGAGEMENT GROUP
PATIENT PANEL

Bringing in Patient voices, a new patient engagement and leadership structure.

Our goal is to make sure that we have a wide range of patient voices. To do this we will establish a Patient Panel. By this we mean we will ask people to volunteer to give us their feedback and opinion from time to time. To help us do this we will ask them to register their interest and in doing so, they will become a member of our patient panel. This won't bring any obligation, other than for us to contact them, from time to time and offer an opportunity to become involved. This involvement will vary from a simple survey or focus group, to being part of a short-term working group to solve a problem or shape a change or improvement. Patients taking part in any activity for us will be reimbursed for out-of-pocket expenses such as travel and meals.

In addition to this, we need patients to be the champions of patient engagement and to work with us on a more regular basis. To do this we will create a Patient Engagement Group. This will replace our previous Patient Liaison Group, broadening its previous function.

The Patient Engagement Group will be made up of 12 people, who will be drawn from across the populations that we serve. Their role will be champions for patient engagement and promote the opportunities of being part of the Patient Panel with patients from all backgrounds and experiences. The group will work with us to review our achievements against this intent and Strategy. Its members will receive training and support to participate in a range of activities bringing the expert patient voice including attending various governance and planning activities within the Trust. The Chair of this group will attend the Trust Board with a specific focus on being the conscience and voice of the patient. Further members of the Patient Engagement Group will also attend other Trust Committees.

The design and development of the new Velindre Cancer Centre provides a once in a generation opportunity and will need the patient voice threaded through a myriad of activities starting on the appointment of the contractor and continuing till we open the doors to the first patients and beyond. Setting up a Patient Panel will be key to ensure we hear from patients as they help us to design a cancer centre fit for the future. There will be many opportunities for engagement as we move through the stages of the development and our transition to the new centre and also the changes in service that we anticipate across the region such as the development of the new radiotherapy centre at Neville Hall.

This Strategy gives us the opportunity to ensure that there is a collective process around patient engagement and to ensure that patients stay at the centre and at the heart of what we do.

Measuring our progress, our success and share the benefit this brings

A delivery and action plan will underpin this Strategy and work is being undertaken to shape this plan in parallel with the development of this Strategy.

As part of this delivery plan we will develop a set of indicators that we will use to measure our success. Our communication plan for Patient Engagement will include how we share our opportunities and successes with staff, patients and other stakeholders.

Our progress will be reviewed and monitored by the senior team at the cancer centre, the Executive team, the Patient Engagement Group and the Board with each making suggestions and proposals based on their role.

March 2022

Appendix 1

The legislative and policy context in Wales
Within the legislative and policy context in Wales, the patient voice and the recognition of the patient voice, is increasing in importance. The policies and legislation outlined below are all relevant to our services at Velindre and highlight the importance of patient engagement.

A Healthier Wales
A Healthier Wales builds on the philosophy of Prudent Healthcare and the central idea of the Quadruple Aim, focusing on:

- Improved population health and wellbeing.
- Better quality and more accessible health and social care services.
- Higher value health and social care, and
- A motivated and sustainable health and social care workforce.

A Healthier Wales highlights the need for the citizen and patient voice to be recognised and acknowledged, empowering people with the information and support they need to understand and manage their health and wellbeing and allowing them to make decisions about care and treatment based on 'what matters' to them. It also recognises the need for simple, clear, timely communication and co-ordinated engagement, appropriate to age and level of understanding.

National Clinical Strategy
The National Clinical Strategy sets out a coherent vision for the strategic and local development of NHS clinical services, and it is a vital part of a much broader approach, that was described in A Healthier Wales. Its purpose is to improve patient outcomes and support the planning and delivery of resilient clinical services.

The Strategy describes how clinical services should be planned and developed, based on an application of prudent and values-based healthcare principles, recognising the importance of co-production between health care professionals and patients. In doing so, it recognises the need to continue to shift focus from hospital-based care to person centred, community-based care.

There is also a broader challenge related to understanding what matters to the patient, in that treatment pathways can be recommended without fully comprehending what matters to the patient by a process of co-producing their care.
The emphasis should be on quality of life and what matters to the patient.

Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are one of the important tools that we need to give us ways in which we can measure the effect of the services we provide and here again there is a need for developing our approach.

The Quality Statement for Cancer (Welsh Government)
This statement is part of the enhanced focus on quality in healthcare delivery that was described in A Healthier Wales and the Quality and Safety Strategy. In the future, quality statements will be integral to the future planning and accountability arrangements for the NHS in Wales.

The statement outlines the quality attributes for cancer services in Wales; equitable, safe, effective, efficient, person-centred and timely. It describes the need for person-centred cancer care to be culturally embedded, for patients to be involved in the co-production of their care and where eligible, that patients are offered the opportunity to take part in clinical trials.

Health and Social Care (Quality and Engagement) Act
This piece of legislation is likely to come into force in spring 2023. The Act has a number of purposes, one of which is to strengthen the citizen voice.

The drive towards closer integration of health and social services, with improved public engagement, is reflected in the aims of A Healthier Wales, which sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement. To realise this ambition, this piece of legislation replaces Community Health Councils (who currently represent the patient voice in the health service only) with a new national - the Citizen Voice Body ('CVB') - that will exercise functions across health and social care. The CVB will work locally, regionally and nationally.

The aims of the new body are to:

- strengthen the citizen voice in Wales in matters related to both health and social services, ensuring that citizens have an effective mechanism for ensuring that their views are heard.
- ensure that individuals are supported with advice and assistance when making a complaint in relation to their care, and
- use the service user experience to drive forward improvement.

Currently we do not know about the practical details of changing from Community Health Councils to the Citizen Voice Body, which will extend to include social care. We will be keeping up to date with consultations and keeping in contact with our Community Health Council representatives as the changes are planned and implemented.

We will adapt our patient engagement strategy and any associated actions necessary as soon as we have a better understanding about the role of the new body.

Quality and Safety Strategy: Learning and Improving (Welsh Government)
This Strategy states that organisations, at every level within the NHS, should function as a quality management system, to ensure that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable. This Strategy builds on the documents outlined above and the impact of the pandemic on out healthcare systems.

The Strategy outlines the importance of engaging and listening to patients in developing quality, person-centred care services that are continuously improving. One of the actions within the Strategy places a duty on NHS organisations to demonstrate, through their plans, that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.

Health and Care Standards (2015)
The Health and Care Standards will continue to form the cornerstone of the overall quality assurance system within the NHS in Wales. There is a clear intent to revise the current standards and we will adapt our approach to meet these new criteria.

The standards highlight the importance of the patient voice and the coproduction of care outlining that co-production can support the delivery of person-centred care, which prioritises putting patients at the heart of all health care decisions and plans.

