Public: Strategic Development Committee

Wed 15 May 2024, 14:00 - 15:00

HQ Meeting Room and via Microsoft Teams

Agenda

14:00 - 14:05
5 min

1. STANDARD BUSINESS

1.1. Welcome & Introductions

Led by Stephen Harries, Chair and Independent Member

1.2. Apologies for Absence

Led by Stephen Harries, Chair and Independent Member

1.3. Declarations of Interest

Led by Stephen Harries, Chair and Independent Member

1.4. Minutes of the Committee Meeting held on 21st March 2024

Led by Stephen Harries, Chair and Independent Member

To Approve

Please note these minutes are not yet confirmed by chair.

1.4 Public SDC Minutes 21.03.2024.pdf (12 pages)

1.5. Action Log

Led by Stephen Harries, Chair and Independent Member

To Approve

1.5 Public Action Log.pdf (2 pages)

14:05 - 14:15
10 min

2. PLANNING

2.1. Trust Integrated Medium Term Plan (2024 / 25 – 2026 / 27) - Verbal Update

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

To Note

14:15 - 14:30
15 min

3. SERVICE TRANSFORMATION

3.1. Data & Insight: Developing 3-5 year plan: initial thoughts

Led by Carl Taylor, Chief Digital Officer

To Note

3.1 2024-04-30 SDC Data and Insight Update.pdf (13 pages)

3.1 20240430_SDC_DataInsight.pdf (11 pages)

14:30 - 14:40
10 min

4. DELIVERY

4.1. Welsh Blood Service: Performance Management Framework - KPI Review

Led by Alan Prosser, Director of Welsh Blood Service

To Endorse

4.1 WBS KPI Review SDC Paper May24.docxAP.pdf (16 pages)
4.1 Appendix 1 - WBS KPIs - Narrative and Calc Basis Apr24.pdf (5 pages)

14:40 - 14:50
10 min

5. ASSURANCE

5.1. Trust Assurance Framework

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

To Note

5.1 TAF Paper - SDC- April 24.pdf (7 pages)
5.1 TAF.pdf (25 pages)

14:50 - 15:00
10 min

6. CONSENT AGENDA

6.1. CONSENT FOR NOTING

6.1.1. Velindre Oncology Academy Update

Led by Nicola Williams, Executive Director Nursing, AHP & Health Science

To Note

6.1.1 Velindre Oncology Academy Update (SDC).pdf (3 pages)

6.1.2. Clinical and Scientific Strategy

Led by Joanna Doyle, Clinical and Scientific Strategy Lead

To Note

6.1.2 30.04.2024. SDC paper update Clinical and Scientific Strategy for submission.pdf (6 pages)

6.1.3. Welsh Blood Futures

Led by Alan Prosser, Director of Welsh Blood Services

To Note

6.1.3 Cover Paper WBS Futures Update Apr24.pdf (12 pages)
6.1.3 Appendix 1 - WBS Futures Dashboard April 24.pdf (13 pages)
6.1.3 Appendix 2 - Comms Activity Plan 2023-24 v7.pdf (2 pages)

6.2. CONSENT FOR APPROVAL / ENDORSEMENT

6.2.1. Quality Impact Assessment for Digital Inclusion Plan

Led by Carl Taylor, Chief Digital Officer

To Endorse

- 6.2.1 SDC Digital Inclusion Plan v1.0 Cover Paper.pdf (15 pages)
- 6.2.1 Appendix 1 SDC Digital Inclusion Plan 2024-25.pdf (7 pages)
- 6.2.1 Appendix 2 QIA Digital Inclusion Plan.pdf (7 pages)

6.2.2. Strategic Development Committee Terms of Reference

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

To Endorse

- 6.2.2 EMB Shape Terms of Reference Cover Paper.pdf (6 pages)
- 6.2.2 SDC ToR - TRACKED CHANGES 2024-2025.pdf (8 pages)

6.2.3. Strategic Development Committee Cycle of Business

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

To Approve

- 6.2.3 EMB Shape Cycle of Business Cover Paper.pdf (7 pages)
- 6.2.3 Appendix 1 Cycle of Business 2024-2025 TRACKED CHANGES v2.pdf (3 pages)
- 6.2.3 Appendix 2 Cycle of Business 2024-2025 ACCEPTED TRACKED CHANGES v2.pdf (2 pages)

15:00 - 15:00
0 min

7. ANY OTHER BUSINESS

Prior agreement by the Chair required

15:00 - 15:00
0 min

8. REVIEW OF THE MEETING

Led by Stephen Harries, Chair and Independent Member

15:00 - 15:00
0 min

9. DATE & TIME OF NEXT MEETING

Tuesday 18th June 2024 at 14.00-15.30
Meeting Room, Velindre Headquarters

15:00 - 15:00
0 min

10. CLOSE

The Board is asked to adopt the following resolution:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

15:00 - 15:00
0 min

11. PRIVATE / PART B SESSION

The following items will be discussed at the Private / Part B Session of the Strategic Development Committee:

- Blood Establishment Computer System (BECS) – Outline Business Case
- SACT ePrescribing Procurement
- ePMA Business Case
- Talbot Green Infrastructure – Preferred Option Update
- Radiology Informatics Systems Programme (RISP) – Progress Update

Strategic Development Committee
Public Session
MINUTES OF THE MEETING
Held on 21st March 2024 @ 10.00 – 11.30am
Trust Headquarters, Nantgarw

Chair:		
Stephen Harries	Vice Chair, Independent Member	SH
Members:		
Professor Donna Mead	Chair	DM
Professor Andrew Westwell	Independent Member	AW
Gareth Jones	Independent Member	GJ
Attendees:		
Steve Ham	Chief Executive Officer	SHam
Carl James	Executive Director of Strategic Transformation, Planning and Digital	CJ
Nicola Williams	Executive Director of Nursing, AHPs & Health Science	NW
Matthew Bunce	Executive Director of Finance	MB
Carl Taylor	Chief Digital Officer	CT
Dr Jacinta Abraham	Executive Medical Director	JA
Alan Prosser	Director of Welsh Blood Service	AP
Philip Hodson	Deputy Director of Planning & Performance	PH
Susan Thomas	Deputy Director of OD and Workforce	ST
Joanna Doyle	Clinical & Scientific Strategy Lead	JD
Chris Moreton	Deputy Director of Finance	CM
Claire Budgen	Head of Organisational Development	CB
Additional Attendees:		
Emma Rees	Deputy Head of Internal Audit	ER
Jessica Corrigan	Business Support Officer/Secretariat	JC
Apologies:		
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Sarah Morley	Executive Director of OD & Workforce	SM
Rachel Hennessy	Interim Director of Velindre Cancer Services	RH

1.0	STANDARD BUSINESS	ACTION
1.1	**Welcome & Introductions** *Led by Stephen Harries, Chair and Independent Member* SH welcomed attendees to the meeting.	

1.2 **Apologies for Absence**

Led by Stephen Harries, Chair and Independent Member

Apologies were noted as above.

1.3 **Declarations of Interest**

Led by Stephen Harries, Chair and Independent Member

There were no declarations of interest.

1.4 **Minutes of the Committee Meeting held on 18th January 2024**

Led by Stephen Harries, Chair and Independent Member

The minutes of the Strategic Development Committee held on 18th January were **APPROVED** as accurate record.

1.5 **Action Log**

Led by Stephen Harries, Chair and Independent Member

The following updates were provided to the Strategic Development Committee:

Action 007: This was agreed as being a closed action.

Action 008: Further discussions have been held with Stephen Harries and Carl James regarding the Capital Programme agenda item. The Capital Programme will be brought to Executive Management Board. Following 2023 / 2024 year end, the Capital Programme will be received at Trust Board in May. This action will remain open until the paper has been received at Trust Board on 23rd May.

Action 009: This was agreed as being a closed action.

The Strategic Development Committee **APPROVED** the action log.

2.0 STRATEGY

2.1 **Trust Well Being Objectives**

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

As part of the Trust well-being objectives the objectives are being developed which will be approved by Trust board. The purpose of the

Trust Well-Being Objectives are to demonstrate how the Trust will work to achieve the vision as set out in the wellbeing goals.

The Trust originally developed its Trust Well-Being Objectives in 2015. However, there is now a requirement for the Trust Well-Being Objectives to be reviewed and updated. This is a statutory obligation due to the amendment in the legislation. Under the Act, all named public bodies must review their current objectives to ensure they are still compliant, whenever an amendment is made. The Act has had a minor amendment, changing the word 'fair' to 'decent' under A Prosperous Wales.

The Trust Well-Being of Future Generations Objectives were developed in April 2015 in line with the requirements under the legislation. Following the approval of the Trust Destination 2033 Strategy and supporting strategies together with a slighted change in the Well-being of Future Generations (Wales) Act legislation, there is a requirement to review the Trust Well-Being of Future Generations Objectives. This presents an opportunity to refresh the objectives and ensure tight alignment with the Trust strategies.

The wording for the Trust Wellbeing Objectives is being reviewed as part of the Board Development Sessions.

It was suggested by the Strategic Development Committee members to think about how we engage with the younger population, as they are the future generations.

The Trust Wellbeing Objectives will be reviewed on an annual basis tracking progress.

A discussion took place regarding the use of the Noddfa and the staff wellbeing support that is in place. Sue Thomas confirmed the furniture will be ordered for the Noddfa wellbeing areas. The Noddfa wellbeing areas have also been discussed during the Quality, Safety and Performance Committee. The updates and relevant papers on Noddfa will be fed through Quality, Safety and Performance.

The Strategic Development Committee:

- **NOTED** the current, Trust Board approved, Trust Well-Being Objectives (Appendix 4)
- **NOTED** the engagement and consultation process which has been undertaken to receive feedback on the existing Trust Well-Being Objectives (Appendix 1- and 2)

- **NOTED** the feedback received in relation to the Trust Well-Being (Appendix 3(a) and Appendix 3(b))
- **NOTED** the next steps in relation to the finalisation of our Trust Well-Being Objectives (Page 3)

2.2 **Strategic Equality Plan**

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

The Trust has worked in partnership with eleven other public bodies to develop a shared set of Strategic Equality Plan Objectives for the period between 2024 to 2028.

Following the Trust's own Strategic Equality Plan consultation, it was found that people largely agreed with the chosen objectives, however some issues were raised about the specific language used in them.

The implementation plan will be monitored and reviewed through the Healthy and Engaged Steering Group.

The Strategic Equality Plan will benchmark against peer networks and feedback comments.

The Strategic Development Committee **ENDORSED** the Strategic Equality Plan and objectives for Trust Board approval.

2.3 **Clinical and Scientific Strategy**

Led by Joanna Doyle, Clinical and Scientific Strategy Lead

An update of the Clinical and Scientific Strategy was provided to the Strategic Development Committee. It was confirmed there has been engagement with over 800 stakeholders.

Clinical and Scientific Strategic Board meetings have been set up on a quarterly basis and it was reported that the Clinical and Scientific Strategic Board has good membership across the Trust.

A huge amount of content has been developed for the Clinical and Scientific Strategy. The aim is for the Clinical and Scientific Strategy to be published in September. The Strategic Development Committee were assured the Clinical and Scientific Strategy will go through the appropriate governance routes for Board approval.

The Clinical and Scientific Strategy will not be duplicating work within other strategies.

Following discussions with Llais and the need to undertake further engagement with the public and some stakeholder groups, the actions required and timetable for completing this work has been revised.

Once the Clinical and Scientific Strategy is in a mature state it will be brought to Trust Board. Previously the Clinical and Scientific Strategy has been through Board Development sessions. The Clinical and Scientific Strategy will continue to report to Executive Management Board and Strategic Development Committee for progress updates.

It was confirmed in due progress the strategic aims will become more focused and streamlined.

The next steps for the Clinical and Scientific Strategy will be Independent Member engagement. A meeting is currently being arranged.

The Strategic Development Committee:

- **NOTED** the contents of the report
- **REVIEWED** the emerging themes, draft strategic aims, objectives, means of achievement and core principles
- **NOTED** the revised plan and timetable for completing the Clinical and Scientific Strategy

3.0 PLANNING

3.1 Integrated Medium Term Plan – Update

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

The Integrated Medium Term Plan was presented to the Strategic Development Committee.

It was suggested the Integrated Medium Term Plan and the Trust Assurance Framework need to be triangulated. The Trust Assurance Framework needs to include the objectives within the Integrated Medium Term Plan.

During the Quality, Safety and Performance Committee on 14th March 2024, it was discussed at length the challenges faced by SACT. Phil

Hodson highlighted the Integrated Medium Term Plan demonstrates how the Trust is planning on tackling the challenges within SACT.

Assurance was provided to the Strategic Development Committee that action plans and delivery plans sit under each area of the Integrated Medium Term Plan.

A discussion took place regarding the Quality Impact Assessments being submitted as part of the Integrated Medium Term Plan. Nicola Williams confirmed the Quality Impact Assessments need to be completed for the Integrated Medium Term Plan. These will be circulated outside of the Strategic Development Committee PH

A discussion took place regarding the capacity and demand for the SACT services. From the information we have access to currently, the capacity set up within the plan is based on the servicing that level of activity. From the information we have currently the capacity and the demand are in balance. The Trust will need to ensure the plan is executed in a timely way so the capacity and demand remain in balance.

It was confirmed the Integrated Medium Terms Plan is a balanced plan based on income. The Director of Finance for NHS Wales has communicated to all NHS Wales organisations his intentions which is outlined in the allocation letter.

All LTA's have been sent to commissions for signing. Currently we have not received any LTA's back from the commissioners but the deadline is 30th June 2024. As the Integrated Medium Term Plan is being submitted by the end of March it was confirmed there is a standard dispute resolution in place if any of the LTA's come back as being disputed.

Subject to the Quality Impact Assessments being circulated and being made available to the Trust Board, the Strategic Development **ENDORSED** the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2024 / 25 – 2026 / 27. The IMTP includes the following:

- Service plans for the Welsh Blood Service and for the Velindre Cancer Service
- The Trust Financial Plan
- Plans for our enabling functions e.g., Digital Services

4.0 SERVICE TRANSFORMATION

4.1 Talbot Green Infrastructure Programme: Progress Update

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

The Supply Chain Partner and Healthcare Planner have been commissioned to complete the Outline Business Case. The Programme is currently considering the economic benefits of each option in order to reach a preferred solution to develop into a full Outline Business. The Programme Board will consider and approve the preferred option at the Programme Board meeting in April 2024.

The final draft of the Outline Business Case is on track to be completed in August 2024 and, following a 12-week internal approval process, will be submitted to Welsh Government in November 2024.

There is a potential for a hybrid option: Outline Business Case and Full Business Case, further discussions will be held with Welsh Government and fed back through the Strategic Development Committee. The hybrid approach of Outline Business Case and Full Business Case will reduce time and costs.

A walkaround for Independent Members, Carl James, Alan Prosser and the team is currently being arranged.

The Strategic Development Committee **NOTED** the Talbot Green Infrastructure Programme: Progress Update

4.2 Velindre Oncology Academy

Led by Nicola Williams, Executive Director Nursing, AHP & Health Science

Nicola Williams explained following Executive Management Board the paper was not updated in relation to the branding. It has been requested to use the Velindre University NHS Trust colours and revised graphics for the branding for Velindre Oncology Academy. This work will be completed by the end of March 2024 and circulated through the appropriate governance routes.

All roles recruited to, and a small number have commenced. The last role to be recruited into is the lecturer / practitioner role.

Office space for the academy staff has been identified within the Noddfa Building in Velindre Cancer Centre. Clinical training space has also been identified.

A dedicated room for education, training and development is now in full use. The room fulfils the requirement of the agreement with the University of Wales Technical Institute to have a dedicated teaching space. The University will need, as part of the accreditation process assess the suitability of the space.

The Strategic Development Committee highlighted it's a steady progress being made and pleased to see the Velindre Oncology Academy progressing at pace.

The Strategic Development Committee **NOTED** the Velindre Oncology Academy Implementation Board Highlight report.

4.3 **Quality Management System**

Led by Nicola Williams, Executive Director Nursing, AHP & Health Science

There was an error within the Quality Management System cover paper, the updated paper will be circulated following the Strategic Development Committee. If any members have any comments, please send them across to Nicola Williams following the updated paper being circulated to members.

There is an anticipated delay with the Quality Management System.

Discussions are being held between Audit Wales and Internal Audit.

Thanks to Zoe Gibson who has put a lot of work into the Quality Management System.

The Strategic Development Committee **NOTED** the paper as being received but **NOTED** a revised paper will be circulated.

4.4 **Digital Inclusion Plan**

Led by Carl Taylor, Chief Digital Officer

Overall, 7% of adults in Wales are digitally excluded, but some sections of the population are more likely to be digitally excluded than others.

Digital Communities Wales is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales with an overview of the user of digital technology for health in Wales which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services.

Appendix 1 outlines the Digital Inclusion Plan for 2024 – 2025.

A discussion took place regarding the Quality Impact Assessment, it was confirmed by Nicola Williams the Quality Impact Assessment is required for the Digital Inclusion Plan.
Subject to Quality Impact Assessment being completed and circulated to members the Strategic Development Committee:

- **ENDORSED** for Approval the Digital Inclusion plan for Trust Board.
- **NOTED** that the Trust is going to seek accreditation against the Digital Inclusion Charter and the commitment to the 6 pledges.

6.0 DELIVERY

6.1 Value Based Healthcare Update
Led by Matthew Bunce, Executive Director of Finance

The Value Based Healthcare has been progressing well since the previous Strategic Development Committee.

Various posts have successfully recruited into for Value Based Healthcare team:

Positive feedback has been received regarding the Value Pre-operative Anaemia Pathway Project.

During the next update to the Strategic Development Committee the Value Based Healthcare will include specific dates for the programme workstreams.

The Strategic Development Committee **NOTED** the Value Based Healthcare progress update.

6.1.1 **Trust's Food Mission**

Led by Matthew Bunce, Executive Director of Finance

The Trust has developed a Food Mission, with the support of a not-for-profit organisation, Trust staff, stakeholders in the Welsh food system and Welsh Government funding.

The Trust's food mission will be co-ordinated through the Healthy and Engaged Steering Group with the goal of improving the overall experience for staff in all areas of the Trust.

In March 2023, the Trust were successful in being awarded grant funding of £30,000 from Welsh government to develop a mission for local food sourcing and an agroecological food supply chain.

There are various benefits identified by Velindre Trust adopting the missions which include improving staff wellbeing by increasing access to healthier food, reducing absence rates and reducing workplace related stress and greater staff retention due to improved working conditions.

A wide range of stakeholders have been engaged throughout the whole process. Positive responses received by the staff survey.

It is hoped by 2035, at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly and globally responsible. Originally it was aimed by 2030 the Trust will source 80% of food environmentally friendly, globally responsible and locally but it was decided to make this more ambitious and achievable to reduce to 70% and by 2035.

It was confirmed, the Quality Impact Assessment will need to be completed.

As the paper currently states the Equality Impact Assessment is not required for the Trust's food mission, it was confirmed this will continue to be monitored and completed at any stage if required. Benchmarking activities have been completed against other Health Board's and they have also not completed an Equality Impact Assessment. It was noted the concerns raised as it was assumed this would be required. It was confirmed for Chris Moreton to review the Equality Impact Assessment for the Trust's Food Mission.

Subject the Equality Impact Assessment being reviewed the Strategic Development Committee **ENDORSED FOR APPROVAL**.

6.2 **NHS Staff Survey Results**

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

The Strategic Development Committee felt it was best for the NHS Staff Survey Results to be presented at the Quality, Safety and Performance. This will be presented to the Quality, Safety and Performance in May.

The Strategic Development Committee **WITHDREW** the NHS Staff Survey Results.

Some of the aspects of the NHS Staff Surveys results might be brought back to the Strategic Development Committee is suitable.

7.0 ASSURANCE

7.1 **Trust Assurance Framework**

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

As the Trust Assurance Framework was covered during the public Joint Extraordinary Audit Committee and Quality, Safety & Performance on 21st March 2024. The item was **DEFERRED** from the Strategic Development Committee.

8.0 CONSENT AGENDA

8.1 **CONSENT FOR NOTING**

8.1.1 **RD&I Highlight Report**

Led by Jacinta Abraham, Medical Director

The Strategic Development Committee **NOTED** the Research, Development & Innovation Sub-Committee Highlight Report.

5.0 ANY OTHER BUSINESS

There were no additional items of business brought for discussion.

6.0 REVIEW OF THE MEETING

There were no additional comments or questions raised.

7.0 DATE AND TIME OF NEXT MEETING

The next Strategic Development Committee will be held on Thursday 21st March 2024 at 10am in Meeting Room, Velindre Headquarters.