The standards also set out the criteria for health services to demonstrate how they respond to user experience to improve services and ensure feedback is captured, published and demonstrates learning and improvement

Strategy for Assuring Service User Experience (2018)
The NHS in Wales has adopted a service user experience Strategy which describes the evidence based key determinants of a good service user experience and identifies the key attributes and uses of a range of feedback methods.

Service user experience can be defined as ‘what it feels like to be a user of the NHS in Wales’. A service user can be defined as someone who uses or has access to health services in any setting, including their families and unpaid carers.

The Well-being of Future Generations Act 2015
The Well-being of Future Generations Act is a unique piece of legislation for the people of Wales.

We know that as a public body we have a number of duties relating to how we engage and involve our patients, their families and carers, for example to:

- Use a variety of accessible, inclusive engagement methods and formats
- Train relevant staff in principles and practices of public involvement
- Ensure patients are having ‘what matters’ conversations
- Involve people at the earliest possible opportunity
- Carry out a ‘you said, we did’ exercise

At Velindre we will continue to use the Wellbeing of Future Generations Act, the wellbeing goals and the five ways of working as the context in which we plan. This will ensure that how we work, who we involve and the decisions that we make will impact positively both now and in the future.

Appendix 2
VUNHST Mission and Vision – attached when it is completed

STRATEGIC DEVELOPMENT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	16/05/2022

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	9/05/22	Supported

1. SITUATION

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

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF), which may affect the achievement of the Trust's Strategic Objectives, and the 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 within the Trust.

1.2 The Strategic Development Committee is asked to:

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

b. **ENDORSE** the updated Trust Assurance Framework Dashboard that will be submitted to the Trust Board in May 2022.

c. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 3.3.

2. BACKGROUND

2.1 The Trust Board must be able to assure itself that the Trust is operating effectively and meeting its Strategic Objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

2.2 The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high-level Principal Risks that may

threaten the achievement of the organisation's Strategic Objectives and intent, a further update was reported to the Trust Board in March 2022.

2.3 As previously indicated there is not expected to be significant movement in the articulation of these risks in the short-term, instead these will be reviewed and evolved in line with the Trust's strategic planning cycle or in response to significant external changes.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following provides a high level summary of the work undertaken since March 2022, to update the Trust Assurance Framework, support its continued development, articulation and operationalisation within the Trust.

3.1 Revised reporting mechanism

3.1.1 Following discussion and engagement with risk colleagues in other Health Boards across Wales and the identification and assessment of increased automation of the Trust Assurance Framework colleagues in the Datix team are liaising with the Hywel Dda Datix team regarding the development of principal risks within Datix Version 14.

3.2 Trust Assurance Framework Dashboard

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

3.2.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since March 2022 in respect of the following Principal Risks:

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATED			
			MAR	APR	MAY	JUN
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**				

3.2.3 The following is a high level summary of the key changes that have been made to the Trust Assurance Framework since March 2022, a full overview of these changes is provided in the Trust Assurance Framework Dashboard at ***Appendix 1:***

- To note, 'Residual' Risk Score is the current score, with the current control environment, and its effectiveness, taken into account. 'Inherent' is the risk score without the control environment operating.

- **TAF 01: Demand and Capacity**

    - **At present Residual Risk Score –** has increased from 12 to 16. This is as a result of further review of the risk by the risk owner and both Divisions. The risk was rearticulated to be:
      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.

      The previous articulation focused on the Business Intelligence capacity – as it was recommended that restating in terms of the risk on actual capacity more clearly focused on the risk and also resulted in the score increase in both residual and inherent risks.

    - **Overall Level of Control Effectiveness -** has been assessed as 'Partially Effective'. Key controls and sources of assurance have undergone detailed review during the May cycle.
    - **Sources of Assurance –** Key controls and sources of assurance have undergone detailed review during the May cycle.
    - **Action Plan for Gaps Identified –**These will be reconsidered as part of next reporting cycle.

- **TAF 02: Partnership Working / Stakeholder Engagement**

    - ***Residual Risk Score*** - has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is being developed to specifically address the

control deficiencies and will be reviewed through Executive Management Board Shape to then update on in the May 2022 reporting cycle.

- ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
- ***Action Plan for Gaps Identified*** – Ways of working changes, including with partner organisations, has been agreed with Internal Audit as an advisory piece for the 2022/23 work programme.

- **TAF 03: Workforce Planning**

  - ***Residual Risk Score*** – has remained at **9** in this report. However, following Executive Management Board discussion in the May meeting, it was requested that the scoring of this strategic risk to be reconsidered – as Executive Management's Board's view is that it was likely to have increased in score. This work will now be undertaken and reflected in the next reporting cycle.
  - ***Overall Level of Control Effectiveness –*** has been assess as 'Partially Effective'.
  - ***Sources of Assurance –*** have not been assessed but within the action, log third lines of assurance are planned to be reviewed, with a target date of July 2022.
  - ***Action Plan for Gaps Identified –*** Continued review and reporting through committee cycle is planned. Additionally a review of third lines of defence are planned for completion by July 2022.
  - Key Control **C1** - People Strategy is due to be finalised in May 2022. This will provide the strategic framework for effective workforce planning arrangements going forward and an update reflective of this will be included in the next reporting cycle.

- **TAF 04: Organisational Culture**

  - ***Residual Risk Score –*** has remained at **9** in this report. However, following Executive Management Board discussion in the May meeting, it was requested that the scope and scoring of this strategic risk to be reconsidered in light of the

wider organisational change programme which is currently being shaped. This work will now be undertaken and reflected in the next reporting cycle.

- ***Overall Level of Control Effectiveness –*** has been assessed as 'Partially Effective'. However, the action plan includes further development of key controls to an effective level.
- ***Sources of Assurance –*** The action plan sets to identify third lines of assurance, as identified in the gaps in assurance.
- ***Action Plan for Gaps Identified –*** The action plan sets out the plan to continue to review and report through meeting cycles, develop third line of defence assurances and develop control effectiveness to an acceptable level.

- **TAF 05: Organisational Change / 'strategic execution risk'**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is in place to address the gaps in controls identified.
  - ***Sources of Assurance*** – There has been no change in this review
  - ***Action Plan for Gaps Identified*** – The action regarding development of enabling strategies is on target for completion in May 2022.

- **TAF 06: Quality & Safety**

  - ***Residual Risk Score*** - has remained the same at **15**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective', this is a change from the last reporting cycle, where an effectiveness rating of 'Not Yet Effective' was recorded.
  - ***Sources of Assurance*** – Sources of assurance remain unchanged from the last report.
  - ***Action Plan for Gaps Identified*** - has been reviewed and actions remain on target for completion by target dates.

- **TAF 07: Digital Transformation – Failure to embrace new technology**

    - ***Residual Risk Score*** - has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
    - ***Sources of Assurance:*** all key controls remain in place.
    - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance, slippage as outlined above has been the result of the existing vacancy for the Chief Digital Officer.
    - A full review is planned for this risk, which will be reported in the July meeting cycle.

- **TAF 08: Trust Financial Investment Risk**

    - ***Residual Risk Score*** – has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. This has not changed since the last review.
    - ***Sources of Assurance:*** the risk has been reviewed and no changes made to sources of assurance.
    - ***Action plan:*** Actions are on target for completion as expected.

- **TAF 9: Carl James – Future Direction of Travel**

    - ***Residual Risk Score*** – has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
    - ***Sources of Assurance:*** the existing key controls remain unchanged since the last review.
    - ***Action plan:*** progress has been updated and target dates remain unchanged and on target.

- **TAF 10: Lauren Fear – Governance**

    - ***Residual Risk Score*** – has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. This remains unchanged since the last review.
    - ***Sources of Assurance:*** the existing key controls in place remain unchanged since the last review.
    - ***Action plan:*** the action plan remain unchanged since the last review.

3.2.4 In addition to the above, the following provides a high level summary of the two remaining Principal Risks that were reviewed with no changes made to the overall risk status, with key controls and sources of assurance in place.

3.3 **Key Points from March and April Governance Cycle**

3.3.1 There were three key themes which were discussed in the March Strategic Development Committee, the March Trust Board and the May Audit Committee to note:

3.3.2 **Link to Risk Register, Performance Framework and Quality Framework** - At the March Strategic Development Committee and March Trust Board, the link between the risk register and the Trust Assurance Framework was discussed. It was agreed that this is to be developed to link relevant risks on the register to the strategic risks in the Trust Assurance Framework within this year's work plan for the framework's development. Following the development of the performance and quality frameworks, key metrics relating to the strategic risks will also be linked. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards. The first step is to link the risk register and Trust Assurance Framework – and this work will be completed over the summer for September 2022.

3.3.3 **Reverse Stress Testing** - There was an in-depth discussion at the March Strategic Development Committee was to understand the impact of the overall profile and the impact of a collection of these risks being brought together. The concept of reverse stress testing was commented on, that 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.

In the March Trust Board, this point was acknowledged in the paper and confirmed would be worked into the work plan for the framework's development. To note that in May Audit Committee, Independent Member expectation was that this should be progressed fairly quickly and so approach is currently being worked through. At a high level, it is proposed that this happens in parallel with the review of the overall risk profile, as approaching the macro level risk questions in this way will be a useful tool and input into the annual review.

3.3.4 **Link to Strategy Development** – At the March Trust Board, there were questions raised by Independent Members regarding the on-going development of the strategic risk profile, which forms the basis of the Assurance Framework.

In reviewing the profile over the next couple of months, 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 out thinking on macro strategic risks. For instance, articulations include matters such as:

- Sustainable, resilient operations
- Climate change
- Balance between human workers and intelligent robots
- Shifting talent pool and changing employee experience
- Flatter, more agile organisations
- New forms of funding

- Cyber crime
- Geo-political for Europe and China
- Consumer and service users expectations for authenticity
- Health care systems face the challenge of managing even more data
- Concerns over clinician burnout will continue
- Patient expectations for care at home
- Patient mental health and emotional continued focus
- Co-opetition and integration in system working

Also it will be important to frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then need to culminate in a Board Development Session in September.

4. 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.

5. RECOMMENDATION

The Strategic Development Committee is asked to:

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

b. **ENDORSE** the updated Trust Assurance Framework Dashboard that will be submitted to the Trust Board in May 2022.

c. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 3.3.

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	May-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Jul-22	
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	16	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)		Senior Management Team, COO review and EMB Review, QSP committee and Board.		Welsh Government Quality, Planning and Delivery Review.	

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		Performance Report Senior Management Team and EMB Review, QSP committee and Board		Welsh Government Quality, Planning and Delivery Review	
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		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	

GAP IN CONTROLS	GAPS IN ASSURANCE
During May, the risk description has been updated as are the key controls and sources of assurance. Gaps and action plan now being confirmed	

TAF DASHBOARD

DEMAND AND CAPACITY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jun-22	
EXECUTIVE LEAD	Carl James	

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	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 Committeee	IA	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 Committeee	IA	Wales Audit Office/Welsh Government	PA

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	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 Committeee	IA	Regulatory scope re MHRA tbc	PA
2.2	Local Partnership Forum		X	X		PE	Feedback from LPF	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
2.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
3.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
3.2	with effectively delivering ways of working/ work programmes			X		PE	Collectively agreed to and documented work programme	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
3.3	and data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

4.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				
4.2	with effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
4.3	and data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

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 of defence assurance are in place to a certain extent across most of the key controls. However, there is limited coverage from second and third line perspectives

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.	Jul-22
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 goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Jul-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	May-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Jul-22	
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	9	3	3	9	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	Not Assessed	Internal Audit Reports		To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	Not Assessed	Trust Board reporting against Trust People Strategy		To be completed as per compliance/ reg tracker update	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	Not Assessed				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	Not Assessed				

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	Not Assessed				
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	Not Assessed				
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	Not Assessed				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	Not Assessed				
C9	Agile 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	Not Assessed				

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

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

WORKFORCE PLANNING

1.1	Ongoing updates to EMB and Committee forums	Sarah Morley		Jul-22
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Jul-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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jul-22	

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	**9**	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		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	
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		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	

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					
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					
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					
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					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					

TAF DASHBOARD

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					
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					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

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	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		Jul-22
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Jul-22
1.3	On going updates in EMB and Committee fora'	Claire Budgen		Jul-22

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Jul-22									
EXECUTIVE LEAD	Carl James	**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	2	**4**

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x				Executive Management Board review		Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x				Executive Management Board review		Strategy Committee/QSP/Internal Audt 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		Executive Management Board review/ patient and donor feedback		Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x			Executive Management Board review		Strategy Committee/QSP/Internal Audt Review / CHC	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				Executive Management Board review / staff feedback		Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x						Internal Audt Review		Audit Wales/HIW	IA

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)	May-22
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 (on track for September 2022)	Sep-22
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022)	Sep-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	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.		
LAST REVIEW	May-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Jul-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

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

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

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews					
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 not finalized due to pandemic	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 & Candour guidance still under development	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 Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
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 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	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	May-22

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	May-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	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	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	Jun-22
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.	Jun-22

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	May-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Jul-22	
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	3	4	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

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports	PA	To be completed as per compliance/ reg tracker update	PA
Trust digital governance reporting	PA	Internal Audit Reports	PA		
Staff feedback	IA	Trust Board reporting against Trust Digital Strategy	PA		

TAF DASHBOARD

DIGITAL TRANSFORMATION

C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA		
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA		
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA		
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA				
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA				
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	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		

GAP IN CONTROLS	GAPS IN ASSURANCE

TAF DASHBOARD

DIGITAL TRANSFORMATION

Each of the controls (with exception of 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
	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

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	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (on track for July 2022) (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.3	New Performance measures for digital services (on track for July 2022)	Chief Digital officer		Jul-22