8.0 CLOSE

The Board is asked to adopt the following resolution:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Strategic Development Committee
May 2024
Action Summary

Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
008	**Role of Committee and Capital Programme** It was noted the Executive Management Board approve the Capital Programme. Further discussions will be held regarding the purpose of bringing the Capital Programme to the Strategic Development Committee. In addition, this action was referred to in *"Review of the meeting"* It was requested that when the agreed Capital Programme is brought to the Strategic Development Committee, the paper should also include a reminder for the Independent Members of the process by which capital is agreed within the Trust and the governance process behind this. SH will have further conversations with colleagues.	Carl James	07/11/2023	23/05/2024	Further discussions have been held with Stephen Harries and Carl James regarding the Capital Programme agenda item. The Capital Programme will be brought to Executive Management Board. Following 2023 / 2024 year end, the Capital Programme will be received at Trust Board in May. This action will remain open until the paper has been received at Trust Board on 23rd May.	**OPEN**

010	**Integrated Medium Term Plan** Complete Quality Impact Assessment for the Integrated Medium Term Plan and circulate to Strategic Development Committee members via email.	Phil Hodson	21/03/2023	31/03/2024	The Quality Impact Assessment was circulated to all Strategic Development Committee members and Trust Board on 26th March 2024.	**CLOSED**

STRATEGIC DEVELOPMENT COMMITTEE

Data & Insight: Developing 3-5 year plan – Initial Thoughts

DATE OF MEETING	15/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kate Mackenzie, Assistant Director of Data & Insight
PRESENTED BY	Carl Taylor, Chief Digital Officer
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	We continue to make progress with the implementation of the Digital Strategy and this paper updates progress made towards creation of the Trust-wide Data and Insight team. Since Kate Mackenzie joined in Jan 2024, the reporting lines for both Welsh Blood Service and Velindre Cancer Services business intelligence teams have changed to create the Data & Insight team, as part of Digital Services, for **NOTING**. In line with plans shared in previous papers (Dec 2023), a strategic/functional review has been

	conducted. The current state of availability, accessibility and usability of data is shared here, along with a high-level assessment of workforce data skills and confidence for **NOTING**. The appetite and aspiration to improve delivery of services through better use of data & insight is **NOTED** at every level of the organisation. The capability, capacity and operating model of the Data & Insight team cannot robustly meet the current business need let alone supporting the goal of becoming an insight-led organisation. An Organisation Change Process is required to improve resilience, along with investment to increase analytical capacity for **NOTING.** Next steps are proposed to progress from this formative discussion to 3-year plan for **NOTING**.

RECOMMENDATION / ACTIONS	SDC are asked to **NOTE** the update on ongoing work around the creation of the Trust wide Data and Insight Service and **NOTE** investment will be required to increase capacity of the data & insight team.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB (Shape)	**15/04/2024**

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The update of the work undertaken as part of theme 3 of the digital strategy was shared at EMB (Shape) on 15 April. The overview of the strategic / functional review was noted and the need for Organisational Change Process and investment in the Trust data & insight team discussed.

Next steps agreed at EMB will be to:

- identify the optimal organisational structure of the data & insight team to meet the needs of the Trust for future discussion and develop the investment case;

- maintain Executive sponsorship and role-modelling to encourage early conversation and co-production with data professionals across the organisation.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the* ***"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	

1. SITUATION / BACKGROUND

1.1 Theme 3 of the Trust digital strategy sets out our ambition to become an insight driven organisation, described as optimising the use of data and knowledge to help us make informed and insight-driven decisions within the organisation and in collaboration with partners across organisational boundaries.

1.2 In April '23, EMB approved the case for the creation of a Trust wide Data and Insight team. Business Intelligence and the wider Information Services functions (including the Analytics, Insights, Data Quality and Clinical Coding functions) are key enablers for Velindre University NHS Trust to become a Data-Driven, Insight-led Organisation.

1.3 A "Staged Transition to a new Data and Insight organisational structure" was the selected option. First stage of appointment of a new role of Assistant Director for Data and Insight is complete with Kate Mackenzie joining the Trust in January 2024.

1.4 Initial steps to create a single Trust-wide Data & Insight team, as part of Digital Services, has been taken with the reporting lines for the WBS and VCS Business Intelligence teams moving to the AD Data and Insight.

1.5 At this time, the structure and operating model of the respective teams has not changed significantly, and broadly remains a traditional transactional 'Business reporting' model.

1.6 In line with plans shared with EMB in Dec 2023, a strategic / functional review has been conducted, the paper provides the formative output of that review.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Strategic vision for insight-led organisation

2.1.1 The commitment as articulated in Theme 3 of the digital strategy remains sound – the key commitments are achievable and align with similar activities that either have been or to be undertaken in peer organisations. In line with the aspiration of the wider Digital Services, there will be additional emphasis on evolving the data & insight operating model to have a strong ethos of co-production (between service experts and data professionals). Continued Executive sponsorship and role-modelling will be crucial to support the necessary shift in mindset and business practice.

2.2 Current state of availability, accessibility and usability of data

2.2.1 The ageing data warehousing and server infrastructure was highlighted as significant business risk by KPMG in April 2021. Subsequent investment in architecture and development resource has significantly reduced this risk and is anticipated to further reduce with the migration to new server infrastructure in Q1 FY24/25. The benefit of this investment is being realised within Velindre Cancer Services. Progress to achieve a similarly robust infrastructure and automated reporting is slower within Welsh Blood Service and is hampering current business operations.

2.2.2 The National Data Resource (NDR) programme remains a significant opportunity to improve data sharing and linkage across organisational boundaries. Whilst the national programme has reduced funding, the anticipated benefits of using value-based principles to analyse a patient pathway and blood donation from vein to vein remain eminently achievable.

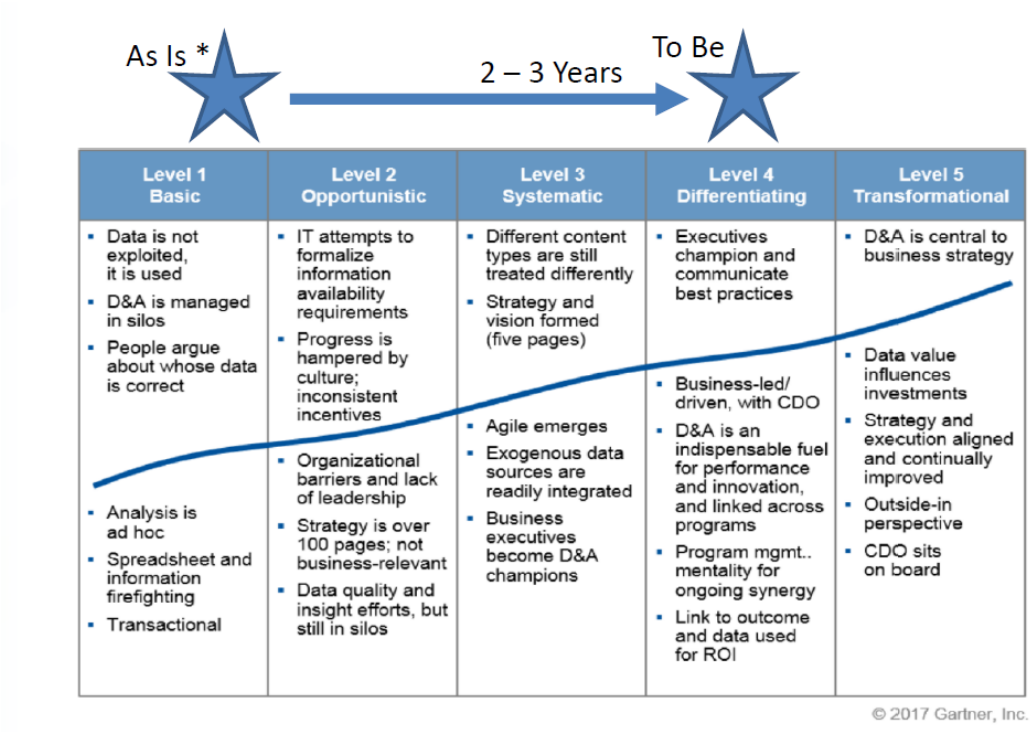


Figure 1: Current state of maturity of data systems

2.2.3 Business intelligence operates a traditional transactional reporting model, where requesters (e.g. service managers) specify the requirement and a product such as a report or dashboard is provided. There is a high volume of reports and dashboards created on an ad-hoc basis provided through Business Intelligence portals (on the intranet) for specific purpose. There has been limited opportunity to properly index the reports, assess the ongoing useability and / or share with other potential users. There is a business risk that reports continue to be used that have outdated logic or analytical methodology.

2.2.4 There are pockets of co-production for data products but these opportunities have generally been limited by resource constraints and capability. This places a significant expectation for requesters to be data experts in terms of what is available through the data warehouse, what is possible to be calculated, created or visualised directly from the warehouse and the best tool to consume that information. MS Excel is routinely used across the Trust as a means of supporting the delivery of services. This carries a significant business risk in terms of human error, data insecurity, poor systematic version control, limited scalability, reduced workflow efficiency and increased workload for non-data specialists.

2.2.5 The existing data products require significant improvement to be more accessible to support user interpretation. There has been an explosion in the tooling for business

intelligence and the M365 tenancy provides numerous opportunities to improve our data products and provide insight for quicker decision making.

2.2.6 Work to automate the monthly production of the Performance Management Framework is a good example of making better use of modern analytical tools and techniques to reduce the manual production of regular reports.

2.3 Workforce data skills and confidence

2.3.1 The following points are based on conversations with key stakeholders across the Trust, observations of current working practices such as requesting data, and meetings, spanning both service divisions, and some corporate teams. They are offered without judgement, they are not specific to any individual, or team and are not intended to cause offence.

2.3.2 The data comfort of the workforce – that is the skills and confidence to make good use of data and insight – is generally low. This aligns with observations of NHS Wales workforce and is not unique to the Trust.

2.3.3 The appetite and aspiration to improve delivery of services through better use of data & insight is noted at every level of the organisation. There is a strong desire to make better use of data and insight and a general held belief that it will improve the quality of services which will benefit donor, patient and staff experience.

2.3.4 There is low confidence in the quality of the data held within information systems which combined with continued service pressure is hampering timely availability of data and generating bespoke validated data sets that are difficult to maintain and track over time.

2.3.5 There is a business risk that manual workarounds, generation of bespoke or locally held data sets are restricting the Trust's ability to share data transparently and securely and to be make best use of data. There is often high confidence in the quality of these bespoke data sets, however these data are rarely collected, defined or organised in a manner that will enable aggregation with other datasets for value-added analytics. It is recognised that urgent business need has often led to the creation of these data sets with little opportunity to involve data professionals.

2.4 Current structure Data & Insight team

2.4.1 Initial steps to create a single Trust-wide Data & Insight team, as part of Digital Services portfolio, has been taken with the reporting lines for the WBS and VCS Business Intelligence teams moving to the AD Data and Insight.

2.4.2 Like many areas of the Trust and wider NHS Wales, the dedication, strong work ethic and patient and donor focus is readily apparent across the Data and Insight team.

2.4.3 However, the capability, capacity and operating model of the Data & Insight team cannot robustly meet the current business need let alone supporting the goal of becoming an insight-led organisation.

2.4.4 In terms of Business as Usual, there are a wealth of reports and dashboards available to support daily operations of many areas of the service divisions. For Velindre Cancer Services, many of these are produced or updated on a daily basis with no manual involvement and significantly improves the robustness of the service for key areas of the service, such as Outpatients, Radiotherapy and SACT. There is a legacy of MS Excel based reports that remain available (noting earlier concerns). However, there are fewer data products that support newer or smaller service areas such as Therapies, SDEC and Acute Oncology Services.

2.4.5 The clinical coding team operate as part of the Data & Insight team with their work aligning with the provision of good quality data. The team ethic and appropriate working practices supports a stable operating model resulting in very low staff turnover. This is notably different to coding teams in peer organisations and further improves the accuracy of coding. Opportunities to improve ways of working are being considered on a national basis and we are involved in discussions.

2.4.6 There is a wealth of reports the majority in MS Excel format provided to many areas of the Welsh Blood Service. Known limitations for example, the ability to upload donor information during clinics reduces opportunity to automate reporting processes end to end, placing a significant burden on a very small team each day to manually update business critical information and is severely reducing opportunity to make best use of the skills of the team for business impact.

2.4.7 Provision of data and analytics to support for Trust-wide enabling functions and also the Futures programmes is not systematic or adequately resourced in terms of the workplan.

2.4.8 There is some provision for service modelling and forecasting future demand but it is limited and requires updating to be more relevant to the services as currently structured, along with embedding its output into routine business practices.

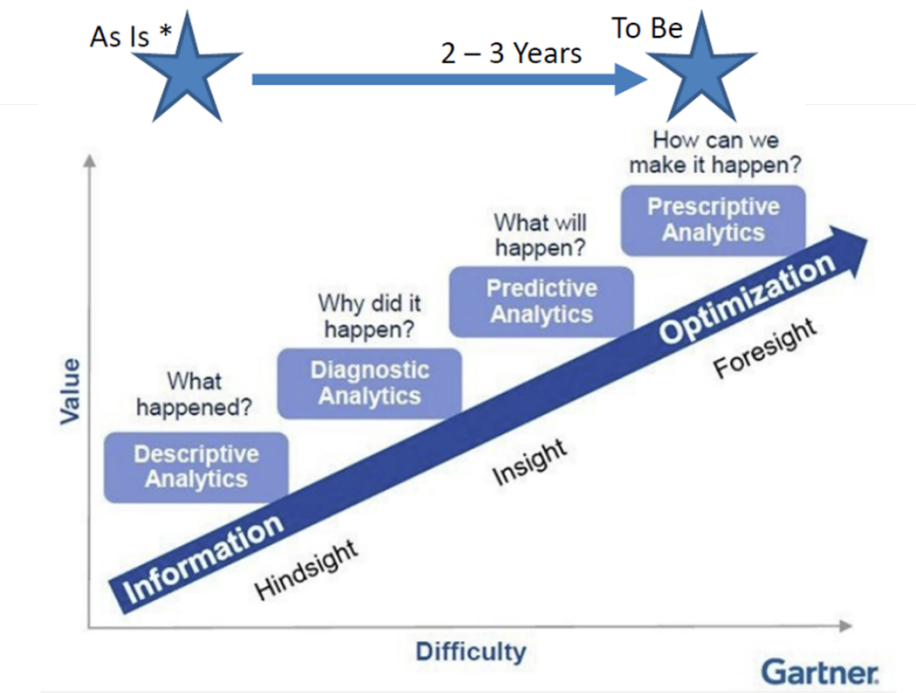


Figure 2: Current state of analytics provision

2.4.9 The reporting and colocation of Data and Insight team with the wider Digital Service supports the improved delivery of the Digital portfolio

2.4.10 An Organisation Change Process is required to improve resilience – there are business critical functions, particularly in Welsh Blood Service which depend on a very small pool of people. This is having a business impact as well as impacting team wellbeing. It is anticipated that a common team purpose along with common operating standards and procedures should increase resilience. There are common skill sets which can be developed whilst preserving the subject matter expertise of, and relationships with the respective services.

2.4.11 As noted in the previous paper (Dec 2023), demand for data and insight is higher than current resource, and prioritisation of workload is difficult. It is anticipated that there needs to be an increase in analytical capacity within the team to support the evolution to a data-driven, insight-led organisation.

2.4.12 Additional resources have been made available to continue to support the Value Intelligence Plan (PSC supporting) and facilitate the migration to new server infrastructure. However, there continues to be open positions in both the VCS and WBS teams complicating delivery.

2.4.13 Without wishing to prejudge the OCP, based on the current state and drawing on experiences of other health boards and trusts who are further along their journey to be more data-driven, we should consider a business partner analytical role who has strong skills and experience of problem elicitation, problem structuring and user design to work with specific areas of the business to co-produce data products for reporting on past activity, forecasting future activity and optimising services for predicted demand.

2.4.14 Early assessment of additional resource indicate that as a minimum we might require an estimated ~£200k p.a:

Lead	Analyst:	8a,	1.0	WTE
Advanced	Analyst:	7:	1.0	WTE
Senior	Analyst:	6:	2.0	WTE

2.5 Plan for becoming a Data-Driven Organisation

2.5.1 This paper provides a formative discussion regarding the current state of data provision and the case for change. Key activities by area are suggested in outline plan in Figure 3

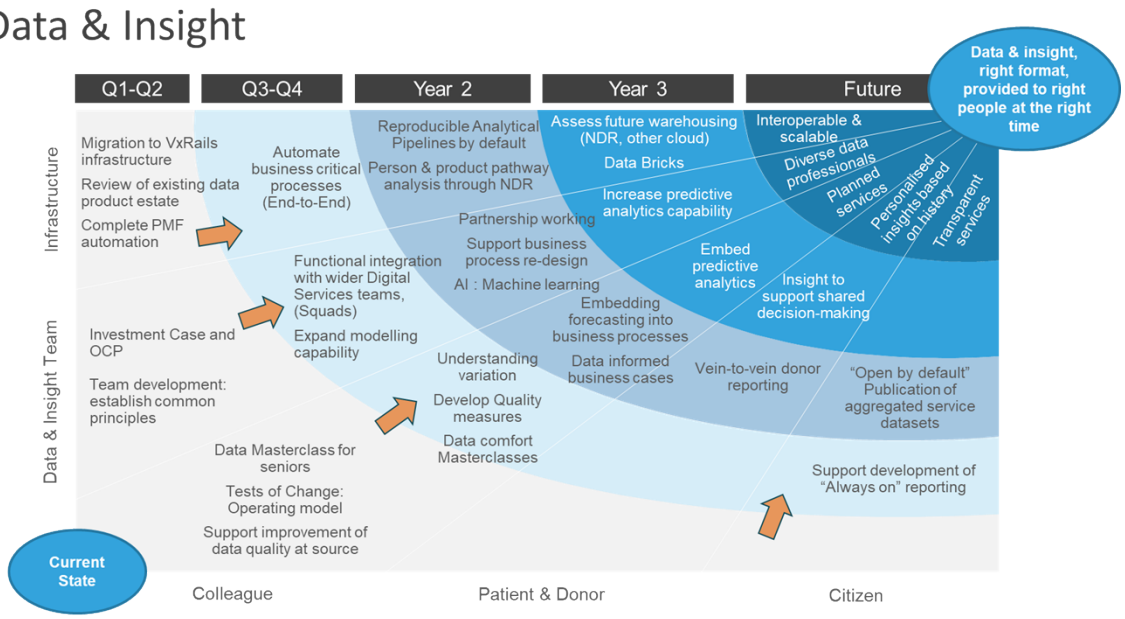


Figure 3: Key steps for Insight-led organisation

2.5.2 The next steps are to ensure that the:

- capability and capacity of the data and insight team are appropriate to meet the current business need;

- infrastructure and business processes for the Welsh Blood Service are robust;
- service areas continue to be supported for daily operations, are involved in the specific timings and prioritisation of the data & insight plan along with improving relationships and data comfort where appropriate;
- major programme business cases have improved support from data and insight.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	07 - Digital Transformation - Failure to Embrace New Technology
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* As an enabling strategy for Destination 2033, the Digital Strategy and the creation of the Trust wide Data and Insight team will have a role to play in support of the six domains of quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. Individual Data and Insight proposals will be considered for the Socio Economic Duty

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Individual proposals under the Data and Insight work will be assessed against the Equality Impact Assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

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

Data & Insight
Becoming an insight-led organisation

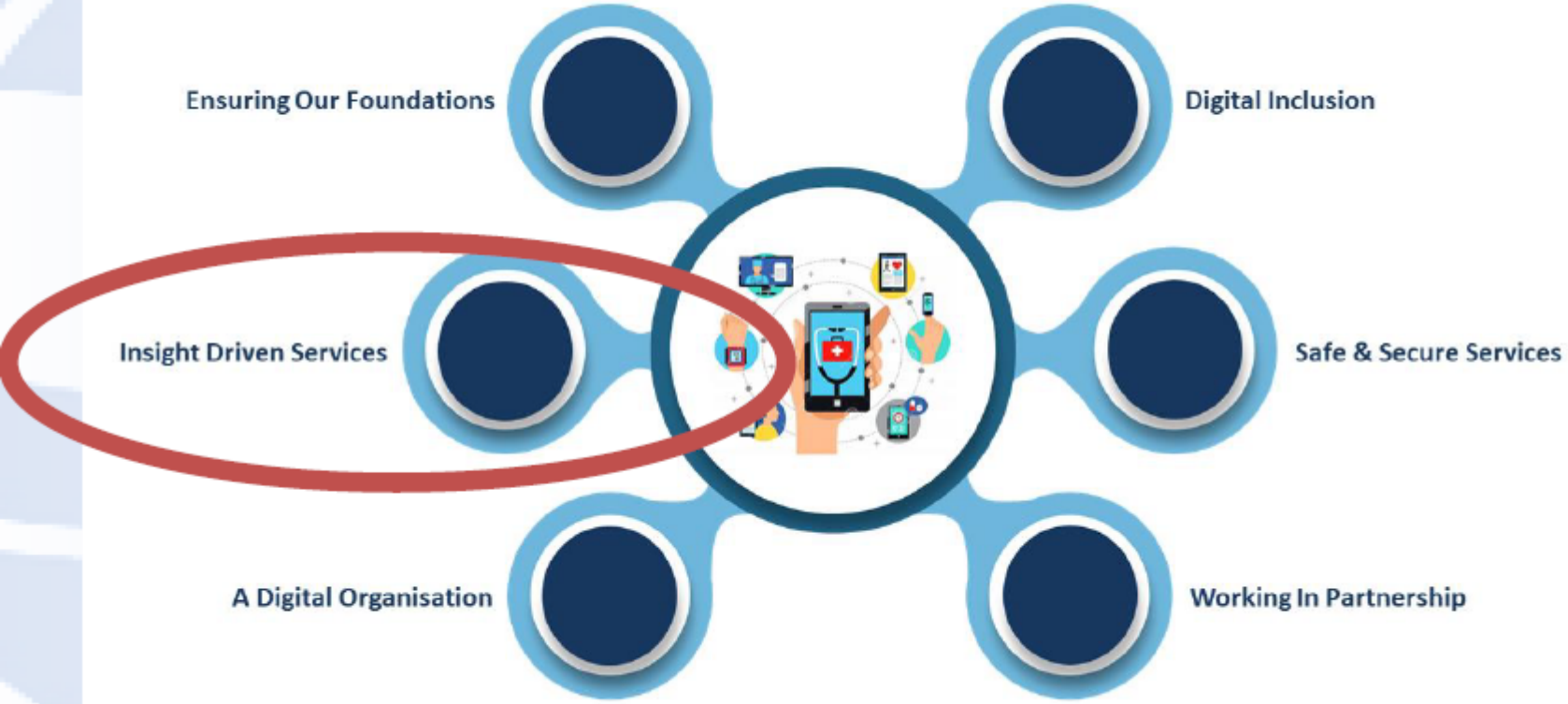
Strategic Development Committee

May 2024

Points of Discussion

- Current state
  - Availability, accessibility and usability of data
  - Workforce data skills and confidence
  - Structure of the Data & Insight team
- Case for change
- Next steps

Digital Excellence: Our Strategy



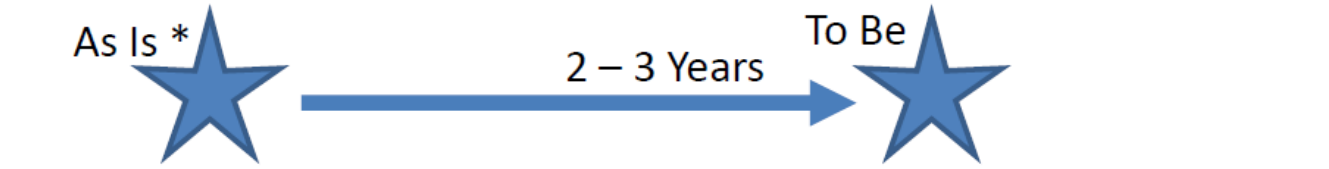
Insight Driven Services

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

Current availability, accessibility and usability of data

- Traditional information systems and legacy data structures
- Improving picture for Velindre Cancer Services
  - Focus on automated processes for business reports
  - Robust design of data warehouse
  - Imminent migration to new infrastructure
- Welsh Blood Service infrastructure and processes require similar focus to support business operations

Current availability, accessibility and usability of data



Level 1 Basic	Level 2 Opportunistic	Level 3 Systematic	Level 4 Differentiating	Level 5 Transformational
▪ Data is not exploited, it is used ▪ D&A is managed in silos ▪ People argue about whose data is correct ▪ Analysis is ad hoc ▪ Spreadsheet and information firefighting ▪ Transactional	▪ IT attempts to formalize information availability requirements ▪ Progress is hampered by culture; inconsistent incentives ▪ Organizational barriers and lack of leadership ▪ Strategy is over 100 pages; not business-relevant ▪ Data quality and insight efforts, but still in silos	▪ Different content types are still treated differently ▪ Strategy and vision formed (five pages) ▪ Agile emerges ▪ Exogenous data sources are readily integrated ▪ Business executives become D&A champions	▪ Executives champion and communicate best practices ▪ Business-led/ driven, with CDO ▪ D&A is an indispensable fuel for performance and innovation, and linked across programs ▪ Program mgmt.. mentality for ongoing synergy ▪ Link to outcome and data used for ROI	▪ D&A is central to business strategy ▪ Data value influences investments ▪ Strategy and execution aligned and continually improved ▪ Outside-in perspective ▪ CDO sits on board

Current availability, accessibility and usability of data

- Traditional transactional business intelligence operating model
  - Burden on the service teams to specify requirements
  - Limited opportunities for co-production
  - Data products are not systematically reviewed for use, update or assessed for wider opportunities
- Heavy reliance on MS Excel
  - Great as a spreadsheet tool for individual one-off analyses
  - Should **not** be used for operational service delivery
    - Human error, data insecurity, poor systematic version control, limited scalability, reduced workflow efficiency and increased workload for non-data specialists.
- Data rich, information poor

Current Workforce data skills and confidence

- Appetite and ambition to improve delivery of services through better use of data & insight is noted at every level of the organisation.

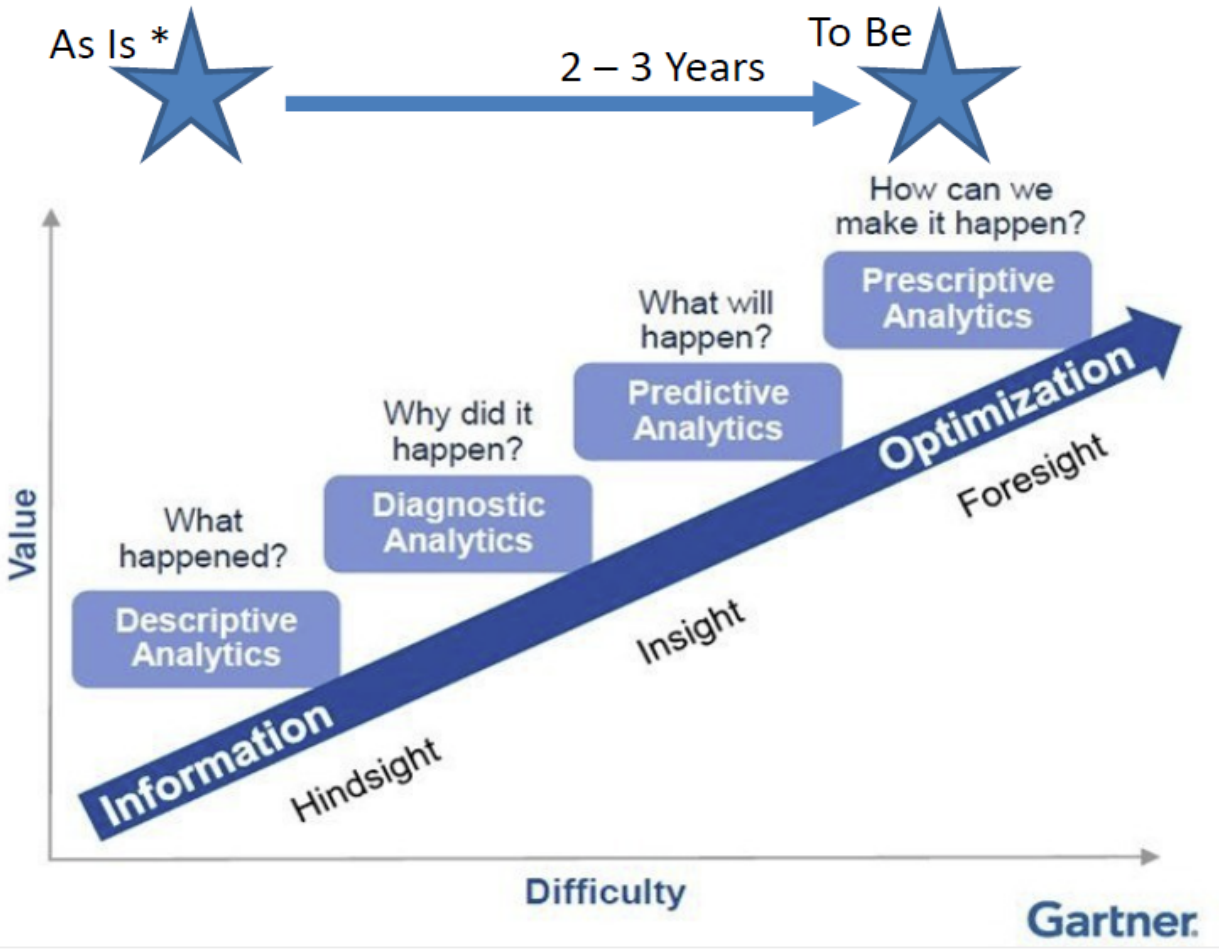
- Data comfort – skills and confidence - is generally low
  - Similar to wider NHS Wales

- Low confidence in quality of data held in information systems
  - Presumption that the data must be perfect to be usable
  - Manual workarounds and generation of bespoke validated datasets.
  - High burden of effort on small groups of people
  - Reduced ability to systematically maintain and track over time

Current Structure of the Data & Insight team

- Single Data & Insight team
  - Previous business intelligence teams for WBS and VCS reporting to AD Data & Insight
- Dedicated, good work ethic, donor and patient focussed
- Data engineering excellence
- Analytical capacity and capability not sufficient to meet current need
- Scarce resource remains focussed on Service divisions
  - Support for wider-Trust functions and major programmes is ad-hoc

Current provision from Data & Insight Team

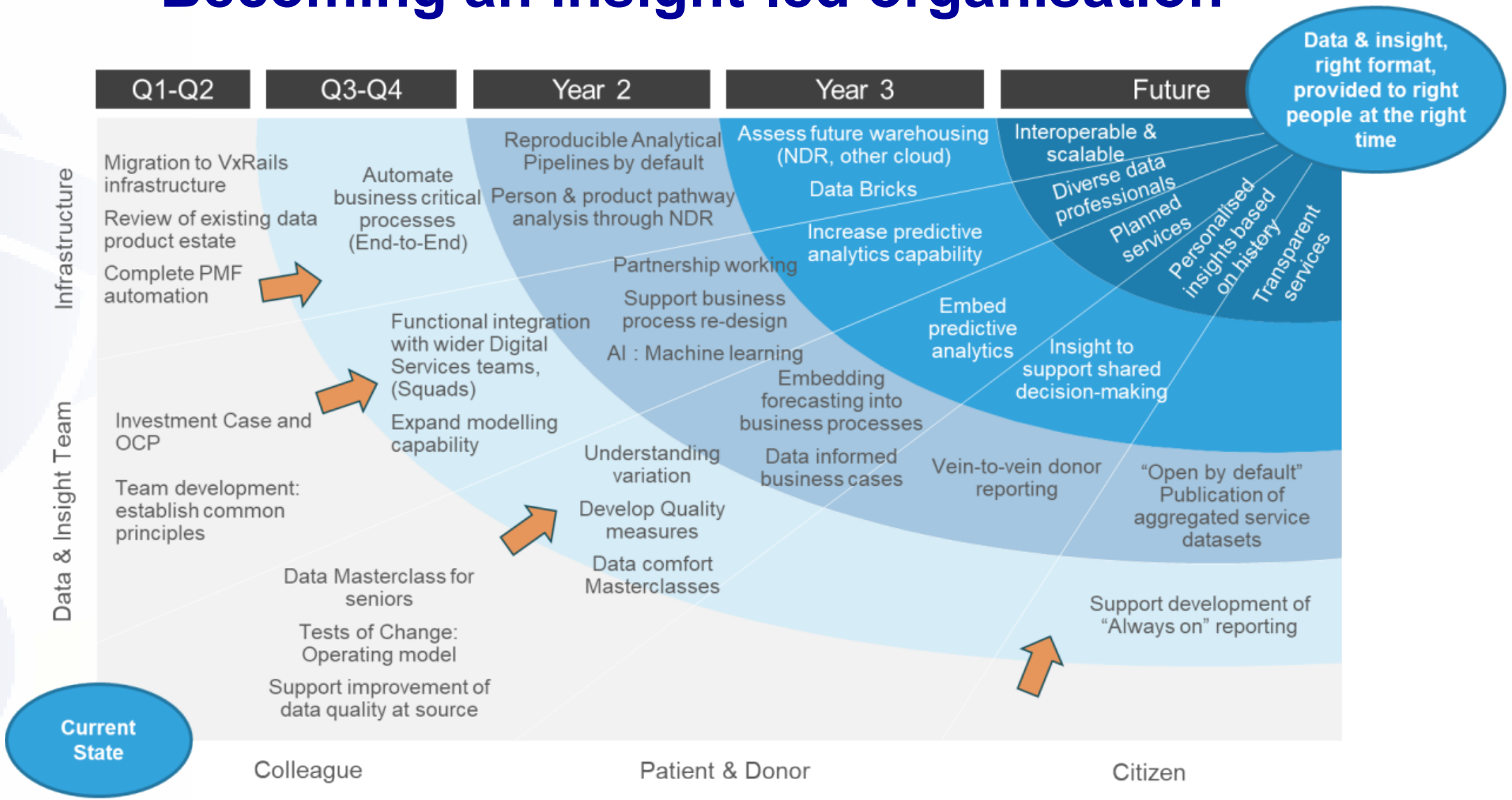


Current Structure of the Data & Insight team

- Organisation Change Process will be required
  - Improve resilience to meet current business need
  - Improved consistency of processes and procedures
  - Increased career development opportunities

- Investment in additional capacity
  - Additional analytical resources required: capability and capacity
  - Evolving the operating model

Becoming an insight-led organisation



STRATEGIC DEVELOPMENT COMMITTEE

WBS Performance Management Framework – KPI Review

DATE OF MEETING	15/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ENDORSE FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	SARAH RICHARDS, HEAD OF PLANNING AND PERFORMANCE SERVICES
PRESENTED BY	Alan Prosser, WBS Director
APPROVED BY	Steve Ham, Chief Executive

EXECUTIVE SUMMARY	In response to the Velindre University NHS Trust performance reviews, WBS have taken the opportunity to evaluate the WBS Performance Management Framework (PMF). This paper provides an overview of the work completed to date and details the proposed new suite of KPIs for the Executive Management Board (Level 2) that have been triangulated against the WBS 5 Year Strategy and the WBS Integrated Medium Term Plan (IMTP) objectives.

RECOMMENDATION / ACTIONS	The Strategic Development Committee are asked to **ENDORSE** the contents of this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS Senior Leadership Team	10/04/2024
Executive Management Board (Run)	29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ENDORSED FOR APPROVAL	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	KPI Narrative & Calculation Basis

1. SITUATION

1.1 In response to the Velindre University NHS Trust Performance Management Framework (PMF) reviews, WBS have taken the opportunity to evaluate the WBS PMF to ensure the Key Performance Indicators (KPIs) are relevant, timely, and provide the appropriate level of assurance in relation to service delivery.

1.2 The proposed updated PMF includes 'SMART' (Specific, Measurable, Achievable, Realistic and Timebound) measures, focussing on patient/donor outcomes and improved value, and includes updates on sustainability, People and Organisational Development (POD) and financial performance. It will support departments to

better monitor their own performance, using data to understand the impact of actions and service changes. The new KPIs are aligned to the WBS 5 Year Strategy and the Integrated Medium-Term Plan (IMTP) objectives.

1.3 This paper provides an overview of the work completed to date and details the proposed new suite of KPIs for the Executive Management Board (Level 2).

2. BACKGROUND

2.1 The WBS Planning and Performance Department have led a piece of work to review the existing KPIs for WBS. This has included reviewing other UK Blood Services frameworks to inform decisions on the structure and content of the new PMF for WBS.

2.2 The aim was to develop a PMF which joins up planning, performance, and improvement processes to assist management of risk in these areas. The new PMF includes outcome-based measures, targets, and standards for service delivery, which support positive ownership and accountability.

2.3 The PMF is aligned to the six domains of quality as outlined in the Health and Social Care (Quality and engagement) Act 2020 to support delivery of high-quality, person-centred services that actively involve service users and drive continuous improvement in service delivery.

2.3 The development process has considered how the updated WBS PMF links to both the Trust's IMTP and the Quality Standards Framework.

2.4 The updated PMF has been developed following engagement with the Senior Leadership Team (SLT), the Heads of Department and the departmental KPI owners to ensure a more meaningful, relevant, and effective performance measurement system.

2.5 The following principles have underpinned development of the new framework:

- The KPIs provide assurance to the wider Trust committee structure, donors/patients and service users and the general public that the Welsh Blood Service is meeting its service objectives.
- The KPIs align to best practice and are evidence-based.

- The KPIs align to comparative services e.g., NHSBT/European Blood Alliance (EBA) rather than general NHS Wales benchmarks where appropriate.

3. ASSESSMENT

3.1 The review undertaken to date has resulted in proposing the following KPIs as part of the WBS PMF for the Executive Management Board (Level 2). Further work is required to develop the hierarchy for the Quality, Safety and Performance Committee (QSP) and Trust Board (Levels 3 & 4). The new KPIs have been highlighted in blue and the amended KPIs in green in the tables below for clarity.

3.2 Safety KPIs

KPI	Existing / New / Amended	Rationale / Comments
Number of health & safety incidents recorded	E	n/a
Number of health & safety incidents that exceeded target date for closure	N	To provide supporting information for 'Number of health & safety incidents recorded'
Number of health & safety incidents that remain overdue (point in time)	N	To provide supporting information for 'Number of health & safety incidents recorded'
Number of incidents reported to regulator / licensing authority	E	n/a
Number of incidents reported to regulator / licencing authority that exceeded target date for closure (also show as % of activity)	N	To provide supporting information for 'Number of incidents reported to regulator / licencing authority'
Number of incidents reported to regulator / licensing authority that remain overdue (also show as % of activity)	N	To provide supporting information for 'Number of incidents reported to regulator / licencing authority'
Number of quality incidents recorded (also show as % of activity)	N	Replaces 'Quality Incidents closed within 30 days'
Number of quality incidents that exceeded target date for closure (also show as % of activity)	N	To provide supporting information for 'Number of quality incidents recorded'
Number of quality incidents that remain overdue (also show as % of activity)	N	To provide supporting information for 'Number of quality incidents recorded'
Number of non-conformances	A	Amended from 'Number of critical and major non-conformances through external audits or inspections'

Number of non-conformances identified internally	N	To provide supporting information for 'Number of non-conformances'
Number of non-conformances identified externally	N	To provide supporting information for 'Number of non-conformances'
% staff compliance who have completed Core Skills and Training Framework Level 1	E	n/a
Number of staff RIDDOR incidents, injuries, and work-related accidents	E	n/a
Number of Duty of Candour incidents recorded (also show as % of activity)	N	Added from Quality Framework
Number of Never Events recorded (also show as % of activity)	N	Added from Quality Framework

3.3 Effective KPIs

KPI	Existing / New / Amended	Rationale / Comments
Number of new whole blood donors	E	n/a
Number of new apheresis donors	E	n/a
Number of stem cell collections	E	n/a
Number of new stem cell volunteers	E	n/a
Clinical demand for red cells met	N	Replaces '% demand for red blood cells met without import'
Clinical demand for platelets met	N	Replaces '% demand for platelet supply met'
Blood stock stability (average days of stock)	N	Replaces 'Red blood cell stock level (below 3 days)'
% time expired red blood cells (adult)	E	n/a
% time expired platelets (adult)	E	n/a
% personal appraisal development reviews compliance	E	n/a
% rolling average sickness levels	E	n/a

3.4 Experience KPIs

KPI	Existing / New / Amended	Rationale / Comments
% of donors that rate their experience as excellent	A	Replaces '% donor satisfaction (donors that scored 5/6 out of 6 for donation experience)'
% of stem cell donors that rate their experience as excellent	N	Expanded to include stem cell donors
Number of concerns received (blood donors) (also show as % of activity)	E	n/a
% Acknowledgement to concerns within 'Putting Things Right' timescale (formal & informal)	A	Replaces '% Responses to informal concerns within 'Putting Things Right' 2-day timescale'
% Resolution to formal concerns with 30 working day 'Putting Things Right' timescale	A	Replaces '% Responses to formal concerns with 30 working day 'Putting Things Right' timescale'
% Customer Hospital complaints	N	Added to include Blood Health Team metrics
Number of incidents of violence & aggression	E	n/a
Number of incidents of violence and aggression that exceeded target for closure (also show as % of activity)	N	To provide supporting information for 'Number of incidents of violence & aggression'
Number of incidents of violence and aggression that remain overdue (also show as % of activity)	N	To provide supporting information for 'Number of incidents of violence & aggression'
Number of donors that attended clinic but failed to donate (also show as % of activity)	N	Replaces '% unsuccessful venepuncture' & '% Part blood bags collected'

3.5 Timeliness KPIs

KPI	Existing / New / Amended	Rationale / Comments
% turnaround times antenatal anti-D & anti-c quantitation (within 5 working days)	E	n/a
% turnaround times antenatal (within 3 working days)	E	n/a
% turnaround times Reference serology (within 5 working days)	A	Increased from 2 to 5 working days to bring in line with national guidelines / benchmarking
% turnaround time deceased donor typing for solid organ transplantation (within 4 hours)	E	n/a

3.6 Efficient KPIs

KPI	Existing / New / Amended	Rationale / Comments
Whole Blood Collection Productivity	E	Definitions to be agreed at EBA Benchmarking Group
Manufacturing Productivity	E	Definitions to be agreed at EBA Benchmarking Group
Electricity performance kilowatt hours (kWh) against target consumption budget profile	E	n/a
Gas performance in kilowatt hours (kWh) against target consumption budget profile	E	n/a
Water performance usage in cubic metres against target consumption budget profile	E	n/a
Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	E	n/a

WBS expenditure (£k) on Bank and Agency staff against target budget profile	E	n/a
Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	E	n/a

3.7 Equitable KPIs

KPI	Existing / New / Amended	Rationale / Comments
Ethnic split of donor panel for blood donors	N	Added as important metric for WBS (pie chart)
Ethnic split of donor panel for stem cell volunteers	N	Added as important metric for WBS (pie chart)
Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	E	POD currently collecting annually Trust-wide – exploring feasibility of reporting divisionally. Triangulate with Equality Strategy.
Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	E	POD currently collecting annually Trust-wide – exploring feasibility of reporting divisionally. Triangulate with Equality Strategy.
Diversity of Workforce – % People with a Disability within workforce	E	POD currently collecting annually Trust-wide – exploring feasibility of reporting divisionally. Triangulate with Equality Strategy.
% of Workforce declared Welsh Speakers at Level 1	E	POD currently collecting annually Trust-wide – exploring feasibility of reporting divisionally. Triangulate with Equality Strategy.

3.7 Summary of KPIs Removed

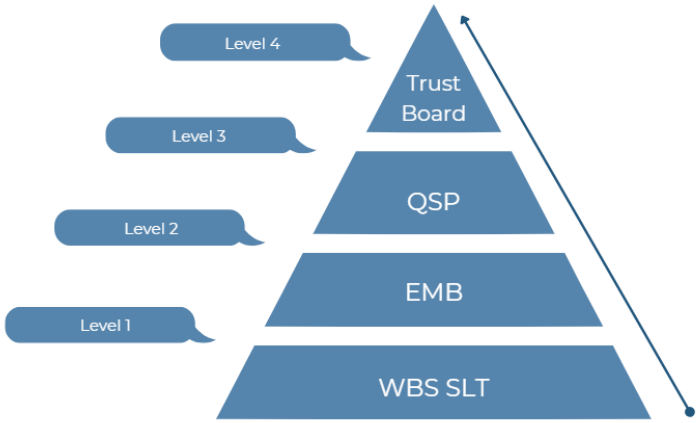
KPI	Rationale / Comments
Quality incidents closed within 30 days	Replaced with 'Number of quality incidents recorded' & 'Number of quality incidents that exceeded target date for closure' & 'Number of quality incidents that remain overdue'
% demand for red blood cells met without import	Replaced with 'Clinical demand for red cells met'
% demand for platelet supply met	Replaced with 'Clinical demand for platelets met'
Red blood cell stock level (below 3 days)	Replaced with 'Blood stock stability (average days of stock)'
% unsuccessful venepuncture	Replaced with 'Number of donors that attended clinic but failed to donate' – original KPI will remain as SLT KPI (Level 1)
% Part blood bags collected	Replaced with 'Number of donors that attended clinic but failed to donate' – original KPI will remain as SLT KPI (Level 1)

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Strategic Development Committee are asked to **ENDORSE** the proposed KPIs for the Executive Management Board (Level 2) outlined in the document.