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Jul-22	**Goal 2**									
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	**12**	4	4	**16**	3	4	**12**	

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		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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	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		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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
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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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.	Jul-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.	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Jul-22	**Goal 2**								
EXECUTIVE LEAD	Carl James	**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**	**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			PE	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 Committeen and performance	IA	Audit Wales Reviews	PA

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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 Management	IA	Audit Wales/External Research organisations & Welsh	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	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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	May-22
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	May-22
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions in May 2022)
1.5	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions in May 2022)

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	May-22	1 - Outstanding for quality, safety and experience			
NEXT REVIEW	Jul-22	**Goal 1**			
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	PA	Internal Audit of Board Committee Effectiveness	PA

TAF DASHBOARD

GOVERNANCE

								Trust Board		Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements		

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 assurance) 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

TAF DASHBOARD

GOVERNANCE

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
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.		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		Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete

STRATEGIC DEVELOPMENT COMMITTEE

NUFFIELD TRUST INDEPENDENT ADVICE – A PROGRESS UPDATE

DATE OF MEETING	16/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carys Jones, Senior Programme Delivery & Assurance Manager Carl James, Director of Strategic Transformation, Planning and Digital
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TCS Programme Delivery Board	21.04.22	Noted

ACRONYMS	
CCLG	South East Wales Cancer Collaborative Leadership Group
FBC	Full Business Case
LHBs	Local Health Boards
NT	Nuffield Trust
OBC	Outline Business Case
VT	Velindre University NHS Trust

1. PURPOSE

1.1 The purpose of this paper is to provide an update on progress against the recommendations contained within the Nuffield Trust (NT) report[1] published on 1st December 2020.

1.2 This paper provides an update against the action plan as at **19th April 2022**.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Nuffield Trust were commissioned by Velindre University NHS Trust in September 2020 to provide independent advice on the regionally integrated model for non-surgical tertiary cancer services across South East Wales.

2.2 The report sets out 11 recommendations for Velindre University NHS Trust and Health Board (HB) partners to consider in securing planned and sustained improvements in cancer services in the immediate, medium and long-term.

2.3 The current position against each of the recommendations is set out in the 'Progress' column in Annex A. **Updates for April 2022 are illustrated in *red italics text*.**

2.4 The final column in the table at Annex A denotes which VUNHST committee is responsible for overseeing *the VUNHST accountabilities* within each recommendation.

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

[1] *Advice on the proposed model for non-surgical tertiary oncology services in South East Wales* (Nuffield Trust, December 2020)

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 update.

Annex A Nuffield Trust Recommendations: Progress Update (as 19th April 2022)

	Recommendation	Key actions	Lead	Target date	Progress	Committee responsible for oversight of fulfilling the VUNHST accountabilities within each recommendation
1	The planning process for all South East Wales cancer services needs to be reviewed and its coordination improved, with the development of a common dataset and planning approach put in place. Steps have been taken to support this and it is going to be very important that the CCLG is effective – this will help to fill the strategic gap in the planning of cancer services that has existed across South East Wales. There are some lessons from the development of the more successful cancer alliance models in England that could be followed. These take responsibility not only for the planning of cancer services but also for leadership and performance management.	**<u>Developing the cancer system (alliance approach)</u>** • Agree strategic approach for SE Wales e.g. Alliance or Vanguard model • Develop approach/plan to evolve CCLG e.g. programme/ governance/resources **<u>Developing strategy for South East Wales</u>** • Initial discussions across region/scoping • Establish arrangements for strategy development • Develop plan/ identify resources/ arrangements etc	HBs/VUT HBs/VUT HBs/ VUT	Tbc following workshop Apr 2022 (this date is subject to system decisions at workshop	• CEOs/CCLG all agree on principle of approach • Regional workshop and approach agreed with CCLG Chair • Supplier for the external facilitation identified and initial scoping discussion held • *System Workshop to be held on 29th April.* • *Exec attendance from each SEW HB secured.* • *External facilitation from Nigel Edwards, CEO Nuffield Trust (NT) secured.*	Strategic Development Committee

				in April 2022	• *Workshop agenda agreed with HB partners and NT* • *External speakers from SE London Cancer Alliance sharing their learning.* • *Director of Welsh Cancer Intelligence and Surveillance Unit (WCISU) providing population health context.* • Agreement in principle of benefits of SE Wales Cancer Strategy.	
2	Full co-location would have advantages but is not practical for a significant period of time. However, action is required soon to deal with the issues with the estate and linear accelerators at the VCC.	• Secure approval of Commercial Approval Point (CAP) 1 • Secure approval for OBC for new Velindre Cancer Centre • Secure approval of Commercial Approval Point (CAP) 2 • Procurement and Pre-Qualification Questionnaire (PQQ) of bidders • Run Competitive Dialogue and award contract	VUT VUT VUT VUT VUT	Feb 2021 Mar 2021 Aug 2021 Jul 2021 Sep 2021	• Complete • Complete • Complete • Complete • *On track. Competitive dialogue nearing completion (commenced w/c 6th*	TCS Programme Scrutiny Sub-Committee

					Sept). Dialogue and 3-week Bootcamp elements complete.	
		• Secure approval of Commercial Approval Point (CAP) 3	VUT	Feb 2022	• *Complete*	
		• Secure approval of Commercial Approval Point (CAP) 4	VUT	May 2022	• *On track*	
		• Construction of nVCC	VUT	Dec 2024	• On track	
		• Secure approval for OBC/FBC for Integrated Radiotherapy Solution for SE Wales	VUT	May 2022	• *On track. Final IRS tender evaluation report to Board in May 2022. FBC being drafted.*	
3	In the near future, each HB needs to: a) Develop and implement a coordinated plan for: - analysing and benchmarking cancer activity against their areas - advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E	HBs required to develop plan: • Benchmarking plan etc • develop a revised target operating model for non-surgical tertiary oncology services	HBs/ VUT HBs/VUT		• HBs have a range of benchmarking in place for clinical services. Further work required for key system markers. To be considered following system workshop.	Strategic Development Committee – for design and development Quality, Safety & Performance

	- acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haemato-oncology and solid tumour work together	including alignment of the AOS/ambulatory care models **Phase 1:** V@UHW: scoping commenced Feb 2021 - Archus consulting commenced to support - Develop Programme Brief and establish governance - Establish project work streams and run clinical design workshops: **i. RD&I**	CAV and VUT CAV and VUT	Feb 2021 May 2021 Jun; Sep; Oct 2021 Oct 2021	• AOS business case approved and Phase 1 implementation underway. • Complete • Brief complete and agreed May 2021. • *Joint Planning Manager post appointed (CAV& VUT) to support the V@UHW work.* • RD&I – Final Cardiff Cancer Research Hub Clinical Output Specification (COS) complete. • Endorsed at CCLG (Oct 2021) for detailed business case development work to commence.	Committee – for delivery

					• *COS agreed by all partners (endorsed by Velindre Trust Board Jan 2022). CAVUHB to approve route for final governance sign off (Board or Management Executive level)* • *All partners agreed initial phase 1 funding to support moving solid tumor trials to UHW* • *Agreed lead for funding strategy and benefits realisation work* • *Project Board established and well attended by all tripartite partners.*	
	b) Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods	**ii. unscheduled care;**		Dec 2021	• Acute / Unscheduled Care Data analysis complete • Acute / Unscheduled Clinical Design Workshop (Sep) and follow up sessions held (Oct & Jan '22).	

	for improving access to specialist opinion.	**iii. haematology and oncology** - Redesign pathways - Develop business proposals/implementation plans			• *Integrated non-elective cancer pathway between UHW and VCC developed via clinical workshops.* • Scope and ToR agreed • Limited progress due to capacity constraints	
4	The new model should not admit those who are at risk of major escalation to inpatient beds on the VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the VCC therefore need to be revised to reduce the risks associated with acutely ill	• Agree changes to current admission criteria and other required internal VCC changes	HBs/VUT	May 2021	• Complete: Internal VCC operational changes completed, delivered via Velindre Futures. Retrospective audit against revised admissions criteria completed and final results shared at Jan	Strategic Development Committee – for design and development Quality, Safety & Performance Committee – for delivery

	patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review	• Changes in operational flows of small number of acutely unwell patients to DGH Phase 1: V@UHW Phase 2: V@AB and V@CTM • Development of regional Acute Oncology Service: - Development of project brief/governance - Development of clinical model - Development of proposal / business case - Approval of business case	CAV/VUT CTM/AB/ VUT	Oct 2021 Mar 2022 (initial model) – up to 2024 for new infrastructure Oct 2021	clinical design workshop. • Agreement to develop Acute Deteriorating Patient Pathway between VCC & UHW. • *Joint formal pathways for USC and IO (including triage) are being developed with CAV clinical teams. Pathway document drafted.* • *Formal transfer pathways for unwell/acutely unwell patients being developed with CAV clinical teams. Transfer document for SOS/Unwell patients is in place.* • Complete • Complete • Complete	

		- Implementation			• Approved by VUT, CAV and ABHB Boards. • *Awaiting confirmation when CTM Board will receive revised local business case for consideration of the preferred option*. • SRO confirmed as Exec Director of Planning, ABUHB • Regional Project Manager appointed to support implementation. • On track. Preparatory activities for implementation underway in parallel with BC approvals (e.g. recruitment prep). • *IT Upgrade to VCC conference room planned for April 2022 to support virtual oncology advice.* •	

5	To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of the VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.	• Develop Velindre Research strategy • Identification of options/solutions to develop a hub at existing UHW • Development of clinical model for research V@UHW • Develop business proposals/implementation plans • Implementation • Exploration of strategic solution for long-term V@ facility in UHW2 and alignment of strategic capital business cases	CAV/VUT CAV/VUT	Apr 2021 Jun 2021 Oct 2021 Oct 2021 Tbc – awaiting confirmation of UHW2 timelines	• Complete • Complete • On Track – see above Rec 3 • On Track – see above. • On Track. Project Board in place to oversee implementation plan if/when governance approvals received.	Strategic Development Committee – for design and development Quality, Safety & Performance Committee for delivery
6	The ambulatory care offer at the VCC should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic	• Review of current arrangements to determine what further opportunities exist for change in patient flows for (i) SACT (ii) diagnostics. • Development of regional operating model (as per recommendation 3) for:	See Rec 3 & 4	See Recs 3 & 4		Strategic Development Committee – for design and development Quality, Safety & Performance Committee for delivery

	resource for South East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics.	(i) V@UHW (ii) V@AB (iii) V@CTM			(i) See Rec 3 (ii) SACT Outreach discussions underway with provision at NHH (iii) Work included in outreach and clinical projects, but further work required. See also AOS business case (complete)	
7	The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.	• Development of regional operating model developed for non-surgical tertiary cancer services which finalises V@ requirements for at home/outreach care • See Recs 3 & 4		See recs 3 & 4	See recs 3 & 4	TCS Programme Scrutiny Sub-Committee (as already part of PBC) Also – linked to 4-6 above, therefore as part of linked updates to: Strategic Development Committee – for design and development Quality, Safety & Performance Committee for delivery

8	The development of a refreshed research strategy is a priority and further work is required to fully take advantage of the networked model.	• Development of Velindre Research strategy • Alignment of Research, Development & Innovation strategies across South East Wales - alignment with development of service/infrastructure: (i) UHW acute/research hub (ii) Velindre@ AB (iii) Velindre@ CTM	VUT HB/ VUT C&V/VUT AB/VUT CTM/VUT	Apr 2021 May 2021 Oct 2021	• Complete • Complete – regional ToR agreed to by CCLG • Complete (phase 2 – implementation plan being developed)	Research, Development and Innovation Sub-Committee
9	Organisational development and other work to create a successful cancer network is going to be required but has not featured much in our conversations for this report.	• Development of regional workforce plans	HBs / VUT		• National cancer workforce discussions with HEIW and partners – national work in place • Further approach determined following CCLG workshop in April 2022	Strategic Development Committee
10	Flexibility in design is going to be important both for the new VCC and for whatever is developed at the new UHW due to the rapid	• Flexibility built into new Velindre Cancer Centre specification	VUT	31sh Mar 2021	• Complete	Transforming Cancer Services Sub-Committee

	change in the nature of treatment and research.	• Strategic review of future opportunities across the region in advance of proposed developments e.g. community diagnostics strategy; local cancer plans; split acute/elective sites; proposed UHW2 development etc	HBs / VUT		• Initial high level scoping discussions undertaken • Further scoping to be undertaken regionally • Awaiting confirmation of UHW2 timelines	Strategic Development Committee
11	There are future strategic development opportunities provided by the development of a new VCC and a proposed UHW2. Working together over the 15- to 20-year window, the health system should look to exploit these development opportunities in light of future service needs.	• Establishment of strategic planning capability under the leadership of the CCLG to identify service/infrastructure requirements in planned infrastructure • Partnership between Cardiff ULHB, Velindre University NHS Trust and Cardiff City Council on master planning activities in North Cardiff	HBs / VUT	tbc	• CCLG workshop (see Rec 1) will also enable a discussion on the strategic planning capability • Awaiting confirmation of UHW2 timelines	Strategic Development Committee

STRATEGIC DEVELOPMENT COMMITTEE

Developing the cancer system in South East Wales: next steps following workshop with South East London Cancer Alliance

DATE OF MEETING	16/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carl James, Director of Strategic Transformation, Planning and Digital
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Significant progress has been made across South East Wales in improving the quality and outcomes of cancer services for patients. Notwithstanding this, there remains a lot to do to deliver outcomes that compare favorably with the best elsewhere. The challenges across all NHS services have been accentuated by the Covid-19 pandemic and the impact of these will be felt acutely in cancer services across the UK and wider over the coming years.