4.2 A hierarchical structure for the Performance Management Framework is being developed and will consist of the following levels:

1. WBS Senior Leadership Team (SLT)
2. Executive Management Board (EMB)
3. Quality, Safety & Performance Committee (QSP)
4. Velindre University NHS Trust Board



This Paper outlines the KPIs proposed for the Executive Management Board (Level 2). Further work is underway to agree KPIs for Quality, Safety & Performance Committee (QSP) and Velindre University NHS Trust Board (Levels 3 & 4).

4.3 Further work will be undertaken with the Head of Transfusion Services to understand if the recommendations from the recent external review of RCI have identified any other areas for inclusion within the updated PMF.

4.4 Work is underway with Digital to develop divisional KPIs for inclusion in WBS PMF.

4.5 Focussed and measurable KPIs for Research, Development and Innovation (RD&I) will be considered once the draft RD&I Strategy has been approved.

4.6 The automation of the WBS PMF is progressing with Business Intelligence.

5. IMPACT ASSESSMENT

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Socio Economic Duty Assessment is underway.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below:
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This report provides an update on progress only. The detail is available in the WBS Futures Financial Plan. **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected:

	Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Equality Impact Assessment is underway.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

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

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

Proposed KPI Narrative & Calculation Basis

Safety KPIs

KPI Narrative	Calculation Basis
Number of health & safety incidents recorded	Number (recorded in DATIX & QPulse) reported in a calendar month
Number of health & safety incidents that exceeded target date for closure	Number (recorded in DATIX & QPulse) that exceeded target close date in a calendar month
Number of health & safety incidents that remain overdue	Number (recorded in Datix / QPulse) that remain overdue on last working day of month
Number of incidents reported to regulator / licensing authority	Number of Serious Adverse Blood Reactions & Events (SABRE) reported to external regulators e.g., Medicines and Healthcare products Regulatory Agency (MHRA) and the Human Tissues Authority (HTA) in a calendar month
Number of incidents reported to regulator / licencing authority that exceeded target date for closure	Number (recorded in DATIX & QPulse) that exceeded target close date in a calendar month. Also show as % of activity
Number of incidents reported to regulator / licensing authority that remain overdue	Number (recorded in Datix / QPulse) that remain overdue on last working day of month. Also show as % of activity
Number of quality incidents recorded	Number (recorded in DATIX & QPulse) reported in a calendar month. Also show as % of activity
Number of quality incidents that exceeded target date for closure	Number (recorded in DATIX & QPulse) that exceeded target close date in a calendar month. Also show as % of activity.
Number of quality incidents that remain overdue	Number (recorded in Datix / QPulse) that remain overdue on last working day of month. Also show as % of activity.
Number of non-conformances	Number (recorded in DATIX & QPulse) reported in a calendar month
Number of non-conformances identified internally	Number (recorded in DATIX & QPulse) reported in a calendar month
Number of non-conformances identified externally	Number (recorded in DATIX & QPulse) reported in a calendar month
% staff compliance who have completed Core Skills and Training Framework Level 1	***Data provided by POD***
Number of staff RIDDOR incidents, injuries, and work-related accidents	Number (recorded in DATIX & QPulse) reported in a calendar month
Number of Duty of Candour incidents recorded	Number (recorded in DATIX & QPulse) reported in a calendar month. Also show as % of activity

Proposed KPI Narrative & Calculation Basis

Number of Never Events recorded	Number (recorded in DATIX & QPulse) reported in a calendar month. Also show as % of activity.

Effective KPIs

KPI	Calculation Basis
Number of new whole blood donors	Number recruited to the donor panel per calendar month
Number of new apheresis donors	Number recruited to the donor panel per calendar month
Number of stem cell collections	Number collected per calendar month
Number of new stem cell volunteers	Number recruited to the donor panel per calendar month
Clinical demand for red cells met	***Definition in development***
Clinical demand for platelets met	***Definition in development***
Blood stock stability (average days of stock)	***Definition in development***
% time expired red blood cells (adult)	Number of adult red blood cells, excluding paediatric bags, which have time expired, as a % of the total number of adult red blood cell bags manufactured in calendar month
% time expired platelets (adult)	Number of adult platelets which have time expired, as a % of the total number of platelets manufactured in calendar month
% personal appraisal development reviews compliance	***Data provided by POD***
% rolling average sickness levels	***Data provided by POD***

Experience KPIs

KPI	Calculation Basis
% of donors that rate their experience as excellent	Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied) with their "overall" donation experience after they have been registered on clinic to donate.

Proposed KPI Narrative & Calculation Basis

% of stem cell donors that rate their experience as excellent	Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied) with their "overall" donation experience after they have been registered on clinic to donate.
Number of concerns received (blood donors)	Number of formal and informal concerns received from blood donors. Also show as % of activity.
% Acknowledgement to concerns within 'Putting Things Right' timescale (formal & informal)	% of formal and informal concerns acknowledged as required by the "Putting things Right" regulations
% Resolution to formal concerns with 30 working day 'Putting Things Right' timescale	% of formal concerns resolved within 30 working days as required by the "Putting things Right" regulations
% Customer Hospital complaints	Number recorded per calendar month
Number of incidents of violence & aggression	Number (recorded in DATIX & QPulse) reported in a calendar month
Number of incidents of violence and aggression that exceeded target for closure	Number (recorded in DATIX & QPulse) that exceeded target close date in a calendar month. Also show as % of activity.
Number of incidents of violence and aggression that remain overdue	Number (recorded in Datix / QPulse) that remain overdue on last working day of month. Also show as % of activity.
Number of donors that attended clinic but failed to donate	***Definition in development – will include part bags, failed venepuncture.*** Also show as % of activity.

Timeliness KPIs

KPI	Calculation Basis
% turnaround times antenatal anti-D & anti-c quantitation (within 5 working days)	% Anti-D & -c Quantitation results provided to customer hospitals within 5 working days
% turnaround times antenatal (within 3 working days)	% antenatal results provided to customer hospitals within 3 working days
% turnaround times Reference serology (within 5 working days)	% samples referred for red cell reference serology work-ups provided to customer hospitals within 5 working days
% turnaround time deceased donor typing for solid organ transplantation (within 4 hours)	% Deceased Donor Typing/Crossmatching provided to customer hospitals within 4 hours

Proposed KPI Narrative & Calculation Basis

Efficient KPIs

KPI	Calculation Basis
Whole Blood Collection Productivity	Number of viable whole blood donations collected per clinic hour per rostered per member of staff ***New definition to be agreed at EBA Benchmarking Group – to continue with existing until then***
Manufacturing Productivity	Number of blood components being manufactured per standardised Full Time Equivalent (FTE) ***New definition to be agreed at EBA Benchmarking Group – to continue with existing until then***
Electricity performance kilowatt hours (kWh) against target consumption budget profile	***Data provided by Estates***
Gas performance in kilowatt hours (kWh) against target consumption budget profile	***Data provided by Estates***
Water performance usage in cubic metres against target consumption budget profile	***Data provided by Estates***
Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	***Data provided by Estates***
WBS expenditure (£k) on Bank and Agency staff against target budget profile	***Data provided by Estates***
Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	***Data provided by Estates***

Equitable KPIs

KPI	Calculation Basis
Ethnic split of donor panel for blood donors	Split of donor panel by ethnicity (pie chart)
Ethnic split of donor panel for stem cell volunteers	Split of donor panel by ethnicity (pie chart)

Proposed KPI Narrative & Calculation Basis

Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	***Data provided by POD – currently collected annually Trust-wide – not available by division at present.***
Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	***Data provided by POD – currently collected annually Trust-wide – not available by division at present.***
Diversity of Workforce – % People with a Disability within workforce	***Data provided by POD – currently collected annually Trust-wide – not available by division at present.***
% of Workforce declared Welsh Speakers at Level 1	***Data provided by POD – currently collected annually Trust-wide – not available by division at present.***

Strategic Development Committee

Trust Assurance Framework

DATE OF MEETING	15/05/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This paper summarises the next steps for Trust Assurance Framework for April and May.

RECOMMENDATION / ACTIONS	EMB are asked to **DISCUSS AND NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	15TH APRIL
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	
1	Trust Assurance Framework

1. SITUATION

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

2. ASSESSMENT

Actions for April/ May

1. It was agreed in Executive Management Board on 15th April that the two risks for focus in Quality, Safety & Performance Committee in May will be strategic workforce risk (TAF 03) and strategic financial stability risk (TAF 08). There will be triangulation with other key papers on the agenda on these matters.

2. May reporting cycle actions – as per below, in particular to reference that an approach to action 3 has been agreed in two phases.

   The first is to provide an additional section in the format to include the IMTP actions. This mapping will be completed following a series of 121s between the Executive Directors and Director Corporate Governance with support from the Strategic Transformation team. This work will be completed during May for June/July reporting cycle.

   The longer term approach will be to re-orientate the TAF according to strategic objectives. The template and approach for this to be agreed by October, in order to allow the development of the 2025-2028 IMTP and TAF to progress on this basis during Q3 and 4.

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

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	To be confirmed
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	**Closed** – Included in this paper
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	June/July reporting cycle – following approval of IMTP
4	Deep dive of two risks at Quality, Safety &	Following reporting of refresh framework of	May reporting cycle

	Performance Committee going forwards	strategic risks, this will recommence from the next reporting cycle.	
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may include further Board development time etc.	June 2024 - in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.
6	Tracked changes	Tracked changes will be highlighted more clearly to show recent updates. In addition, the cover paper will be developed to include clearer commentary of key changes.	July reporting cycle

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**

<table>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
• A beacon for research, development and innovation in our stated areas of priority ☐
• An established ‘University’ Trust which provides highly valued knowledge for learning for all. ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>Choose an item
All Strategic Risks are related.</td></tr>
<tr><td rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td>The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government’s Quality and Safety Framework: Learning and Improving (2021).

All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.</td></tr>
<tr><td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</td><td>Not required</td></tr>
</table>

For more information: https://www.gov.wales/socio-economic-duty-overview	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS **SOURCES OF ASSURANCE**

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	IA	Jul-25	National oversight group is currently discussing with C&V in light of new supplier for All Wales LIMS solution.	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A1.1	Working with DCHW to support the Blood Transfution Module of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	IA		Discussions ongoing about funding solutions for blood tracking/fating to patient,	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	PA		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	18.4.24	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service onow commenced in role - as at Dec 2023			

SECTION 1

RISK ID		RISK TITLE		STRATEGIC GOAL		RISK SCORE TREND	
RISK LEADS				RISK THEME			

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

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

SOURCES OF ASSURANCE

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

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further	First line and second lines of defence assurance are in place to a certain extent	
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commsissioning and specialsit cancer	Replace of CCLG not in place yet so no regioanl assurance regarding strategic	
Agreement of need for improved regionsal cancer commissiong (core services)		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Phase 1 complete. Development of Phase 2 of PMF with additionalperfromance measures/quality metrics commenced	Carl James	Mar-24	Design stage commenced	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded. Progress being made on a number of projects (Food mission; cancer dashboards etc	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc). Still no commencement date	11/04/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountabilioty arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	April/May 2024	Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage	11-Apr-24	Unknown at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James	tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023. Regional programme working	22-Dec-23	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system	The level of assurance should increase
1.9	Establishment of new national commissioning body (bringing	Welsh Government	01-Apr-24	Implementation of new commissioing body well progressed	11/04/2024	Anticipated it will reduce level of risk by providing	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE						
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
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	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
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	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	E	Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA
C9	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X	X	X	E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	External Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	**IA**	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged (H&E) Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff. The next H&E meeting was to be on the 28.03.24 but cancelled due to Strike action, this plan will now be agreed in April by the group for 24/25. Task and Finish group has been set up to embed the Values and Behaviour Framework into the recruitment process.	19.04.2024	Plan is moniitoted via Health and Engaged Steering group	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	**PA**	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	**IA**	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	**PA**	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	Development of a Strategic workforce plan	Susan Thomas	**IA**	Sep-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy. Workforce models will be developed inline with the Clinical and Scientific Strategy	19/04/2024	The Clinical & Scietific Strategy is still under dvelopment. Work underway in the interim is described in the Workforce Supply & Shape Paper coming to QSP Committee in May 2024	
1.6	Development of a Trust Retention Plan	Susan Thomas	**IA**	Apr-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. Paper on the plan to be presented to EMB in May	19.04.204		
1.7	Review Exit Interview Process	Susan Thomas	**IA**	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		May-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in April 2024. This paper also proposes that the conversations continue as routine in person and virtually.	18/04/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	18/04/2024	We have received the Trust level data from the 2023 staff survey. The more detailed dahsboards are expected by the end of April. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream.	
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. Initial project report to be considered by EMB in April	19.04.2024	Initial programme completed - ongoing work to trianguale with wider cultural work	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS **SOURCES OF ASSURANCE**

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

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Agreed Digital Inclusion plan - C4,C7 - This has now been agreed by EMB/SDC and is no longer a gap in control	Assurance Arrangements for Digital Architecture will need to be established -	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team -	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist started 1st April '24, will close out for May update
3193/3197 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degredation of critical WBS (NHS Wales) supply chain activities	15	Outline Business Case at EMB/SDC in April '24
R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.0	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Jun-24	Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session	11.4.24	Impact to be asseessed when programme delviered	
2.0	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.25	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Jun-24	Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams. Good progress made however further embedding required with Senior Leadership Teams.	11.4.26	Impact to be asseessed when delviered	
4.0	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.27	Requirement for C7 to be put in place	
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	4	Jun-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	11.4.28	Impact to be asseessed when programme delviered	
6.0	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	1	May-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.29	Impact to be asseessed when delviered	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	**RISK TITLE**	**CURRENT RISK RATING**	**RISK TREND**
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable
2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	22.3.24	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	22.3.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
A3	Intergrated Quality and Safety dashboards to be developed that align with PMF	Transofrmation, planning, performance and digital	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed	22.3.24	Should reduce risk	Enhanced control and assurance
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Working Group established within VCS, Lead by the VBHC Team & external company PCS	22.3.24	Should long term reduce risk	Enhanced assurance
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Work commenced	22.3.24	Reduce risk	Enhanced control
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24		22.3.24	Reduce risk	Enhanced control
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan developed	22.3.24	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce	1	Mar-26	Opportunities for mult-professional consultant posts being considered	22.3.24	Reduce risk	Enhanced control
A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process being drafted based on benchmarking outcomes and review of national standards	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	22.3.24	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Director / Exec Director Nursing, AHP & HCS	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB.	22.3.24	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024, followed by consultation period. .	22.3.24	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and	22.3.24	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	

SECTION 1

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

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA
Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA
Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group, including WBS Pre-Operative Anaemia project; Value Intelligence Centre and Food Mission	22.3.24	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	tbc
F2	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Ongoing	Pharmacy review has been conducted and will be presented to Exec Management Board early in 2024. Following this a review of medicines management governance (including financial aspects), will be conducted by September 2024.	22.3.24	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability	tbc
F3	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing	Capital financial control procedure approved by Audit Committee	22.3.24	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Criteria have been drafted and Board Reporting Template updated to reflect types of initiatives and sources of funding available for investments	22.3.24	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-24	Cardiff Cancer Research Hub market engagement exercise to identify potential sources of external funding to support development Strengthening private patient cash collection and pricing	22.3.24	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. The first major programme this has been applied to is the IRS programme. A Scheme of Delegation and Governance Framework needs to be developed for nVCC	22.3.24	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Service Capacity**	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	**Cath O'Brien Rachel Hennessey Alan Prosser**
02	**Partnership Alignment**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**Carl James Nicola Williams Jacinta Abraham**
03	**Workforce Supply and Shape**	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**Sarah Morley**
04	**Organisational Culture**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**Sarah Morley**
05	**Digital Transformation**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**Carl James**
06	**Organisational and Clinical Governance**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**Lauren Fear**
07	**Patient Outcomes**	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**Nicola Williams Jacinta Abraham Cath O'Brien**
08	**Financial Sustainability**	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**Matt Bunce**

DEFINITIONS

CONTROL EFFECTIVENESS

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

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

LEVELS OF ASSURANCE DESCRIPTORS

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

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

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

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisatio of and sepa of duties • Pre-employ screening o potential sta
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords access cont • Staff rotatio regular cha supervisors • Exposure re by installati hours worke
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performanc reporting • Regular rev

RISK SCORE

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

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

IMPACT MATRIX

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

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue **Programme/ projects** Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective. Minor impact on service. **Programme/ projects** 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. **Programme/ projects** 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. **Programme/ projects** 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure **Programme/ projects** >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07	Quality *Quality/complaints/ audit / GxP*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practioner.	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry Gross failure to meet national standards Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)
08	Reputational *Adverse publicity/ reputation*	 Potential for public concern	Local media coverage Minor reduction in public confidence	Local media coverage Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

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

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

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

on limits
aration

ment
f
aff

or other
trols
n and
nge of

eduction
on on
ed

e

iew

STRATEGIC DEVELOPMENT COMMITTEE

Velindre Oncology Academy Implementation Board Update

DATE OF MEETING	15/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Hannah Russon, Head of the Velindre Oncology Academy
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VOA	Velindre Oncology Academy

1. PURPOSE

1.1 This paper had been prepared to provide the Strategic Development with details of the key updates provided by the Velindre Oncology Academy Implementation Board at its meeting on the 9th April 2024.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no matters to alert / escalate.
ADVISE	• The trajectory timescales for the accreditation process of courses between Velindre Cancer Centre and University Wales Trinity St David are yet to be confirmed and early indications have estimated between 6 to 12 months. 6 months is the Academies preferred timescale so that first accredited courses can commence in September 2024. Active negotiations are underway. • The Branding company have been commissioned to undertake further design work on the Velindre Oncology Academy logo / branding following feedback that although it needs to be competitive within the international academic community it also needs to have some alignment with the current Cancer Centre. The final branding / logo concept is expected by the 19th April 2024. • ARC Funding: Funding agreed through ARC to support the academy infrastructure costs was agreed in the absence of the documented ARC governance structure being in place and formal paper will be taken to the next ARC Board on 10th July. • Moodle Online Learning Platform: There have been delays with the Data Protection Impact Assessment due to a Cloud Risk Assessment being required and there being outstanding queries with regards to storage of data. Following discussions with Information Governance Lead & Cyber Security Manager this is due for completion by the end of April 2024.
ASSURE	Overall good progress made: • A dedicated room for education, training and development is now in full use. The room fulfils the requirement of the agreement with the University of Wales Technical Institute to have a dedicated teaching space. The University will need, as part of the accreditation process, to assess the suitability of the space. • All Academy roles recruited into except for lecturer/practitioner role. Project Manager, Administrator and Events & Marketing Officer have started their roles, Business Support Manager & Digital Officer to follow by the end April 2024. • Curriculum Development Board in partnership with University of Wales Technical Institute established, Terms of Reference have

	been signed off in principle at meeting held on 7th March 2024. A slight amendment to the Terms of Reference will be made separating the meeting into two parts: Part A looking at the educational requirements of the Academy and Part B to look at the wider educational requirements of the Trust. • It has been noted that 9 delivery workstreams have been approved by the Implementation Board. • Accommodation has been completed with office space identified for the service within Noddfa. Medical Education will now be a separate workstream to Education due to the complexities and scope that the work entails. • Workshops are to be held with key stakeholders over the coming month to scope out the deliverables and outputs for each workstream and a working group will be held monthly to monitor the delivery of these. These working groups will report into the Implementation Board. • Work packages are to be developed for each of the projects' workstreams outlining the outputs, benefits, tolerances and roles & responsibilities for each workstream which will be brought to the next Implementation Board for sign off. These outputs will contribute to the wider project plan where activities will be assigned to key stakeholders and timescales set. • A provisional launch date for the Velindre Oncology Academy has been identified week commencing 5th June. The Event & Marketing Officer will work with the Velindre Communications team in readiness for the event.
INFORM	No additional items to inform.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Strategic Development Committee are asked to **NOTE** the Velindre Oncology Academy Implementation Board Highlight report.

STRATEGIC DEVELOPMENT COMMITTEE

Clinical & Scientific Infrastructure & Strategy Update

DATE OF MEETING	15/05/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not applicable
REPORT PURPOSE	For Noting
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	No
PREPARED BY	Joanna Doyle, Clinical & Scientific Strategy Lead
PRESENTED BY	Joanna Doyle, Clinical & Scientific Strategy Lead
SPONSORED BY	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists & Dr Jacinta Abraham, Executive Medical Director.
EXECUTIVE SUMMARY	The work required to develop the Trust wide Clinical and Scientific Strategy continues to progress. An early draft of the strategic vision, strategic aims, objectives and means of achievement, alongside the core principles continues to be refined based on further engagement with stakeholders. This will be available for consideration by Committee members in May 2024.
RECOMMENDATION / ACTIONS	The Strategic Development Committee are asked to **NOTE** the contents of this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Development of the Trust Wide Clinical & Scientific Strategy & Infrastructure and Clinical & Scientific Strategic Board.	15.04.2024

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES (List the title of any appendices)
Not applicable

1. SITUATION

This paper provides the Strategic Development Committee with an update on the governance infrastructure surrounding the Clinical and Scientific Strategic Board and on the progress that has been made to develop the Trust wide Clinical and Scientific Strategy.

2. BACKGROUND

Since October 2023 extensive work has been undertaken to engage with internal and external stakeholders to seek their views on the clinical and scientific priorities. The information that has been generated through a multi-faceted approach is being used to inform the development of the Trusts Clinical and Scientific strategy. Whilst progress is being made, the need to undertake further engagement with focused groups of stakeholders has impacted on the timeframe for completing this work which is now expected to be completed in September.

3. ASSESSMENT

3.1 Clinical & Scientific Strategic Board Development & Infrastructure

The Clinical and Scientific Strategic Board continues to meet on a quarterly basis and a work plan is being developed to enable the group to prioritise the work, monitor progress and evaluate impact.

As the previous Clinical Advisory Group has been stood down, work continues to review the medical meeting groups in Velindre Cancer Centre. The Site Specific Tumour (SST) team leads meeting and divisional senior leadership team meetings continue, which is where clinical discussions take place. The terms of reference for the Velindre Futures Board are being revised which will help to inform the structure required to ensure that the division can fulfil the requirements set out by the Clinical and Scientific Strategic Board.

3.2 Clinical & Scientific Strategy Development

Since October 2023 the Clinical and Scientific Strategy Lead has engaged with approximately 800 stakeholders to seek their views on what should be the organisations strategic clinical and scientific vision, strategic aims and objectives based on our priorities. Over 1000 pieces of information have been obtained and 4 key themes have emerged, which will be used to inform the strategy.

Plans are underway to hold 2 multi-professional engagement sessions at the end of May, where internal stakeholders will have the opportunity to review and refine the strategy.

3.3 Public, Patient and Donor Engagement

Two meetings have been held with representation from Llais to request their support and facilitate patient/public engagement. Engagement plans have been devised and will be shared with Llais, a comprehensive communication package is being developed and two events will be held in May to engage with the public and seek their feedback.

3.4 Key actions & timetable for developing the strategy

Following discussions with Llais the timeline for developing the strategy was reviewed and agreed by the Executive Management Board in March. Based on engagement plan the actions required to engage with the public have been incorporated into the plan as shown below.

Whilst some actions have fallen behind schedule mitigating action has been taken to address this and minimise impact, as some actions can be undertaken simultaneously, publishing the strategy remains on track for the end September.

Plan & timeframes for developing the Clinical and Scientific Strategy (V4)	Timeframe	Position
Draft the strategy with guidance from the expert reference group	22nd February	Completed
Present draft strategic vision & aims to Board Development session	27th February	Completed
Additional engagement sessions with (internal) stakeholder groups	March & April	Behind schedule 28th May
Executive Sponsors to agree proposal for public engagement	9th April	On track
Submit plan for engagement to Llais	End March	Behind schedule 12th April
Finalise first draft of report	Mid-April	Behind schedule 22nd April
Devise & translate communication materials	End April	In progress & on track
Present an interim report and draft strategy for sign off through the governance framework	April/May	On track
Undertake engagement events via Llais & seek feedback on the draft strategy (6 weeks)	7th May- 17th June	On track
Hold public engagement events	22nd & 23rd May	On track
Finalise the strategy with guidance from the expert reference group	End June	On track
Present the final version of the strategy for sign off through the governance framework	July/August	On track
Strategy produced by publishers	August	On track
Launch & publication of strategy	September	On track

Based on adhering to this timeframe it is anticipated that the strategy will be finalised by the end of June which is when the secondment of the Clinical and Scientific Strategy Lead concludes. Following this date, the remaining actions would need to be reallocated.

4. ONGOING RISKS

The Clinical & Scientific Strategy Lead reduces her hours to 15 hours a week from 1st April 2024 to 31st June 2024 and the post finishes on that date.

As identified at the outset of discussions in relation to the Trust becoming more scientifically and clinically driven a permanent Clinical and Scientific Manager is required (band 7) to ensure the strategy is delivered and that the Clinical and Scientific Board is meeting its requirements. This post will do all the 'leg work', support all the external benchmarking, regional working, public engagement and be the interface with service clinical and scientific leaders.

Long term for this post is required and post needs to be in place by 31st June 2024. To date, a way of resourcing this role has not been identified. This will require either additional funding for this post or repurposing of current resources.

5. IMPACT ASSESSMENT

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

	Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The development and implementation of a robust strategic clinical and scientific infrastructure and strategy will strengthen clinical leadership, set the strategic direction for the Trust over the next 5 years, inform and influence decision making and drive clinical and scientific transformation, which will ensure the delivery of safe and effective care to patients/donors.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	The resourcing to ensure the long term effective functioning of the Clinical & Scientific Board and delivery of the strategy has not been agreed.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	An equality impact assessment will be completed in conjunction with the development of the Clinical and Scientific Strategy. This work has commenced.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Failure to develop and implement a robust strategic clinical and scientific infrastructure and strategy will result in lack of strategic direction for the Trust which will limit opportunities to drive clinical and scientific transformation, innovation, and research.
WHAT IS THE CURRENT RISK SCORE	Moderate. Score 12 (likelihood 4 x impact 3)
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The development and implementation of a robust strategic clinical and scientific infrastructure and strategy will strengthen leadership, set the strategic direction for the Trust, inform and influence decision making and drive clinical and scientific transformation. Engaging stakeholders in the development and delivery of the strategy will ensure a shared vision and commitment to implementation.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	September 2024
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

STRATEGIC DEVELOPMENT COMMITTEE

WBS Futures – Assurance Report

DATE OF MEETING	15/05/2024
PUBLIC OR PRIVATE REPORT	Private
IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sarah Richards, Head of Planning And Performance Services
PRESENTED BY	Alan Prosser, WBS Director
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	This paper provides an update on progress for WBS Futures for the period 14/03/2024 – 14/04/2024. The WBS Futures Delivery Confidence Assessment (DCA) is currently **Green**.
RECOMMENDATION / ACTIONS	The Strategic Development Committee are asked to **NOTE** the contents of this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Senior Leadership Team	10/04/24
Executive Management Board	15/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1. 2.	WBS Futures Reporting Dashboard WBS Futures Communication & Engagement Action Plan

1. SITUATION

1.1 The WBS Futures Delivery Board is responsible for providing overall strategic direction for WBS Futures and ensuring delivery of the identified outcomes and benefits.

1.2 The reporting period for this report covers 14/03/2024 – 14/04/2024 and summarises progress. The next WBS Futures Delivery Board will take place on 12/04/2024.

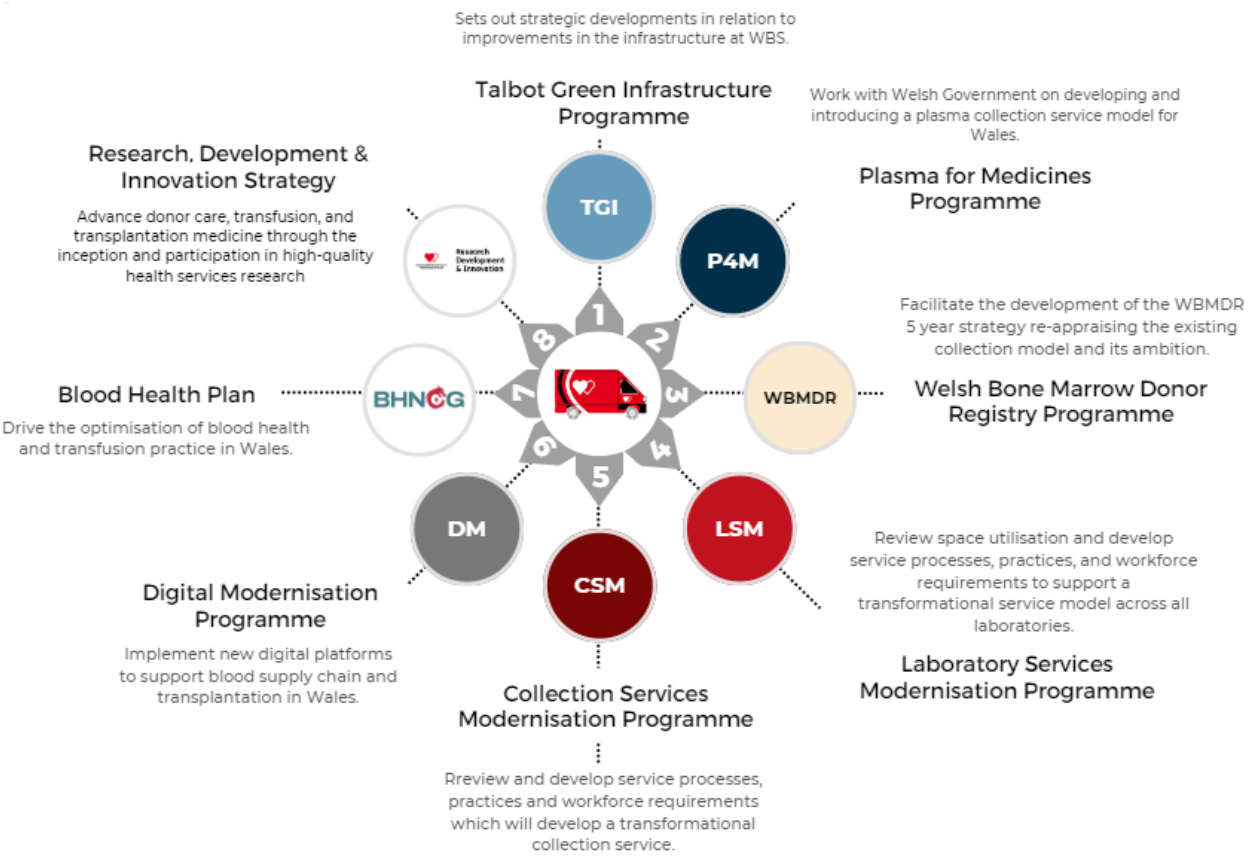
1.3 The reporting Dashboard is attached as appendix 1. Research, Development & Innovation Strategy is currently being developed and will be incorporated into the Dashboard once finalised.

2. BACKGROUND

2.1 WBS Futures has been established to be the vehicle to deliver the vision and to shape services for the future by working in partnership and driving a culture of excellence and continuous improvement. It is supporting the delivery of both the WBS 5 Year Strategy and the WBS Integrated Medium-Term Plan (IMTP).

WBS Futures | *working together to deliver better futures for our patients, donors and staff*

2.2 WBS Futures consists of six key programmes and two associated work programmes.



3. ASSESSMENT

3.1 Key Highlights

The WBS Futures Dashboard is attached for information as Appendix 1. Key highlights to note are outlined below.

Programme	Key Highlights
Laboratory Services Modernisation	• Consultancy report for Red Cell Immunohematology (RCI) Review – report submitted and being shared with SLT and staff on 15/04/2024. • Implementation of West Nile Virus testing – go live scheduled for 01/05/2024. • Foetal DNA Screening Test – go live scheduled for 13/05/2024.
Collections Services Modernisation	• Live connectivity on clinic – access being piloted on clinics operated by the West Wales blood collection team from February 2024 as part of Donor Adverse Event Reporting (DAER) project under Safe Care Collaborative. Aiming to roll out to other blood collection teams as part of pilot from June 2024. Implementation to other systems (e.g. QPulse, Blood Establishment Computer System) planned as part of Collection Services Modernisation Programme once DAER pilot complete. • Booking Portal – Refreshing donor booking portal to improve appearance and functionality for donors and staff. Currently reviewing updates made by Digital Team before re-launch. • Business Case for WBS fleet replacement in development.
Plasma for Medicines	• Outline Business Case approved at Trust Board.

	• Welsh Government approval in process.
Talbot Green Infrastructure	• Following proposal from Specialist Estates Services, Welsh Government were approached to consider combined OBC/FBC. Initial support received from Welsh Government for this approach. • Economic appraisal of short-listed options underway to identify preferred option. Will be shared with Specialist Estates Services and TGI Programme Board in April 2024 to agree way forward.
Welsh Bone Marrow Donor Registry	• Welsh Bone Marrow Donor Registry (WBMDR) digital platform – procurement process commenced. Prior Information Notice (PIN) out for interest. • Bone Marrow Collection contingency planning – Velindre Cancer Service are working on service specification to outline feasibility.
Digital Modernisation	• **Blood establishment Computer Systems (BECS)** – Business case being finalised and will progress through Trust internal governance routes in April and May 2024. Confirmed extension to existing contract with Mak-System until November 2027. • **Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS)** – Procurement phase complete. Business analysts working with SMEs to capture current business processes, data flow and system interaction (70% complete). Quarterly project review scheduled for 1st May 2024. • **Wales Laboratory Information System (WLIMS) 2.0** – Strategic programme review is with the Steering Group for final review. Implementation Group established and first meeting scheduled in April 2024. Testing of

	the Electronic Dispatch Notice using Secure File Transfer is complete.
Blood Health Plan	• The Blood Health Plan was launched in March 2024 at the Blood Health National Oversight Group Annual Conference. • **Pre-operative Anaemia (Value Based Healthcare project)** – raising profile with Primary Care Leads and internal review of the pathway with users underway.
Research, Development & Innovation Strategy	• Draft strategy in development, completion expected in April 2024.

3.2 **Financial Plan**

The proposed template for the WBS Futures Financial Plan was taken to the Delivery Board meeting on 15th March 2024 for comment on structure and format. The template was endorsed, and work has begun on adding the financial detail for each of the work programmes to enable the Delivery Board to monitor funding arrangements, funding performance and financial benefits phasing. This information will be incorporated into the Dashboard once completed.

3.3 **Resource Plan**

The Resource Plan is nearing completion for Qtr 2 2024/25. This will be updated by quarter and will support our understanding of the capacity requirements to deliver WBS Futures and will be monitored by the WBS Futures Implementation Group to assist with phasing and prioritisation of work across the portfolio.

3.4 **Benefits Realisation**

The Benefits log is in development and will be incorporated within the reporting dashboard once completed.

3.5 **Risk**

The WBS Futures Risk Log forms part of the Dashboard (Appendix 1). Key risks have been identified during the planning phase and were scored and mitigated at the Delivery Board meeting on 15th March 2024. Critical risks (risks with a current rating of 15 or above post mitigation) identified at Programme and Workstream level have been escalated to the overarching risk log.

New and closed risks, along with risks that have either been escalated or de-escalated will be highlighted going forward.

3.6 Communication and Engagement

Communication and engagement are recognised as being vital for WBS Futures to succeed. A detailed Communication and Engagement Plan has been developed. The Communication and Engagement Group has been established to support delivery of the Communication and Engagement Plan and meets monthly. The Communication and Engagement Action Plan is attached as Appendix 2.

Communications for the first half of this year have focussed on providing staff with fortnightly introductions to each of the 6 main programmes and two associated programmes of work. Due to Plasma for Medicines being such a new area for the service it was felt that it deserved more attention. The entire month of May is therefore being given over to Plasma for Medicines with communications being split over two items: a general 'Introduction to' the programme in line with the other programmes and a 'What is plasma' item providing more general information on what plasma is used for and the types of medicine that can be made from it. Once the introductions have finished communications will move into a more regular pattern of different communication methods, shared between the programmes.

Executive Leads have expressed an interest in being involved in communications for their respective programmes and the Activity Plan has been updated to reflect this.

A video is in development to provide progress updates for staff. This will be shared at tailored update sessions for each department (including remote site and collection teams to be led by SLT Lead and supported by iHub. In addition, there are also 'drop in' update sessions planned for May 2024.

The WBS Futures intranet hub is regularly updated https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/WBS-Futures-hub.aspx

4. SUMMARY OF MATTERS FOR CONSIDERATION

The WBS Futures Delivery Confidence Assessment (DCA) is currently **Green**.

Colour	Criteria Description
	Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
	Successful delivery of the project/programme appears to be unachievable. There are major issues which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-baselining and/or overall viability re-assessed.

The full reporting Dashboard is attached as Appendix 1.

The reporting dashboard is being further developed to include financial reporting and benefits monitoring across the portfolio of programmes within WBS Futures.

Delivery of the Communication & Engagement Plan Action Plan is progressing as planned.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	Socio Economic Duty Assessment is underway for each of the programmes of work – being developed as detail of the programmes is becoming clearer.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below:

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This report provides an update on progress only. The detail is available in the WBS Futures Financial Plan. **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	Equality Impact Assessment is underway for each of the programmes of work – being developed as detail is becoming clearer.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Risk Log attached as part of the Dashboard.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

APPENDIX 1

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

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

WBS Futures

WBS Futures Dashboard

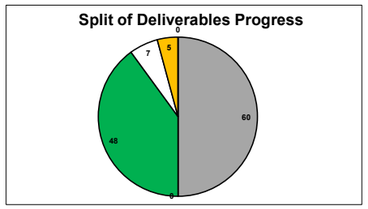
Delivery Confidence Assessment:	Green		Period Covered:	Mar-24

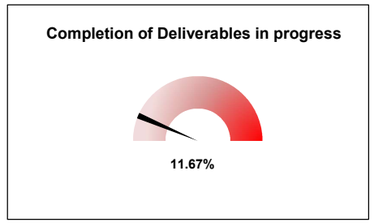
Colour	Criteria Description
	Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.
	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
	Successful delivery of the project/programme is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
	Successful delivery of the project/programme appears to be unachievable. There are major issues which at this stage do not appear to be manageable or resolvable. The project/ programme may need re-baselining and/or overall viability re-assessed.

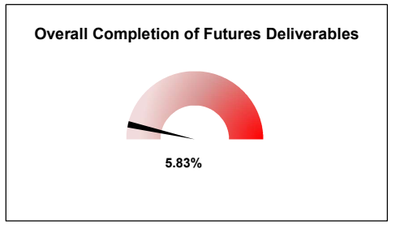
WBS Futures Implementation:

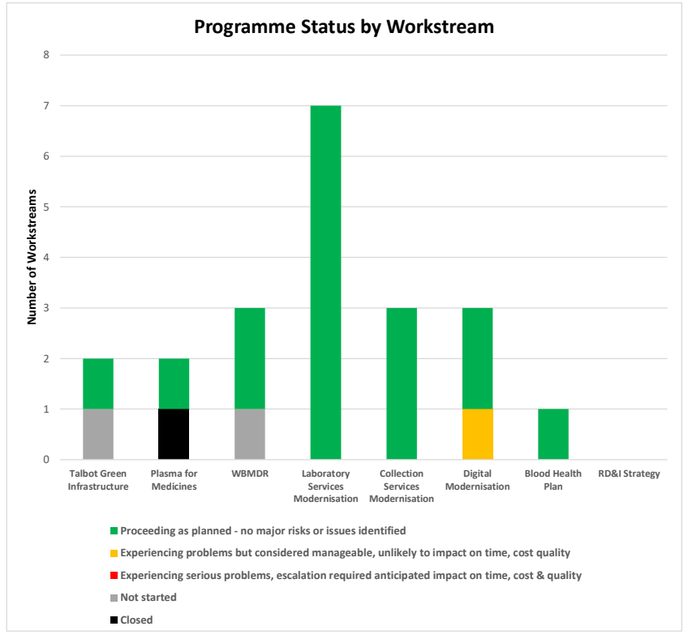
Status	Number
Not started	60
Ahead of Plan	0
On Plan	48
Completed	7
Forecasting Overrun	5
Overrun	0
Total	120

Colour	Criteria Description
Not started	Activities not due to start yet
Ahead of Plan	Activities being delivered ahead of time
On Plan	Activities are being delivered on time
Completed	Activities are completed
Forecasting Overrun	Forecasting delay
Overrun	Activities are delayed



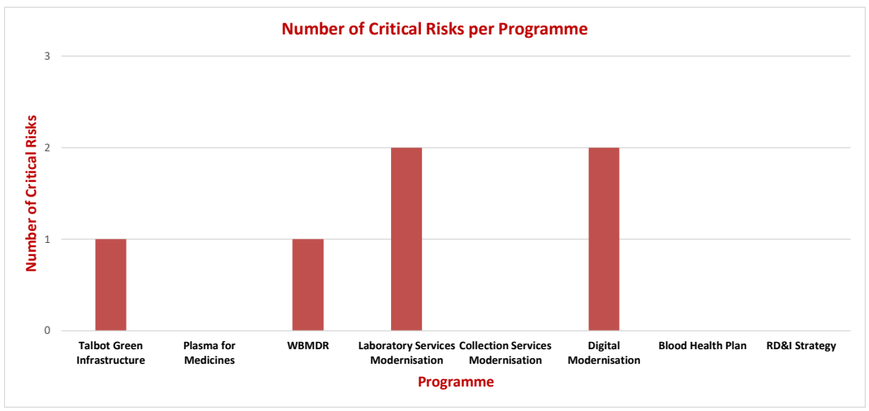


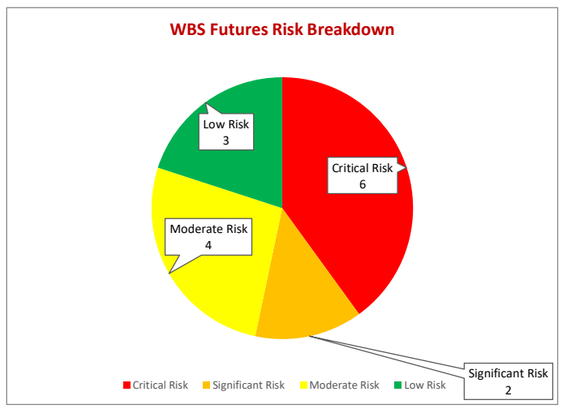




WBS Futures Risk Report

The risk register is refreshed as part of the monthly governance arrangements for WBS Futures.