1.2 The Nuffield Trust undertook review work in South East Wales in 2020 and published a report in December 2020 with a series of recommendations for consideration by Velindre University NHS Trust and Local Health Board, with the view to securing planned and sustained improvements in cancer services in the immediate, medium and long term.

1.3 One of the areas the Nuffield Trust highlighted for review and improvement was the strategic 'gap' in the system design, planning, commissioning and co-ordination of the system across South
East Wales. The report included the following recommendation which was accepted by the CCLG.

1.4 On the 22 March 2021, the Welsh Government published the Quality Statement for Cancer which described what good quality cancer services should look like. The statement is shaped around a quality attributes (equitable; safe; effective; efficient; person centred; and timely).

1.5 At the CCLG meeting in April 2021, Carl James, Director of Transformation, Planning and Digital, Velindre UNHST, provided a presentation on *'Developing a whole systems approach to cancer in SE Wales'* to prompt a discussion in relation to how we might build on the progress made to date by reviewing and improving aspects of the South East Wales cancer to system in accordance with the WG policy direction (Cancer Quality Statement; regional working where appropriate) and learning emerging from other parts of the UK/world regarding whole system working (New Zealand; Nordic countries) and cancer alliances in England.

1.6 Discussion was held on the 'why' (the case for change), the 'where' (what outcomes do we want/what does good look like) and the what/how (what other systems and approaches we may usefully look at to identify improvements/how we might start to move forward). There was a general consensus that a regional/whole systems approach offered an exciting opportunity to evolve cancer services across the region.

1.7 The CCLG:

- welcomed the concept of a system-wide approach to cancer services
- emphasised the importance of starting at a population based lens i.e. across South East Wales
- agreed that any approach needed to include a 'cradle to grave approach' i.e. public health, prevention through diagnosis, treatment, rehabilitation and end-of-life
- need to be able to describe 'what good looks like' in terms of population outcomes and the characteristics of a good cancer system

1.8 A regional workshop was run on 26th April which was attended by all delivery organisation (Aneurin Bevan, Cardiff and Vale, Powys, Cwm Taf Morganwgg UHBs and Velindre University NHS Trust) together with key system partners (Public Health Wales, Wales Cancer Network, Welsh Government). The workshop was chaired by Carl James, Velindre University NHS Trust and facilitated by Nigel Edwards/Hilary Wilderspin (Nuffield Trust), with support/presentation from by Sean McCloy (Managing Director) and Kate Hair (Clinical Chair) (South East London Cancer Alliance. The intended purpose was to determine:

- What are the system characteristics of a high performing system?
- What are the changes we need to put in place to make it happen:-
  - Strategy
  - Leadership & Governance
- What are the service delivery priorities CCLG wants to focus on over the next 12 – 18 months?

Actions

2. The CCLG agreed that the need to work collaboratively and move towards a strengthened 'whole systems' approach/some form of Alliance model was imperative and offered the opportunity to make greater/faster/more sustainable progress in addressing the identified challenges and improving services and outcomes for the population of South East Wales.

2.1 A wide range of opportunities where identified for further action across the system (set out in the CCLG Alliance Workshop Summary Paper). These were discussed and the following areas were suggested as being potential priorities for CCLG to develop over the coming 12 – 18 months.

a. What are the changes we need to put in place to make it happen:-
   - Strategy
   - Leadership & Governance

Priority actions identified:

i. Further exploration of leadership and governance arrangements at South East London to determine what / how we wish to develop the CCLG arrangements going forward e.g. accountability; responsibility; Alliance Board arrangements
ii. Discussions with the Cancer Network to

Resources required: none (Velindre University NHS Trust happy to explore further with SE London on behalf of CCLG.

b. What are the service delivery priorities CCLG wants to focus on over the next 12 – 18 months?

Priority actions identified:

i. development of a strategic workforce strategy/plan for South East Wales cancer services
ii. Identification of three tumor sites and development / application of 'whole systems approach' to the pathway (from prevention through to living with/beyond cancer and end of life care).

Resources required: initial work suggests the need for a Project Manager, business analyst and clinical/professional sessions to commence the identification and planning of the work,

Resources

2.3 To progress the development of the priorities identified in 2.1 above, CCLG will need to identify a relatively small resource to support the work as set out in 2.2 above. SE London Cancer Alliance have also indicated that they are willing to continue to work with CCLG/develop the partnership further. The next CCLG is on 17th May 2022 where the issues will be discussed.

2. RECOMMENDATION

4.1 The Strategic Development Committee is asked to:

(i). note the report and receive a further report on future proposed development of the South East Wales cancer system.

IMPLEMENTATION OF HEPATITIS B CORE ANTIBODY TESTING

DATE OF MEETING	16/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Dr Tracey Rees, Interim Chief Scientific Officer, Welsh Blood Service Huw Lovett, Programme Manager
PRESENTED BY	Alan Prosser, Interim Director, Welsh Blood Service
EXECUTIVESPONSOR	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Senior Management Team	12/05/2022	For Noting

ACRONYMS, INITIALISM AND DEFINITIONS	
WBS	Welsh Blood Service
SaBTO	UK advisory Committee on the Safety of Blood Tissues and Organs
HBV	Hepatitis B Virus
Anti-HBc (or HBcAb)	Antibody against Hepatitis B core antigen

Occult	Not manifest or detectable by clinical methods
OBI	Occult Hepatitis B infection
NHSBT	National Health Service Blood & Transplant
NIBTS	Northern Ireland Blood Transfusion Service
PHW	Public Health Wales
WG	Welsh Government

1. SITUATION

The purpose of this paper is to update the Strategic Development Committee on the progress to date on implementation to minimize Occult Hepatitis B Infection (OBI) in line with recommendations from the UK Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO).

2. BACKGROUND

In December 2021, Welsh Government requested a proposal to implement the SABTO recommendations to further reduce transmission of Hepatitis B Virus (HBV). This was developed and approved by EMB and included the full financial requirement for implementing testing. This has subsequently been confirmed on April 1st by Welsh Government to the Chief Executive.

Welsh Government confirmed full support for the business case and designated it's Senior Medical Officer, Dr Marion Lyons, as the Senior Responsible Owner (SRO) for the project and chair of the Delivery Board.

On the basis of support anticipated from Welsh Government the Welsh Blood Service worked in parallel with the UK blood services. WBS established an internal project structure, to prepare for implementation of testing and has continued to report progress of the project.