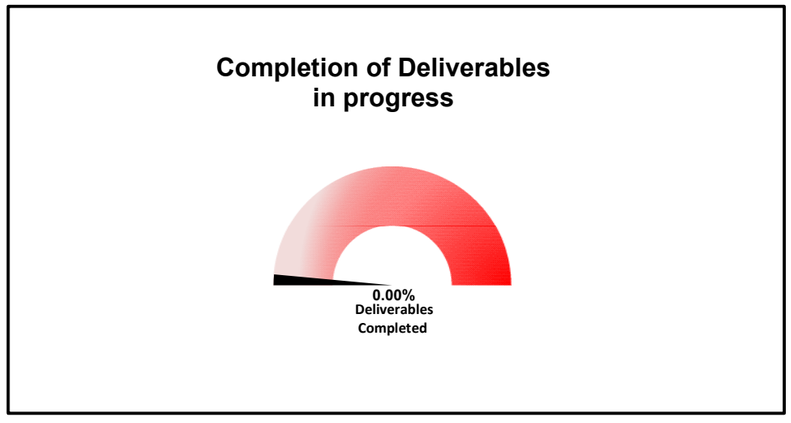
Talbot Green Infrastructure

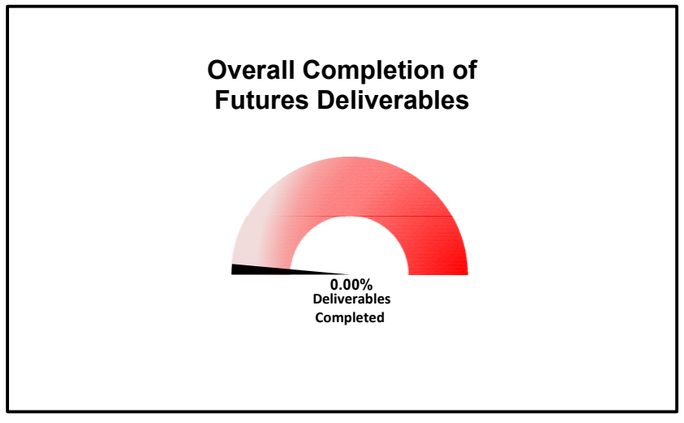
Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies							
Business Case Development																		
OBC Development (Part 1)	Jason Hoskins	**On Plan**	**Spending to Plan**	**Welsh Government**	**Green**	Feasibility study around preferred option nearing completion. Will go to WBS SLT on 10th April 2024 to note. Preferred option to be signed off at the Programme Board Meeting on 11th April 2024.	**05/04/2024**	Following a proposoal from Specialist Estate Services, WG approached to consider combined OBC/FBC. Initial support received from Welsh Government with a request to: - Share preferred options with Specialist Estate Services - meeting scheduled for 11th April 2024. - Submit a bid to Welsh Government for fee support. - Agree a suitable procurement route.		PR000443	TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Laboratory Space Utilisation																		

SLT LEAD: Sarah Richards (Head of Planning & Performance Services)

EXECUTIVE LEAD: Carl James (Executive Director of Strategic Transformation, Planning and Digital)

PURPOSE:
The Talbot Green Infrastructure Programme sets out strategic developments in relation to improvements in the infrastructure at WBS.





Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activities are delayed.

Plasma for Medicines

Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies							
Develop business case for Plasma for Medicines	Peter Richardson	Completed	Not Spending	Not Spending	Closed	Business case developed.	08/04/2024	Internal Approval & Welsh Government approval.	None		TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Business Case agreed by Welsh Government	Peter Richardson	On Plan	Not Spending	Welsh Government	Green	Business case approved at VUNHST Board. Welsh Government approval in progress, however has been paused pending receipt of recommendations from the Infected Blood Inquiry due in May 2024.		Engage with Welsh Government members to advise on WHSCC plan and policy steer.	None		TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Product Journey																		
Donor Journey																		

SLT LEAD: Peter Richardson (Head of Quality Assurance and Regulatory Compliance/Deputy Director WBS)

EXECUTIVE LEAD: Matthew Bunce (Executive Director of Finance)

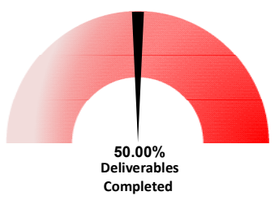
PURPOSE:
The Plasma for Medicines Programme will work with Welsh Government on developing and introducing a plasma collection service model for Wales.

Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

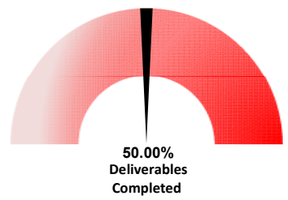
Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.

Completion of Deliverables in Progress



Overall Completion of Futures Deliverables



Welsh Bone Marrow Donor Registry

Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies							
WBMDR Digital																		
Develop URS	EA	On Plan	Not Spending	Not Spending	Green	PIN is out for interest, some initial discussions and scoping work held Video for companies available for tender has been developed. Awaiting responses for initial pricing	08/04/2024	Develop the URS		PR000439	TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Expanding Stem Cell Collection Services																		
Optimising Donor Clinical Services																		
Bone Marrow Collection Contingency Planning	KP	On Plan	Not Spending	Not Spending	Green	Follow up meeting was cancelled. JL working with Jeff O'Sullivan for a joint approach	08/04/2024	EMB shape paper and feasilbilty			TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Hybrid Model G-CSF	KP	On Plan	Spending to Plan	Revenue		Process for Alcura to be available from May 1st Flow Chart complete and areas for VCC interaction have been identified Pharmacy governance and Medicines Management Group Sign off is on track Spend profile being developed for contingency supplier		Benchmark and design service provision model. Agree procurement route for contingency supplier (MPS Nursing). Progress with agreed costings for Alcura	Deadline for implementation May 2024	PR000446	TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP

SLT LEAD: Deborah Pritchard (Head of Transplantation Services)

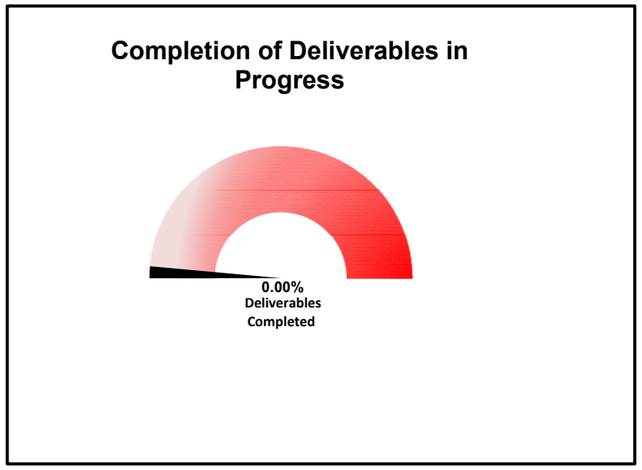
EXECUTIVE LEAD: Dr Jacinta Abraham (Executive Medical Director)

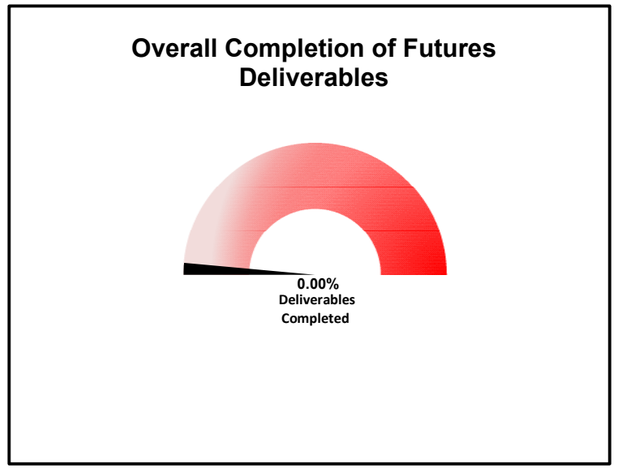
PURPOSE:
The WBMDR Programme will facilitate the development of the WBMDR 5 year strategy reappraising the existing collection model and its ambition.

Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.





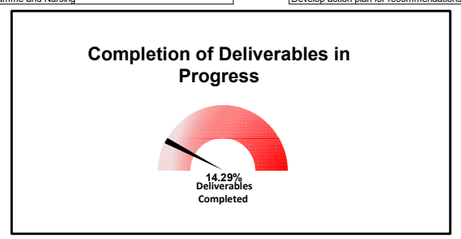
Laboratory Services Modernisation

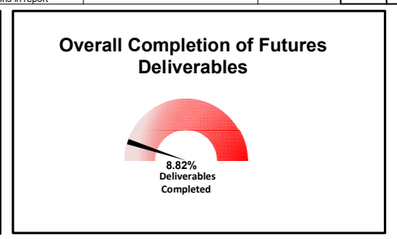
Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies
Laboratory Testing & Automation Theme											
West Nile Virus Workstream - Lead Ann Jones											
Contract change notice with current supplier to include WNV on current contract	Ann Jones	Completed	Completed	Revenue	Green	Contract change control notice signed to add this test to current platform and Managed Service Provision	08/04/2024			PR000426	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
eProgesa development work	Sarah Llewellyn	On Plan	Not Spending	Not Spending		Development work on the interface is 75% complete		Agree date with MAK to make required changes to interface file			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Validate platform for WNV testing	Ann Jones	On Plan	Not Spending	Not Spending		FMEA finalised Go live date agreed of 1st May 2024 Installation Qulaification and Operational Qualification complete		Finalise Validation Master Plan Complete Interface Qualification testing			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Develop donor management system for WNV positive donors	Julie Curry	On Plan	Not Spending	Not Spending		Clinical algorithim has been developed and with Digital to review		Digital to review and implement required changes			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Update donor leaflets and WBS website	Julie Curry	Completed	Not Spending	Not Spending		Updates made to donor leaflets including welsh translation		Add documents to Qpulse			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Cell Free Fetal DNA Screening Workstream - Lead Deb Pritchard											
Validation of solution	Deb Pritchard	On Plan	Spending to Plan	Not Spending	Green	Go live date of 13.05.2024 agreed by WBS and Ante Natal Screening Wales (ASW) Trial report finalised and submitted to PHW Board for noting Order placed for request cards	08/04/2024	Finalise validation documentation Agree proceedure for reporting discrepant results PHW evaluation of Programme meetings to be established with agreed representation from Welsh Blood Service		PR000345	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Procurement of CE marked test	Jen Pepperall	Completed	Spending to Plan	Revenue		Contract placed with Devyser for test kits and all governance paperwork completed					TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Develop digital solution (FEDIS)	Felicity May	On Plan	Not Spending	Not Spending		In development Reporting will be via email to the HB's on go live prior to timelines being agreed for integration into Welsh Clinical Portal by DHCW		Agree timelines with DHCW to include reporting for this test in the Welsh Clinical Portal			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
HLA Strategy Workstream - Jen Pepperall											
Implementation of RT-PCR testing stratgey for HLA B27	Jen Pepperall	On Plan	Not Spending	Not Spending	Green	Change Proposals raised and routes agreed Validation Plan completed	08/04/2024	Finalise test scripts for validation Digital to install B27 IT system		PR000442	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Implementation of Qtype HLA typing kits	Tim Climer	On Plan	Not Spending	Not Spending		Change Proposals raised and routes agreed Single tender action approved Test kits ordered		Work paused as resource prioritised to support Fetal dna project		PR000428	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
NAT Testing Workstream - Ann Jones											
Procurement exercise for required platforms and solution	Ann Jones	On Plan	Not Spending	Capital & Revenue	Green	Resource Request approved by CPG Discussions held with SNBTS on collaborative procurement exercise Procurement timelines established	08/04/2024	Commence development of specification for procurement of replacement platform Finalise FMEA Workstream brief to be reviewed by W/S members		PR000449	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
NEQAS Workstream - Amy De'ath											
Procurement of new NEQAS System	Amy De'ath	On Plan	Forecasting Underspend	Capital & Revenue	Green	Supplier Engagement day taking place 11/04/2024. Discussions with WEQAS ongoing.	04/04/2024	Continue to work with Procurement to discuss suitable supplier option. W/S brief to be approved at Board meeting 17.04.24		PR000415	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Platelet Strategy Workstream - Steve Pearce											
Develop a Platelet Strategy	SP	On Plan	Not Spending	Not Spending	Green	W/S lead continuing to work on this	04/04/2024	Work ongoing			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Develop Workstream & T&F Group Briefs	All	On Plan	Not Spending	Not Spending		Workstream brief has been updated with project member feedback.		Workstream brief to be reviewed by W/S members. To be approved at meeting 11.04.2024			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Develop a current state analysis, which identifies the current process and potential opportunities for improvement for platelet collection, processing and issuing at WBS.	SP	On Plan	Not Spending	Not Spending		Data analysis work underway		Work ongoing			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Develop and Implement a Platelet Manufacturing Planning Tool	SP	On Plan	Not Spending	Not Spending		Work on going with BI		Continue gathering data and developing tool			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Expand the donor panel for HLA selected, HPA 1a-neg and Neonatal platelets	SP	On Plan	Not Spending	Not Spending		First initail meeting held discussing Donor Swab panel and targetting donors to increase HLA donations		WTAIL/DCC to work out what resources are required to support this work, meeting in months time to discuss further. Meeting scheduled to discuss EBA questionaire and next steps on platelet collection/production/wastage			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Implement platelets in PAS for apheresis derived platelets	CG	On Plan	Not Spending	Not Spending		PAS ratio to be reviewed with additional testing required		Produce additional test scripts, run further test		PR000292	TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Identify the benefits and operational suitability of cold storage platelets	CG	On Plan	Spending to Plan	Welsh Government		The second report to HCRW has been submitted and accepted with funding being released. CEDAR are participating in the project to assit with resource, provide expert information and data. 6 platelets have been collected and tested, platelet data is currently being reveiwed.		Once data for the 6 platelets has been accepted a further 6 platelets will be collected and tested and reviewed before proceeding further			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Red Cell Immunohematology Laboratory Review Workstream											
Workstream Brief in development	All	On Plan	Not Spending	Not Spending	Green	V1.0 signed off at workstream level and on agenda for approval	08/04/2024	Sign off workstream brief at March Programme Board meeting			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP
Consultant review	Heather Davies	On Plan	Spending to Plan	Revenue		Final report received and shared with SLT and Executive Lead for LSM Programme and Nursing		Presentation of report to staff and SLT 15th April 2024 Develop action plan for recommendations in report			TGI, Plasma, WBMDR, LSM, CSM, DM, RD&I, BHP

SLT LEAD: Georgia Stephens (Head of Transfusion Services) and Deborah Pritchard (Head of Transplantation Services)

EXECUTIVE LEAD: Sarah Morely (Executive Director of People and Organisational Development)

PURPOSE:
The Laboratory Services Modernisation Programme will develop service processes, practices, and workforce requirements to support a transformational service model across all laboratories.





Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.

Collection Services Modernisation

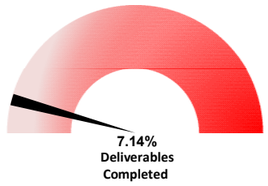
Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies
Donor Engagement Workstrem (Lead - Andrew Harris)											
Complete and implement new donor and advocate strategy	Andrew Harris	On Plan	Not Spending	Not Spending	Green	Latest version with SLT Lead	08/04/2024	AH to discuss final sign-off process requirements with Director WBS			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Review and update the WBS brand toolkit	Andrew Harris	Completed	Completed	Not Spending		Toolkit approved by SLT and in use					TGI Plasma WBMDR LSM CSM DM RD&I BHP
Implement refreshed booking portal	Simon Davies	On Plan	Not Spending	Not Spending		Latest version provided by Digital Team for review.		Complete second part of FMEA and identify validation requirements.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Implement omni-channel software	Simon Davies	Forecasting Overrun	Unplanned Spend	Revenue		Tender documents complete		Awaiting VCS to confirm their requirements	Still waiting for VCS to confirm their requirements. Agree funding source for chosen solution once VCS has responded.		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Operations Workstream (Lead - Sally Gronow)											
Undertake a workforce review, to include roles and responsibilities	Sally Gronow	On Plan	Unplanned Spend	Revenue	Green	Workforce Plan in development utilising 6 Step Model	08/04/2024	Begin to develop consulation document in preparation for OCP.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Develop new job descriptions	Sally Gronow	On Plan	Not Spending	Not Spending		New JDs in draft. To be reviewed once Workforce Plan completed.					TGI Plasma WBMDR LSM CSM DM RD&I BHP
Live connectivity to other systems e.g. Datix, QPulse	Mark Jenkins	On Plan	Not Spending	Not Spending		Access being piloted as part of DAER project.		Implement on other systems once DAER pilot complete.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Review the process for haemoglobin testing	Phillipa Blackford	On Plan	Unplanned Spend	Revenue		Business case developed and submitted for approval.		Continue to monitor impact of removal of haemoglobin testing in NHSBT			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Review of dressings to utilise plasters in place of bandages	Phillipa Blackford	On Plan	Unplanned Spend	Revenue		Reviewing relevant SOPs		Raise VERTO Change Proposal for approval to proceed with change.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Resource, Planning & Logistics Workstream (Lead - Aiysha Baillie)											
Introduce tours for North Wales teams	Leanne Morgan	On Plan	Unplanned Spend	Revenue	Green	Business case written by Collections Operations Management to secure revenue funding.	08/04/2024	Submit Business Case to SLT for approval.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Review of existing blood collection clinic portfolio	Leanne Morgan	On Plan	Spending to Plan	Revenue		Collating data on clinic efficiencies.		Work to be formally captured with T&F Group wrap			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Complete re-introduction of Mobile Donation Clinics	Leanne Morgan	On Plan	Not Spending	Not Spending		Reviewing outstanding required trailer location assessments.		Work to be formally captured with T&F Group wrap			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Temperature Controlled Vehicle replacement	Clive Francis	On Plan	Spending to Plan	Capital		Awaiting build slots for both vehicles.		Confirm build slots (build currently estimated to take place Sep 2024)			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Secure capital funding for vehicles due for replacement within lifetime of the programme	Clive Francis	On Plan	Unplanned Spend	Welsh Government		Capital prioritisation application completed and submitted to Trust. Business case still in development.		Escalate WG business case through VUNHST governance process for sign-off.			TGI Plasma WBMDR LSM CSM DM RD&I BHP

SLT LEAD: Jayne Davey (Head of Collection Services)

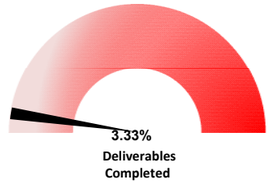
EXECUTIVE LEAD: Nicola Williams (Executive Director of Nursing, AHPs and Health Science)

PURPOSE:
The Collection Services Modernisation Programme will review and develop service processes, practices and workforce requirements which will develop a transformational collection service.

Completion of Deliverables in Progress



Overall Completion of Futures Deliverables



Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.

Digital Modernisation

Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies
BECS Procurement											
Contract extension	EG	On Plan	Spending to Plan		Amber	Contract letter issued to MAK-SYSTEM. NWSSP led discussions w/c 01/04/2024. SDC & Trust Board approval for extension until Nov. '27, supported by requirement to implement a Semester Patch	09/04/2024	Contract breifing paper issued to WG	N/A		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Pre-procurement planning	EG	On Plan	Not Spending			Ongoing dialogue with Mak-System, led by NWSSP: Preferred option: virtualisation of DB server infrastructure (circa £100k) Advantage, will be able to realign the effort that will be going on in parallel to the main procurement.		BECS Competitive Plan & Dialogue Process - in final draft BECS Competitive Dialogue Resource Summary – in draft BECS Procurement and Comp Dialogue timescales – launch beginning of May 2024	N/A		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Outline Business Case	SLT	On Plan	Spending to Plan			Work on the OBC continues. Tight timescales for completion but activities currently remain on track		OBC endorse for approval at SLT 10/04/24, EMB 15/04/24, SDC 30/04/24	N/A		TGI Plasma WBMDR LSM CSM DM RD&I BHP
LIMS for WHAIS											
Finalise contract	JN	Completed	Completed		Green	Contract has been signed by the suplier	09/04/2024	Sign contract.	Dependency on supplier to agree to contract terms.		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Confirm funding	LK	Completed	Completed			Trust Board approved spend profile. Awaiting outcome of business case submission from WG.		Oversee 23/24 spend.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Project intiation activity	JN	Forecasting Overrun	Spending to Plan			Contract is now signed, Server is build awaiting installation of the software.		Update project plan with the supplier and finalise change in Verto. Hold a workstream kick off meeting with the project team and supplier representatives.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Transformation w/s: Capture "as-is" processes	FM	Forecasting Overrun	Not Spending			Business analysts working with SMEs to capture current business processes, data flow and system interaction.		Complete business process mapping.	Process mapping taking longer than planned.		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Transformation w/s: Service Re-design	FM	On Plan	Not Spending			Mapping underway and user centred design training undertaken.		Use UCD tools within WTAIL to identify user needs.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Application w/s: System build	EA	Forecasting Overrun	Spending to Plan			Code of connection completed and submitted to provide supplier access to server environments.		Supplier to install system to the server.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Application w/s: Welsh health system interfaces	LK	Forecasting Overrun	Spending to Plan			New service request submitted to DHCW		DHCW to supply costs and timescales to undertake work.	Dependency on DHCW to prioritise and cost work.		TGI Plasma WBMDR LSM CSM DM RD&I BHP
Data w/s: Develop data migration strategy.	DR	On Plan	Spending to Plan			Discovery work to understand health of data.		Work with data migration consultant to develop data migration strategy.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
WLIMS 2.0											
Establish 'Electronic Dispatch Note'	EA	On Plan	Not Spending		Green	Collaborative development with DHCW. Successful initial test.	09/04/2024	Collaborative development with DHCW			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Brief and ToR	JN/LK	On Plan	Not Spending			Drafted and reviewed for sign off in next DM Board.		Review in June 2024			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Establish Local Deployment Project (LDP) group	JN	On Plan	Not Spending			Created local Teams channel, schedule LDP meetings.		Set up RAID log (stakeholder map/RACI), plan. Schedule and plan initiation session.			TGI Plasma WBMDR LSM CSM DM RD&I BHP
Access to the LIMS 2.0 'sandpit' environment	JN	On Plan	Not Spending			Access for Key users has been granted.		Alignment of key system users, in readiness for next phase			TGI Plasma WBMDR LSM CSM DM RD&I BHP

SLT LEAD: Alan Prosser (WBS Director)

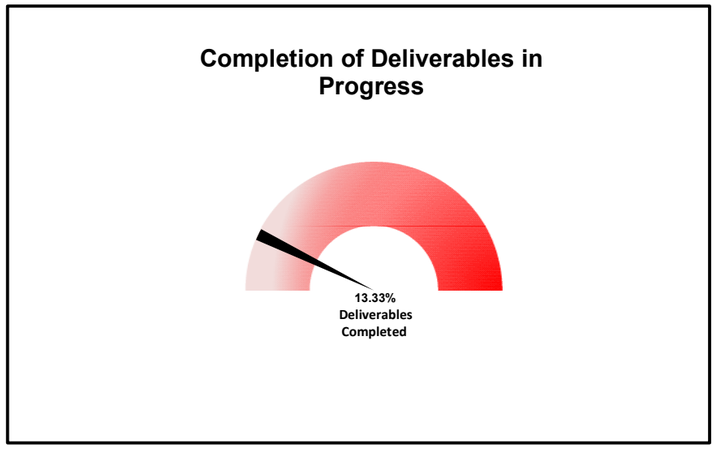
SENIOR LEAD: Carl Taylor (Chief Digital Officer)

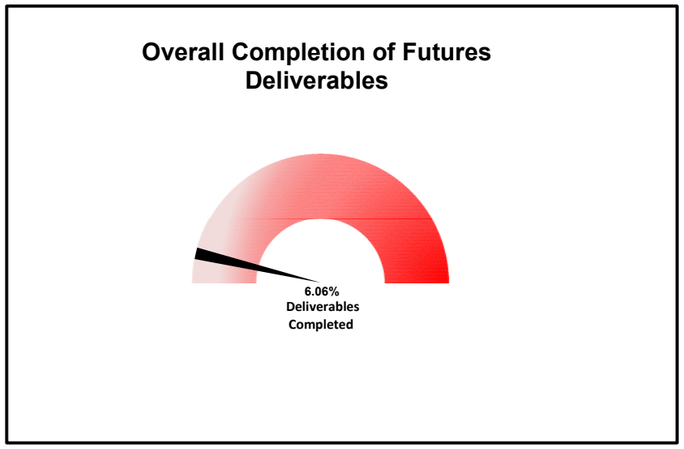
PURPOSE:
The Digital Modernisation Programme will implement new digital platforms to support blood supply chain and transplantation in Wales.

Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.





Blood Health Plan

Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies							
Anaemia Management The anaemia management workstream is currently focussed on the optimisation of anaemia in pre-operative patients. The development of an All-Wales Pre-op Anaemia management pathway has provided this programme with an agreed structure for Health Boards across Wales to follow. Further scoping of other areas of anaemia e.g. obstetrics, paediatrics will be considered once this pathway is fully embedded	Stephanie Ditcham	**On Plan**	**Spending to Plan**	**Welsh Government**	**Green**		**05/04/2024**				TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Intra-operative Cell Salvage ICS workstream is managed via the All-Wales ICS Network this group is responsible for management and promotion of ICS including completion of ICS Data forms to evidence usage of ICS and developing best practice statements to support the use of ICS.	Alister Jones	**On Plan**	**Spending to Plan**	**Revenue**							TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Appropriate use of OD Neg Red Cells Workstream to look at the appropriate use of O D Negs, this includes active stock management of O D Negs, monthly monitoring of issues and wastage and an annual audit of 'Where does O D Neg go'. The All-Wales Guidance for the Use of O D Neg supports both transfusion teams and clinicians in their decision making.	Lee Wong	**On Plan**	**Spending to Plan**	**Revenue**							TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
Appropriate Platelet Use This workstream takes an holistic approach to platelet management, monitoring wastage figures both internally at WBS and at a hospital level. KPIs allow monitoring on a monthly basis to ensure appropriate use. Development of an All Wales Platelet Pathway and biannual audits against national standards also support this.	Louise Minty	**On Plan**	**Spending to Plan**	**Revenue**							TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP

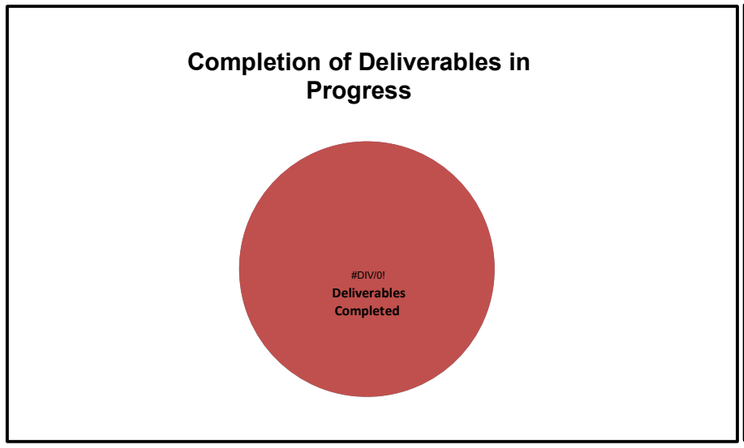
SLT LEAD: Edwin Massey (WBS Medical Director)

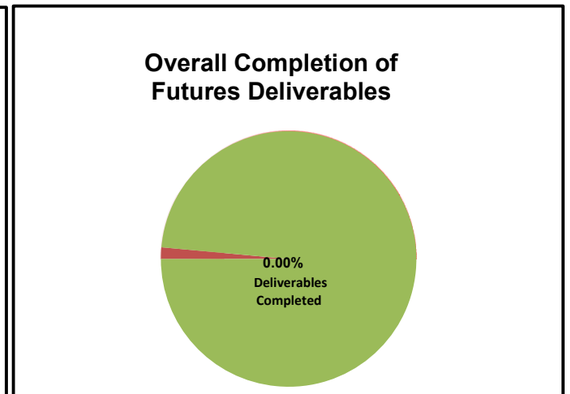
PURPOSE:
The Blood Health Plan will drive the optimisation of blood health and transfusion practice in Wales.

Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.





Research, Development & Innovation Strategy

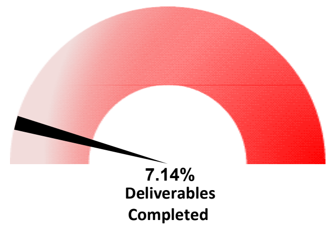
Deliverable	Lead	Progress	Finance	Funding Source	Workstream Status	Latest Update	Last Updated	Next Steps	Issues / Concerns	Change Proposal ID	Interdependencies							
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP
											TGI	Plasma	WBMDR	LSM	CSM	DM	RD&I	BHP

SLT LEAD: Dr Edwin Massey (WBS Medical Director)

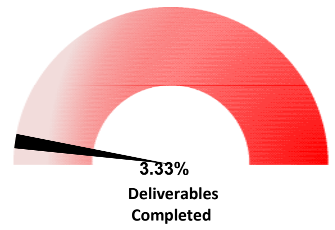
Executive Lead: Dr Jacinta Abraham (Medical Director - VUNHST)

PURPOSE: The RD&I Strategy will advance donor care, transfusion, and transplantation medicine through the inception and participation in high-quality health services research.

Completion of Deliverables in Progress



Overall Completion of Futures Deliverables



Assessment of Workstream Status	
Green	Proceeding as planned - no major risks or issues identified.
Amber	Experiencing problems but considered manageable, unlikely to impact on time, cost quality.
Red	Experiencing serious problems, escalation required anticipated impact on time, cost & quality.
Grey	Not started.
Closed	

Finance Narrative	
Not Spending	No funding required
Underspend	Funding secured and actuals below plan
Spending to Plan	Funding secured and actuals within plan
Completed	
Unplanned Spend	Funding partly secured and actuals at risk of not delivering within plan
Overspend	Funding unsecured / Actuals incurred above plan

Deliverables Progress	
Not started	Activities not due to start yet.
Ahead of Plan	Activities being delivered ahead of time.
On Plan	Activities are being delivered on time.
Completed	
Forecasting Overrun	Forecasting delay.
Overrun	Activites are delayed.

WBS Futures
Combined Risk Log

Only programme risks scoring >15 after mitigation should be recorded here

Risk Rating			
Impact		Likelihood	
1	Insignificant	1	Rare
2	Minor	2	Unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Catastrophic	5	Almost Certain

Risk = 1-3	No action is required over and above existing procedures, review annually	Low risk
Risk = 4-6	Action Required- review 4 months	Moderate risk
Risk = 8-12	Action required-review 2 months	Significant risk
Risk = 15-25	Immediate action required	Critical risk

Welsh Blood Service
Gwasanaeth Gwaed Cymru

ID	Programme	Date Raised	Originator	Description	Description of Potential Impact	Owner	Impact	Likelihood	Risk Rating	Last reviewed	Mitigation Actions	Impact (Revised)	Likelihood (Revised)	Risk Rating (revised)	FMEA	Datix Number	Issue	Open / Closed
R001	WBS Futures	01/11/2023	iHub	There is a risk that the dependent programmes are not in a position to provide appropriate support within the required timescales.	Benefits of the programme will not be achieved, due to capacity constraints of the organisation and demands of other programmes.	SRO	4	5	20	14/03/2024	Careful phasing and prioritising coupled with regular touchpoints between programmes to ensure dependencies are mapped and clearly understood	4	2	8	Not Required		No	Open
R002	WBS Futures	01/11/2023	iHub	There is a risk that there is low staff engagement due to change fatigue amongst WBS staff.	The benefits of the programme will not be achieved.	SRO	4	3	12	14/03/2024	Involve staff wherever possible in co-design of changes Ensure regular cycle of communications to maintain awareness and interest	4	2	8	Not Required		No	Open
R003	WBS Futures	01/11/2023	iHub	There is a risk that staffing capacity will be insufficient for the realisation of the objectives.	The benefits of the programme will not be achieved due to capacity constraints of the organisation and demands of other programmes.	SRO	4	3	12	14/03/2024	Ensure all departments maintain establishment levels Ensure vaccancies are filled quickly Regular monitoring via Scrutiny Panel. Vacancy issues to be escalated to Delivery Board.	4	1	4	Not Required		No	Open
R004	WBS Futures	01/11/2023	iHub	There is a risk that funding will not be available for the realisation of the objectives.	The benefits of the programme will not be achieved due to fiscal constraints of the organisation and demands of other programmes.	SRO	4	3	12	14/03/2024	Ensure Finance representation at FIG meetings and relevant programme/workstream level.	5	1	5	Not Required		No	Open
R005	WBS Futures	01/11/2023	iHub	There is a risk that Welsh translation of required documentation and communications may not be delivered, caused by limited resources with the translation team.	Programme objectives will not be achieved in a timely manner.	SRO	4	3	12	14/03/2024	Conversations to be held with Welsh Language Officer regarding importance of Translation Team support for key communications. Availability of Shared Services translation services under existing SLA. Use of translation tools to be allowed for basic internal communications, subject to review and only in exceptional circumstances.	4	1	4	Not Required		No	Open
R006	WBS Futures	01/11/2023	iHub	There is a risk that BECS re-procurement will not be delivered on time.	Deliverables sitting within other programmes that are contingent upon BECS delivery will not be achieved in a timely manner.	Alan Prosser (Digital Modernisation SLT Lead)	5	3	15	14/03/2024	BECS reprocurement identified as high priority. Dedicated workstream within Donor Modernisation Programme. Interdependencies with other Programmes mapped and subject to careful monitoring to undertand impact on any delays.	5	1	5	Not Required		No	Open
R007	Digital Modernisation	27/03/2023	David Mason-Hawes	**(R001 Digital Programme Board RAID Log)** There is a risk to PERFORMANCE & SUSTAINABILITY as a result of a failure to secure sufficient funding for the delivery of a new BECS contract and software platform, leading to a degredation of critical WBS (NHS Wales) blood supply chain activities (BECS Risk R007)	May impact on organisational operations	BECS Project Team	5	4	20	19/01/2024	Full costs to be confirmed via procurement. Seek to ring-fence monies for BECS, to ensure other operational / clinical critical services are not impacted.	5	4	20	Required	3193	No	Open
R008	Digital Modernisation	31/08/2023	Felicity May	**(R003 Digital Programme Board RAID Log)** There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	May impact on organisational operations	Felicity May	5	4	20	19/01/2024	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.	5	3	15	Not Required		No	Open
R009	Laboratory Services Modernisation	09/01/2024	Amy De'ath	**(R004 on NEQAS RAID log)** There is a risk that cost will not be recovered from NEQAS scheme customers as funding is currently being discussed as coming under Revenue.	NEQAS is a not for profit scheme, any additional cost passed to the customers may result in participants exiting the scheme impacting on organisational operations	Amy D'eath	5	4	20		At present no mitigating action other than to use a provider that is not cloud based.	5	4	20	Not Required		No	Open
R010	Laboratory Services Modernisation	08/02/2024	Michael Veasey	**(R006 on NEQAS RAID log)** There is a riks that Naqoda will not allow the WBS to purchase the IP resulting in WBS not being able to continue use with current system.	Unable to continue use with current system, new supplier to be sought	Amy D'eath	4	5	20		Explore using different supplier.	4	5	20	Not Required		No	Open
R011	Talbot Green Infrastructure	05/04/2024	Sarah Richards	**(R012 on TGI RAID Log)** There is a risk that funding will not be approved by the Welsh Government for the Talbot Green Infrastructure buisness case resulting in the current building not being fit for purpose in the future.	The Talbot Green building will not be fit for purpose in the future.	Sarah Richards	5	4	20	05/04/2024	Early and ongoing engagement with Specialist Estate Services and Welsh Government as key stakeholders. Utilisng a Healthcare Planner to support developing a compelling Business Case.	5	3	15	Required		No	Open
R012	WBMDR	12/02/2024	Deborah Pritchard	**(R007 on WBMDR Raid Log)** There is a risk that MPS will be unable to provide GCSF Contract / Commercial service provision by May 2024, caused by a lack of ability to apply all governance routes to the change resulting in failure to provide a service for peripheral stem cell collection	There will need to be in sourced contingency if the main supplier is unable to support until the contingency supplier contract is agreed at board	Deborah Pritchard	4	4	16	08/04/2024	Procurement are involved in discussions and are actively informing the timelines. Contingency may need to be in sourced whilst procurement develop the necessary procurement routes	4	4	16				
R013									0					0				
R014									0					0				
R015									0					0				

In development

											Funding Performance £'000s						Benefits Phasing £'000s				
WBS Futures Programme Theme	**WBS Futures Scheme**	**Action Lead**	**Resource Requirement**	**Benefits/ Disbenefits (SMART)**	**Interdependencies**	**Capital/ Revenue**	**Source of Funding**	**Secured/ Unsecured**	**Priority Ranking**	**Risk Ranking Expenditure**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Risk Ranking Benefits**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Plasma For Medicines	*Input Resources*	*Georgia Stevens*	*1 BMS and 1 MLA*	*Contribution to Savings Programme*	*Service Fully Lanched*	*Revenue*	*WG Funded Inputs*	*Unsecured*	*1*		*20*	*-20*	*0*	*0*	*0*		*0*	*0*	*0*	*0*	*0*
Collection Services Modernisastion	*Mode of Delivery*	*Jayne Davey*	*None*	*Reduced Venue Costs*	*Collection Services Modernisation concluded*	*Revenue*	*Existing Budgets*	*Secured*	*1*								*-100*	*-100*	*-100*	*-100*	*-100*

Risk Table		**Risk Commentary and KPI**	**Stated Assumptions**
	Funding Secured and Actuals Within Plan	Planned Spend	
	Funding Partly Secured and Actuals At Risk of Not Delivering Within Plan	Unplanned Spend	
	Funding Unsecured/Actuals Incurred Above Plan	Unaffordable Spend	

Expenditure Risk Category						**Benefits Risk Category**				
2024/25	2025/26	2026/27	2027/28	2028/29		2024/25	2025/26	2026/27	2027/28	2028/29
	-20	0	0	0						
						-100	-100	-100	-100	-100
20		0	0	0		0	0	0	0	0
			TOTAL	**0**					**TOTAL**	**-500**

DISCUSSION POINT FOR GROUP - DEFINITIONS OF RISKS AND KPIS - ENSURE ALIGNED

FUNDING SECURED TRANSLATES TO DETAILED BUDGETS - WHERE VARIANCE TRIGGERS KPI ON WHETHER WITHIN SPEND PLANS

Starter for discussion, things to work through include:

Owners for input
Owners for summary and KPI flows
Alignment of definitions - Developed by Huw/Donna
Clear distinction of capital and revenue flows linked to reporting into Committees on delivery
Working through an existing Programme to ensure flow works and captures all requirements - Donna and Huw have worked through an example and dashboard reflective of terminology
Wider governance implications as to managing delegated authority to commit expenditure - Chris has shared paper to be developed
Collections Modernisation Example To Be Worked Through
Benefits Tracking - Savings or Cost Pressures as Net Impact of Programme

													Budget £'000s					Expenditure £'000s					Variance £'000s				
WBS Futures Programme Theme	**WBS Futures Scheme**	**Action Lead**	**Resource Requirement**	**Benefits/ Disbenefits (SMART)**	**Interdependencies**	**Capital/ Revenue**	**Source of Funding**	**Secured/ Unsecured**	**Priority Ranking**	**Risk Ranking Expenditure**	**Cost Centre**	**Subjective**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**
Plasma For Medicines	*Input Resources*	*Georgia Stevens*	*1 BMS and 1 MLA*	*Contribution to Savings Programme*	*Service Fully Lanched*	*Revenue*	*WG Funded Inputs*	*Unsecured*	*1*				*100*	*100*	*100*	*100*	*100*	*120*	*80*	*100*	*100*	*100*	*20*	*-20*	*0*	*0*	*0*
Collection Services Modernisation	*Mode of Delivery*	*Jayne Davey*	*None*	*Reduced Venue Costs*	*Collection Services Modernisation concluded*	*Revenue*	*Existing Budgets*	*Secured*	*1*																		

2023 / 2024	Activity Week 1	Activity Week 2	Activity Week 3	Activity Week 4
August	5 Year Strategy Launch (02/08/23) & Director Update	Departmental Strategy Briefings		
September	WBS Futures Teaser Video 3W	WBS Futures Teaser Video 2W	WBS Futures Teaser Video 1W	WBS Futures Launch
October				
November		WBS Futures Programme Update		
December		News Capture Form Update	**WBS Futures Programme Update**	
2024				
January	Intro to BHP		Intro to WBMDR	
February	**WBS Futures Programme Update**			Intro to CSM
March		Intro to TGI		Intro to RD&I
April	News	Intro to LSM		Intro to DM
May		What is Plasma?		Intro to P4M
June	Director's update		5MW BHP	
July	Focus on WBMDR		Quick Wins CSM	News
August	5MW TGI		Focus on RD&I	
September	5MW LSM	COO update	Focus on DM	
October	Focus on P4M		Focus on BHP	News
November	5MW WBMDR		Focus on CSM	
December	Focus on TGI	Director's update	5MW RD&I	
2025				
January	Focus on LSM		5MW DM	
February	5MW P4M		Quick Wins BHP	
March	Quick Wins WBMDR	COO update	5MW CSM	
April	News			Director's update

Communications Product	Description
COO Update	Update from Chief Operating Officer (VLOG/BLOG) - Approx 500 words
WBS Director Update	Update from WBS Director (VLOG/BLOG) - Approx 300 - 400 words
Focus On	Word blog from programme/workstream lead(s) and Executive Lead - Approx 300 - 400 words
5 Minutes with	Q & A - 5 short questions with programme/workstream lead(s) and Executive Lead
Vox Pop Staff - Quick Wins	3 minute video clip from staff on achievements
Fly on the Wall	Short video clip of workstream meeting
Events	Briefing / update events
WBS in the Community	Case studies & external comms
News	Updates from News Capture Forms

Key	
Talbot Green Infrastructure Programme	TGI
Welsh Bone Marrow Donor Registry Programme	WBMDR
Collection Services Modernisation Programme	CSM
Blood Health Plan	BHP
Plasma for Medicines	P4M
Laboratory Services Modernisation Programme	LSM
Digital Modernisation Programme	DM
Research, Development & Innovation	RD&I

WBG Fortune Planner	Activity Plan																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	1st New Year's Day				Intro to BHP														Intro to WBMOR												
February									WBG Fortune Programme Update														Intro to CSM							
March							Intro to TGI														Intro to RO&I								30th Spring forward (Clocks Change)	31st Easter Sunday
April					News							Intro to LSM														Intro to DM				
May										What is Pauma?														Intro to PAM						
June							Director's update									16th Father's Day					SMM BHP									
July					Focus on WBMOR														Quick Wins CIM											
August									SMM TGI														Focus on RO&I							
September						SMM LSM							COO update							Focus on DM										
October											Focus on P4M														Focus on BHP					31st Halloween
November					5th Bonfire Night			SMW WBMOR		***18th*** Remembrance Sunday												Focus on CSM								
December						Focus on TGI							Director's update							SMW RO&I					***25th*** Christmas Day	***26th*** Boxing Day					31st New Year's Eve

STRATEGIC DEVELOPMENT COMMITTEE

Digital Inclusion Plan

DATE OF MEETING	15/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ENDORSE FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Elin Griffiths, Head of Digital Programme Kate Mackenzie, AD Data and Insight David Mason-Hawes, Head of Digital Services
PRESENTED BY	Carl Taylor, Chief Digital Officer
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Digital Inclusion continues to a key challenge in Wales and impacts on Health outcomes, with digitally excluded amongst the heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services.