This board will be responsible for Pan Wales implementation of testing and lookback and any patient contact tracing.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

There are two parallel but linked work streams which are WBS testing strategy and delivery plan and the overarching coordination of delivery Pan Wales

WBS Testing update

1. A WBS Project Group has been established as is now meeting on a fortnightly basis and a project brief has been developed and shared with EMB.
2. Task and Finish Groups have been established to detail the requirements associated with the key deliverables, including testing, donor tracing, communications and the IT requirements.
3. WBS representatives are attending OBI UK Forum Implementation Group meetings to align implementation and strategy with other UK blood services as closely as possible.
4. Approach to testing has been established and formally approved by Welsh Government by letter of confirmation to Chief Executive.
5. Validation of the test, including interface with WBS Blood Establishment Computer System (BECS) has been completed.
6. Validation of BECS system for required changes has commenced
7. A training plan has been developed for collection team members
8. Additional laboratory staff have been recruited to support new testing requirements and lookback (the process for testing archive samples from previous donations and tracing product fate).
9. Process agreed for NHS Blood and Transplant (NHSBT) to undertake confirmatory testing on behalf of WBS at its Microbiology Screening Lab (MSL) facility.
10. Recruitment for additional nursing staff commenced to support communications with confirmed Hepatitis B Core positive donors.

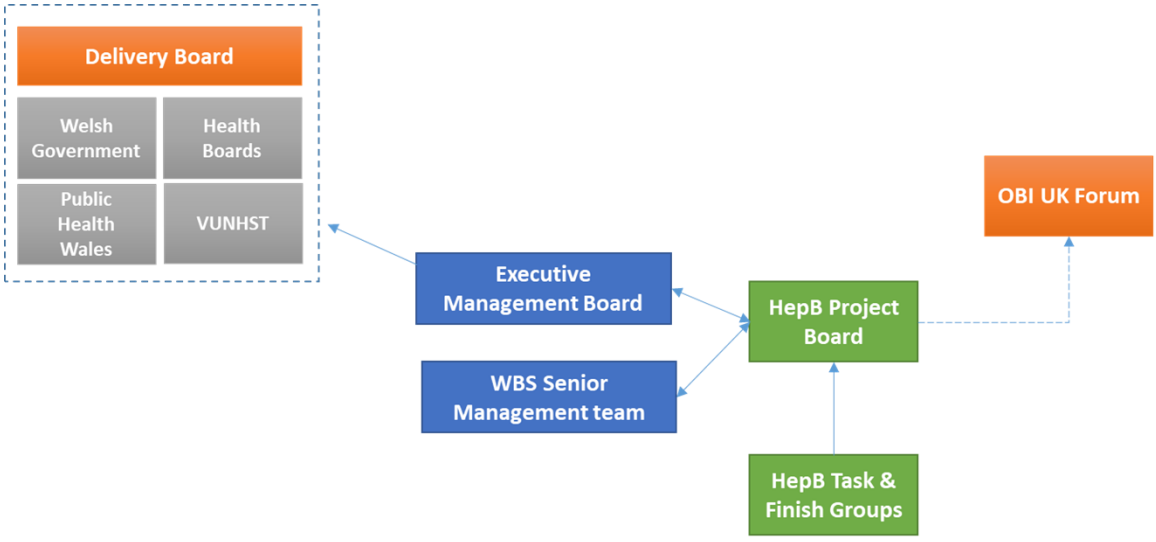
Pan Wales Delivery Board Update

11. A project hierarchy (see organizational chart below) has been developed showing clear lines of accountability to VUNHST Executive Management Board and Welsh Government.
12. A scoping meeting to agree membership of the Delivery Board has taken place. This will include representation from all key stakeholder groups.
13. A Task & Finish Group is to be established under the Delivery Board to consider and agree referral pathways for patients and donors.

14. A letter will be sent to Health Boards from the Welsh Government outlining the additional work required to support recipient tracing and testing.

    The Delivery Board will coordinate delivery between VUNHST, Public Health Wales and Welsh Health Boards with regards to patient tracing and donor follow-up following initial contact from WBS. The Director of Nursing Allied Health Professionals and Healthcare Scientists will provide executive lead representation on the Board supported by the Director WBS, together with the WBS Chief Scientific Officer, Medical Director and Donor Care Consultant.

    The Delivery Board will continue to meet for some time after routine testing has been implemented in order to review and have oversight of the data that emerges from the testing and donor/patient management process in order to understand the wider impact.



3.7 BENEFITS

- Through the implementation of anti-HBc, WBS will reduce the risk of HBV transmission to recipients of blood components in Wales.

3.8 RISKS (ASSOCIATED WITH THE PROPOSAL) & MITIGATION

Current key risks to the project are as follows:

Risk	Mitigation
There is a risk that the implementation puts additional pressure into the service.	Resourcing requested from Welsh Government has been agreed and appointing new positions to support the additional workload.
There is a risk that WBS will not be able to collect enough blood to meet demand, caused by reduced collections activity due to training requirements.	Optimise WBS collections and undertake extra sessions Request blood components under the existing Mutual Aid Agreement if required.
There is a risk that WBS will be unable to align implementation with other UK blood services, caused by the timeline for WG approval of the business case and providing a ministerial mandate resulting in reputational damage due to WBS implementing later than the other UK blood services.	Health Minister has approved business case and mandate. Implementation is aligned with NHSBT and NIBTS.
There is a risk that key stakeholders including Public Health Wales and Health Boards will require time to establish their delivery plan due to the phasing of the establishment of the delivery board.	Preliminary Delivery Board meetings held with part-membership. Agreed that letter be sent by WG to Health Boards advising them of their responsibilities.

Risk	Mitigation
Risk of a HepB positive unit being transfused to a patient, caused by long-dated components already in hospitals being transfused during the period between starting to test and completing replacement of hospital stock with tested products. This could result in patient harm and reputational damage.	Swap-out plan being developed. Stock-building commenced in anticipation of retrospective testing for donations collected up to 2 months previously. Due to this being a rolling swap-out the risk will reduce as each hospital swap-out is completed.
There is a risk of delays to donor and patient treatment, caused by the referral pathway for patient and donor testing not being finalised before testing go-live, resulting in accumulation of donors and patients awaiting contact.	Task & Finish Group being established under Delivery Board to consider and agree referral pathways for patients and donors.

3.9 Financial Implications

Detailed costings for implementing the project, which formed the basis of the business case submitted to the Welsh Government and supported.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Individual Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	This is a mandatory test for the safety of recipients but it will also have potential benefits to donors and their contacts. Donors whose family originates from countries where HBV infection is commoner than the UK (endemic areas) are more likely to test positive for anti-HBc. This is also for current mandatory tests HBV DNA and HBsAg. This does not disadvantage any specific group of donors or recipients as it is for their benefit.
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 PDF above

5. RECOMMENDATIONS

The Strategic Development Committee are asked to **NOTE** progress to date of this programme of work and that going forwards the implementation phase will be reported through Quality Safety and Performance Committee.

STRATEGIC DEVELOPMENT COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	16/05/2022

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	
RD&I	Research, Development and Innovation
QSP	Quality, Safety and Performance Committee
ECMC	Experimental Cancer Research Centre
HCRW	Health and Care Research Wales
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 07/04/2022.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Strategic Development Committee.
ADVISE	**ASSOCIATE MEDICAL DIRECTOR FOR RD&I** Expressions of interest were sought from individuals to apply for the role of Associate Medical Director with responsibility for Research, Development and Innovation in January 2022. Professor Robert Jones was successful and has taken up the role of Associate Medical Director for RD&I.
ASSURE	There were no items identified for **ASSURE** to the Strategic Development Committee.
INFORM	**TRUST INTEGRATED MEDIUM-TERM PLAN 2022-2025** The Trust has a strategic goal to be "A beacon for research, development and innovation". As part of the development of the Trust's Integrated Medium-Term Plan (IMTP) 2022-2025, Research, Development and Innovation (RD&I) has identified four strategic priorities. These are :

	Priority 1: Drive forward the implementation of its Cancer Research and Development Ambitions 2021-2031. The Overarching Cancer Research & Development Ambitions 2021-31 document developed by multidisciplinary research leads from Velindre Cancer Centre, University Partners, and Public and Patient representatives received Trust Board approval in March 2021, with the aims of : • Enhance patient experience and care • Improve patient outcomes and reduce variation • Accelerate the implementation of new discoveries into clinic • Demonstrate the impact of our research on patients and the NHS • Build research capacity and capability at Velindre and across South East Wales **Priority 2**: Maximise the Research and Development ambitions of the Welsh Blood Service (WBS). The aims are to drive improvement, increase research activity, be open to collaboration and build our reputation for research & development, in order to improve donor and patient health. WBS will continue to develop the four WBS Research & Development themes which are : • Transplantation: including solid organ and stem cell transplants • Donor Care and Public Health: including donor recruitment and retention strategies, aiming to enhance their experience and continued engagement • Products: including blood components, immuno-haematology, manufacturing and quality management • Therapies: including preparation of cellular and blood therapies for research **Priority 3**: The Trust will implement the Velindre Innovation Plan. This includes the establishment of an infrastructure and plan that will deliver a step change improvement in the quality and quantity of multi-disciplinary and multi-partner innovation to achieve the Trust's purpose to improve lives. **Priority 4**: The Trust will maximise collaborative opportunities locally, Nationally and Internationally.

The Trust will work across Health Board colleagues to maximise research opportunities for our patients and donors, this includes :

- The Velindre@ Programme that aims to evolve the research infrastructure across South-East Wales, enabling local access to clinical research
- The tripartite partnership with Cardiff and Vale University Health Board and Cardiff University and VUNHST to develop the Cardiff Cancer Research Hub developing a safe environment to provide cutting edge and complex advanced therapies for patients and enable translational research in collaboration with Advanced Therapies Wales and our Haematology and University
- Work with scientists within Cardiff and beyond, through interactions and collaborations with the Centre for Trials Research (Cardiff University), the Experimental Cancer Research Centre,(ECMC) Cardiff the Wales Cancer Research Centre and Health and Care Research Wales (HCRW)and Higher Education Institutions to maximise research opportunities across all fields of cancer research (early diagnosis, interventional therapies and palliative and supportive care)

WALES CANCER RESEARCH STRATEGY (CReSt)

The Sub-Committee received a presentation by Professor Mererid Evans, Velindre Futures Director and WCRC Director on the Wales Cancer Research Strategy (CReSt) and has been presented to Trust Board.

The strategy sets out some key principles which have underpinned the development of the proposed way forward, and the process through which it has been produced. It provides a summary of the current state of cancer research in Wales, and some of the key issues which need to be tackled. It also describes a number of research themes or areas where there is (or could be) a critical mass of research capacity and capability in Wales. The Strategy is with Welsh Government awaiting sign off and hoping to be launched in around June 2022.

VELINDRE FUTURES CANCER R&D AMBITIONS UPDATE:

Oversight and Governance re the Cardiff Cancer Research Hub

The Hub Project Board Meets regularly and feeds into the VCC @ UHW Programme Delivery Board, which in turn feeds into the Trust Executive Partnership Board with CVUHB and CU.

	The Joint Proposal Cardiff Research Hub specification document was formally signed off by VUNHST Board subject to the correct Heads of Terms being developed between the 3 partners (VUNSHT, CU and CVUHB). The joint proposal document is now being reviewed by CVUHB at the Business Case Advisory Board 7th April 2022. Cardiff University are also progressing this proposal through their governance routes. A scoping exercise led by Sarah Townsend is being conducted on the Joint Research Office (currently covering CU and CVUHB research) which will assess opportunities, benefits and risks in terms of Velindre joining for Cardiff Cancer Research Hub. Once the scoping is complete, a briefing paper will be prepared and presented to appropriate Boards for consideration. There will be a need for a financial/investment strategy to be developed for the Hub A business case to secure monies via Charitable Funds (£25k) was approved by RD&I Sub-Committee to commission this piece of work will be considered by the Charitable Fuds Committee 17th May. **Hub Partners** ECMC, Cardiff will be applying to CRUK for continued 5yrs funding in June of this year. Verbal commitment provided that the ECMC bid application will include research nurses to support Early phase and Advanced therapies within the Hub (Haematology Oncology and Solid Tumour). WCRC commits to short-term fund a Clinical Research Fellow post in the (next 12 months.) It will provide short-term finding of a nurse in the Clinical Research Facility that will support the delivery Early Phase and Advanced therapy trials (Solid Tumour and Haematology Oncology). CVUHB and VUNHST has approached HCRW for research delivery staff to support Hub. Business cases are being worked up for a matched funded post between VUNHST and CU which will be a clinical academic post (early phase triallist). **NURSING AND ALLIED HEALTH PROFESSIONAL RESEARCH** The Velindre ambition for nurse, allied health professional and healthcare scientist cancer research is to provide opportunities to

	engage in and take forward cancer care research alongside clinical practice. Having appointed Jane Hopkinson, Velindre Professor of Nursing and Interdisciplinary Cancer Care, progress has been made to support and build nursing and interdisciplinary research in the Trust. Jane Hopkinson and Jane Darmanin, Senior Manager in RD&I Partnerships Engagements, who is heading up this work are in the process of gathering information, requirements and perceived barriers in these staff groups becoming involved in research. An implementation plan is also in development for meeting this Velindre ambition for nurse, allied health professional and healthcare scientist cancer research. **UNIVERSITY DESIGNATION** Organised by Welsh Government, a high-level University Designation face to face workshop will be held on the 30th June and will provide an opportunity to exchange emerging experiences among Health Boards and Trust covering the three pillars of Innovation, Training and Education and Research and Development. 2 research case studies (WBS-Development Component Lab VCC and Cardiff Cancer Research Hub) were submitted and will be presented.
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 07/04/2022.