	This paper sets out our existing achievements and the Trust's plan for Digital Inclusion activities including our accreditation against the standard Digital Inclusion Charter for Wales.

RECOMMENDATION / ACTIONS	SDC are asked to: • **Endorse for Approval** the Quality Impact Assessment for the Digital Inclusion plan by the Strategic Development Committee. The Digital Inclusion plan was previously endorsed for approval at EMB Shape on 18th March and SDC on 21st March. A further request was made at SDC on 21st March for completion of a Quality Impact Assessment and it is that element for SDC endorsement at this meeting. Conducting the QIA has led to no changes to the Digital Inclusion plan.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Digital Programme Board	28/02/2024
• EMB Shape	18/03/2024
• Strategic Development Committee	21/03/2024
• EMB Shape	15/04/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Digital Inclusion plan was discussed at the Digital Programme Board on the 28th Feb ahead of presentation to EMB Shape on the 18th March.

WBS SLT have reviewed.

For assurance of our activities, we have also been engaged directly with Digital Communities Wales and they have contributed to our Digital Strategy and our Digital Inclusion plan. The assessment from Digital Communities Wales is that our plan is ready for accreditation.

The plan was endorsed for approval at EMB Shape on 18th March. A further request was made at SDC on 21st March for completion of a Quality Impact Assessment. SDC endorsed the plan for approval subject to the Quality Impact Assessment being presented at the next meeting.

The Quality Impact Assessment was endorsed for approval by EMB Shape on the 15th April.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
Appendix 1	Full Digital Inclusion Plan for 24/25
Appendix 2	Digital Inclusion Plan Quality Impact Assessment

1. SITUATION

1.1 Over several years, the Trust has undertaken a number of significant developments in Digital Services which have made a difference to the quality, safety and experience for the users of the services that we provide. Alongside this the Digital team have been developing its capabilities and structures to support the future plans for the Trust. This has been articulated in the Board approved digital strategy for the Trust, "Digital Excellence: Our Strategy 2023-2033". We continue to change the way that Digital Services operate in the Trust in support of the Strategy.

1.2 Digital Inclusion is one of the key themes for the Digital Strategy where we continue to make good progress. We are now mature enough in our capabilities that we can set out the Trust's Digital Inclusion plan for approval. Section 3 of this document sets out the plan at a high level and Appendix 1 contains the detailed plan.

1.3 The Digital Inclusion plan will form the basis of our formal accreditation against Wales' Digital Inclusion Charter and will help to improve access to services for our stakeholders.

2. BACKGROUND

2.1 The Velindre Trust and the wider NHS in Wales is committed to enabling people to use digital technologies to manage their own health, wellbeing, care and enable donation. This is at the core of many of our strategies and operational plans across the Trust, such as building a sustainable donor base and a world class donor experience and moving cancer services to home. However, many of our service users who could most benefit from digital services are the least likely to be online and included.

2.2 Overall, 7% of adults in Wales are digitally excluded, but some sections of the population are more likely to be digitally excluded than others[1].

2.3 The 2017-18 National Survey for Wales[2] shows that those who are digitally excluded are more likely to be:

- Older (40% of people over 75 use the internet, compared with 97% of 16–49-year-olds)
- Have a disability or long-term condition (74% of people with a disability or long-term condition use the internet, compared with 90% of those without)
- Less well educated (53% of those with no qualifications use the internet, compared with 95% of those with higher education qualifications)

And that there are four pillars of Digital Inclusion for us to address in our plan.

Figure 1: The Four Pillars of Digital Inclusion

2.4 Digital Communities Wales (DCW). DCW is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. In 2019

[1] https://audit.wales/sites/default/files/publications/digital-inclusion-eng.pdf
[2] Reference: National Survey for Wales https://www.gov.wales/sites/default/files/statistics-and-research/2019-01/national-survey-wales-internet-use-digital-skills-2017-18.pdf

Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales[3] with an overview of the user of digital technology for health in Wales (Figure 1) which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

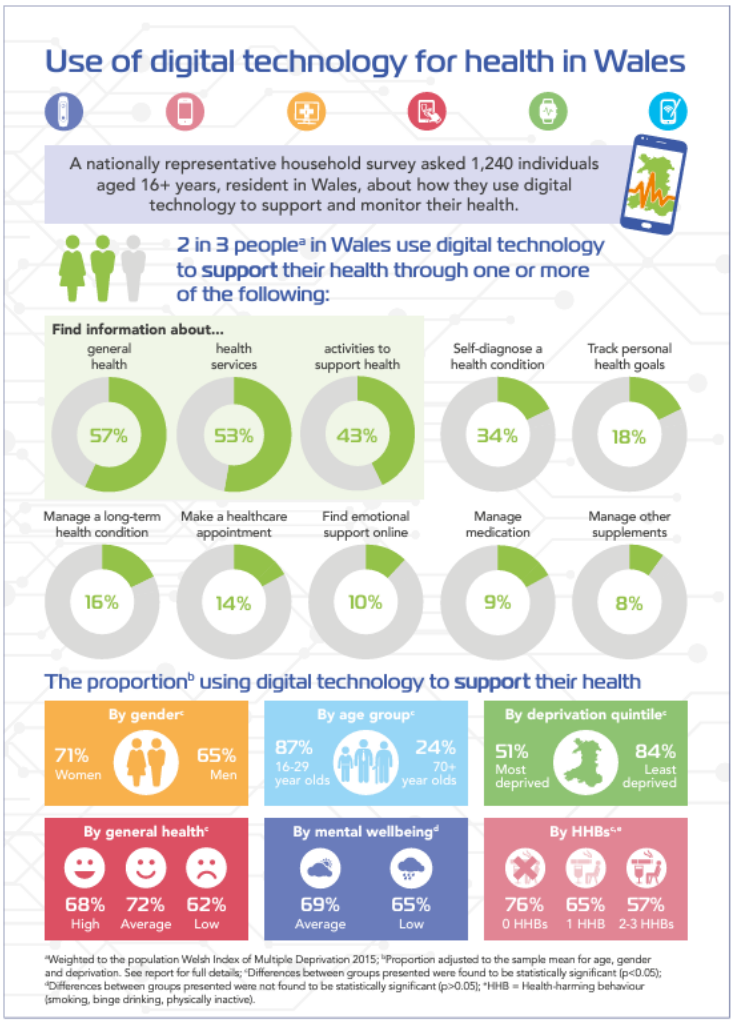


Figure 2: Use of Digital Technology for Health in Wales

2.5 The response to the Digital Inclusion challenge is set out in the Trust's Digital Strategy "Digital Excellence: Our Strategy 2023 – 2033". In recognition and support of the national digital inclusion challenges, Theme #2 in the strategy is *Digital Inclusion* and we have set the vision for the theme as:

[3] https://dhcw.nhs.wales/files/publications/digital-inc-guide-0619-english-pdf/

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

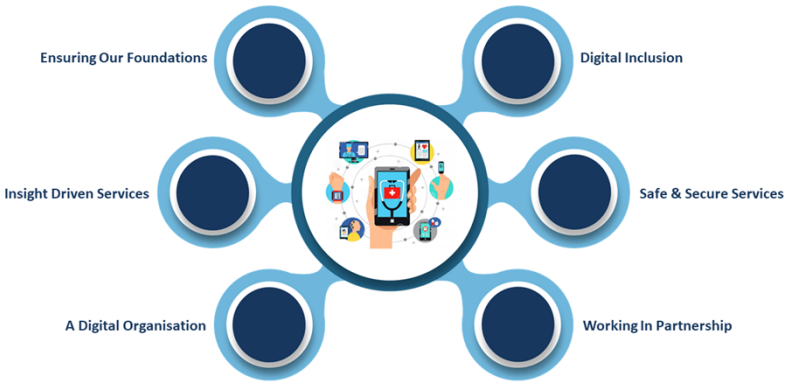


Figure 3: Digital Strategy Themes

2.6 The vision is supported by a set of objectives whose implementation form the Digital Inclusion plan set out in this paper. The objectives are:

- Digitally connect our donors, patients, and carers and staff to our services 24/7
- Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require.
- Deliver the technology which supports the provision of more services at home and as locally as possible.
- Provide our staff with the technology to work from a wide range of locations across Wales.
- Reduce digital exclusion of people across Wales.

2.7 To be successful the Digital Inclusion plan will also need progress in the Digital Organisation theme so that we can continue to upskill our colleagues in support of our objectives. Further, recognising that as we help to bring stakeholders into digital inclusion, which may include first time access/contribution to electronic records, cyber security of our services will be important and this is supported through our Safe and Secure Service theme in the Digital Strategy.

2.8 To demonstrate the Trust's commitment to the Digital Inclusion agenda in Wales in February '23 we became a signatory organisation to Digital Inclusion Charter (https://www.digitalcommunities.gov.wales/digital-inclusion-charter/) which sets out the six pledges below:

1. We ensure that all our staff and volunteers have an opportunity to develop basic digital skills, and that they take advantage of this opportunity.

2. We ensure that digital inclusion principles are embedded into our day-to-day activities and we support the role digital tools have in managing health and wellbeing.

3. We encourage and support our staff and volunteers to help other people to get online and have the confidence to develop basic digital skills, and help other organisations to embrace digital tools.

4. We commit support and resources for digital inclusion activities and initiatives in Wales in whatever ways we can, to ensure every citizen can engage digitally (if they choose).

5. We share best practice and activity around digital inclusion with the Digital Communities Wales – Digital Confidence, Health and Well-being programme so that our activities are co-ordinated for maximum impact and measured consistently.

6. We look to build local partnerships amongst organisations which want to share ideas and co-ordinate activities with others in their area.

2.9 The next step is to gain accreditation against the Charter. We have worked with Digital Communities Wales to assure that the plan set out in the Assessment section will give us the basis for this accreditation.

2.10 This builds on the work we have already completed for Digital Inclusion since we signed the charter last year. As brief examples, we were really pleased in August to donate eight Surface Pro devices to the Women Connect First charity in Cardiff. Women Connect First do great work to empower black and minority ethnic women with projects like Golden Years to enable Older BME women to feel more independent, empowered, and equipped with life skills including computer classes.

3. ASSESSMENT

3.1 For each of our patient, donor, colleague and citizen communities, 'Digital consumption, does not mean digital competence. Digital confidence, does not mean digital acceptability'.

3.2 The Trust's Digital Inclusion Plan 2024-25 seeks to build upon a series of pilot initiatives completed during the 2nd half of 2023-24. The activity planned will provide the Trust with the opportunity to increase our digital engagement with our patient, donor, corporate colleague and wider citizen communities, supporting those on the edges of inclusion.

3.3 Specifically, the digital inclusion initiatives we are committed to delivering in 2024-25, will enable us to work towards and achieve accreditation of the Digital Inclusion Charter. These are to:

- engage, promote and deliver user-centred designed digital services and tools;
- consider accessibility and inclusive user needs;
- understand where and when digital can offer value;
- strive to successfully embed digital ways of working;
- build solid foundations ensuring digital adoption, considers all users across multi touch-points;
- understand our data and insight baseline position and what steps we need to take to successfully deliver a digitally enabled hospital, donor experience and clinical service in the future, which works for patients/donors and staff alike;
- champion the accessibility and acceptability of digitally enabled healthcare for our patients, donors, colleagues and wider communities;
- nurture mutually beneficial relationships, influencing the future design of digital patient and donor pathways;
- work regionally, as an active member of the Digital Inclusion Alliance Wales network;
- and to collaborate outside NHS Wales and the healthcare sector, identifying exemplar practice to inform our support of users on the edges of inclusion.

3.4 Digital Inclusion Charter accreditation demonstrates organisational commitment in supporting people on the edges of inclusion or those digitally excluded, to enjoy the benefits of engaging with user-centred designed digital services.

3.5 The summary of the Digital Inclusion plan below is in line with the agreed 2024-25 IMTPs for both Velindre Cancer Services and the Welsh Blood Service divisions of the Trust.

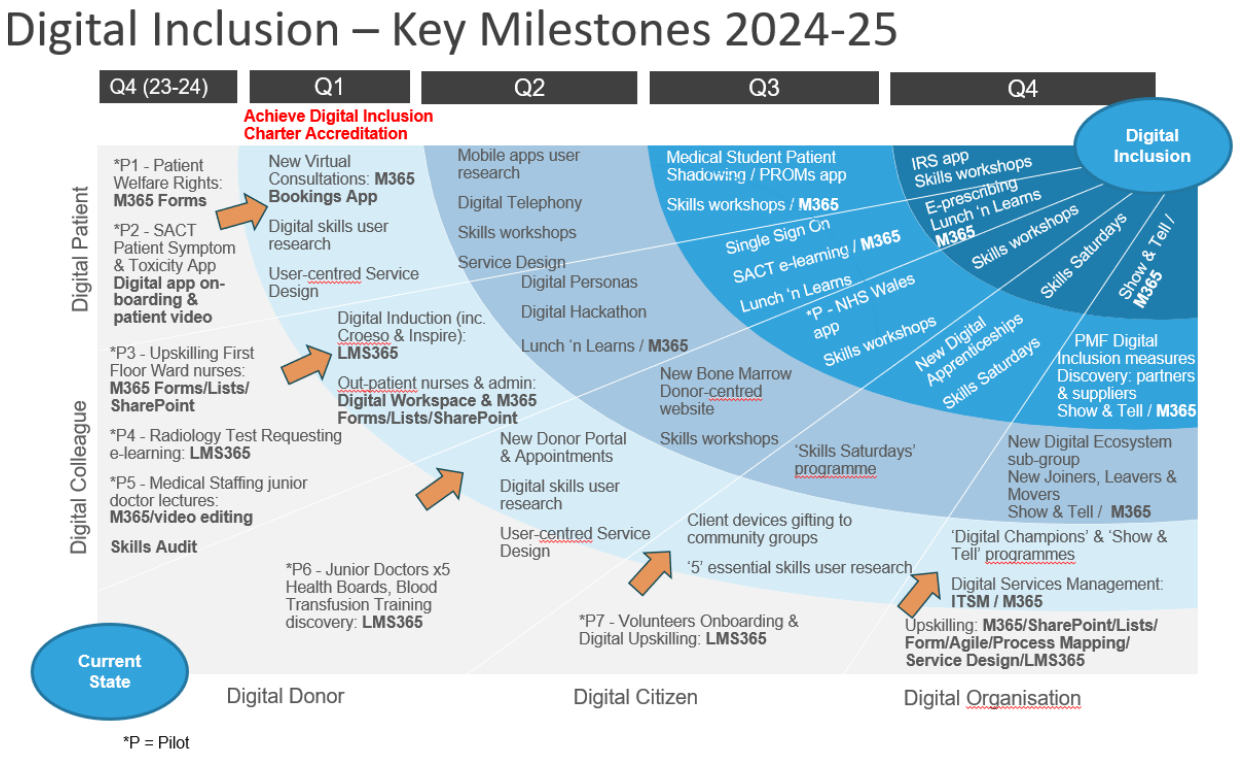


Figure 4: Trust Digital Inclusion Plan 24/25

A full version of the Digital Inclusion Plan, can be found in Appendix 1.

3.6 In this increasingly datafied society, Velindre has a role to ensure that all colleagues positively engage with data collection systems, have the critical thinking skills to analyse and interpret data to support decision-making and can use data as a means of supporting conversations with colleagues, patients and donors. Data Comfort is integrally linked to digital inclusion and reflects the need for skills and confidence to read, analyse, interpret and communicate with data. It is a foundational step in realising the themes of digital inclusion and insight-driven culture of the digital strategy.

3.7 The Plan for an Insight-driven organisation will be shared in full as part of the Data and Insight review (due April 2024), and will include:

- Evaluating our current data report / dashboard stock and retiring rare and unused products;
- Working with current users of Data and Insight products to simplify / redesign routine reports / dashboards using user-centred design principles and modern Business Intelligence tools to improve clarity and acceptability of products;
- Supporting colleagues across the Trust with a range of formal and informal learning opportunities to improve their data comfort;
- Co-producing a plan to improve our sharing of data and information with our patients, donors and citizen communities.

3.8 Digital Inclusion Measures

To measure the impact of our Digital Inclusion plan we are proposing to adopt the following measures as we previously set out in the Digital Strategy. As we define these measures, we will include them within the Performance Management Framework for reporting and assurance. It is anticipated that we will have the measures in place as part of the PMF by Q3 24/25.

Digital Inclusion Measures
• % 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 monitor their health digitally
• % of consultations performed virtually
• % of donors booking on-line
• % of patients / donors notified with via their communication preference of choice (SMS, email, other approved comms channels etc.)
• Increase in Mobile 'app' usage / interactions
• % of buildings with free public wi-fi

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As described in this plan, Digital Inclusion is important to improve the services that we offer our service users. EMB/SDC previously **Endorsed for Approval** the Digital Inclusion Plan. The SDC was subject to completion of a Quality Impact Assessment.

4.2 EMB/SDC **Noted** that as part of the Digital Inclusion plan, we will be seeking formal certification against DCW's Digital Inclusion Charter which will further strengthen the Trust's commitment to the Charter's pledges as set out in section 2.8.

4.3 SDC asked for a Quality Impact Assessment to be completed for the plan and this is now included as Appendix 2. Conducting the Quality Impact Assessment has not changed the Digital Inclusion plan itself, so SDC are asked to **Endorse for Approval** the QIA.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	TAF 05: There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security. Key Control C7: Digital Inclusion in the wider community
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☒

	Equitable ☒ Efficient ☐ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text** Digital Inclusion plays an important role in the quality and safety for the services that the Trust provides: • Digital exclusion in Wales is higher than rest of UK. • 7% of the population, or 180,000 people do not use the internet. • Digital inverse care law whereby socially disadvantaged people receive less, and lower-quality, health care despite having greater need. • Heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Inclusion plan will contribute to the quality and safety of our services. Appendix 2 is the Quality Impact Assessment for the plan.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	Click or tap here to enter text. Given that the overall aim of the duty is to deliver better outcomes for those who experience socio-economic disadvantage we would expect the plan to have a positive impact for our service users. An

	assessment will be made as part of the Digital Inclusion plan.

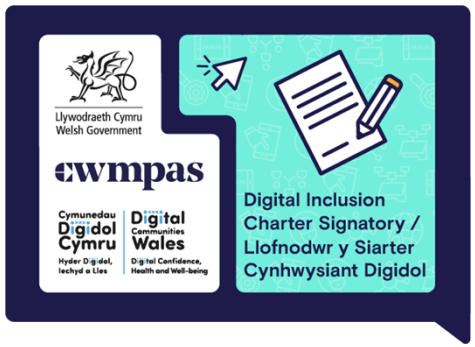
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: We are proposing to allocate £25k per annum to support the Digital Inclusion plan objectives. This would fund engagement activities and skills, making devices available to communities (WiFi, laptops) and materials to support the plan. **Type of Change** **Service Development** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	**Choose an item**

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	The Digital Inclusion Risk is captured as part of the TAF05 Trust Assurance Risk.
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Q4 24/25
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Support for the Digital Inclusion Plan Achieving Digital Inclusion Accreditation
All risks must be evidenced and consistent with those recorded in Datix	



Velindre University NHS Trust - Digital Inclusion Plan 2024-25

The following Velindre University NHS Trust (VEL) digital inclusion plan 2024-25 is supported through our collaborative partnership with Digital Health Care Wales (DHCW), Digital Communities Wales (DCW) and the Centre for Digital Public Services (CDPS).

Period	DI Charter Pledge No.	Proposed Activity	Details	Target Community	Progress Status	Outcome Measure	Owner
May '24	4	Establish 'Digital Inclusion Group'	Trust-wide steering group - Terms of Reference - Key Objectives - Action Plan - Reporting & Governance	Colleagues Partners Suppliers	Not started	Set-up and accountable to Digital Programme governance	VEL
June '24	2	Achieve 'Digital Inclusion Charter' accreditation	Prepare a summary of all digital inclusion achievements/pilots in 2023-24, for submission to DCW. 6 Digital Inclusion pledges https://www.digitalcommunities.gov.wales/digital-inclusion-charter/	Partner	In progress	Successful achievement of full digital inclusion accreditation	VEL DCW
Q1	3	Launch new Virtual Consultations system	Migration of virtual consultations capability form Attend Anywhere to	Colleagues Patients	In progress	Successful migration of existing virtual consultations service	VEL DHCW

			M365 Bookings App. Upskill clinicians and deliver a new adoption strategy.			users to M365 Bookings App	
Q1/Q2	4	Digital Skills Audit	DCW have created a digital skills audit which is based on the UK government National Standard for essential digital skills. It is hoped that every citizen has the following 5 essential digital skills: - Using Devices and handling information - Creating and editing - Communicating - Transacting - Being Safe and Responsible DCW has provided the digital skills audit to Velindre to carry out this audit with our user communities.	Colleagues Patients Donors Citizens	In progress - sample survey shared with VEL	VEL to review, add additional sections and agree timescales.	VEL
Q1	2	User-centred Service Design	Establish user-centred design principles and structures.	Colleagues Patients Donors	In progress - training and upskilling of key digital leads.	User-centred design/service mapping workshop blueprint.	VE CDPS
Q1	3	Digital Induction	Support People & OD division to migrate a) Croeso and b) Aspire programmes onto LMS365.	Colleagues	Scoping in progress.	Accessible e-learning modules for both programmes.	VEL
Q1	1	New Outpatients nurses & admin M365 Workspace	Development & launch of new Workspace, using M365 Forms/SharePoint/Lists and e-learning via LM365	Colleagues	Pilot in progress.	Adoption of new Workspace and full alignment with new ways of working.	VEL
Q1	4	New Donor Portal & Appointments	Re-development of public donor-facing portal	Donors	Infrastructure re-	Launch of new donor portal, with enhanced donor experience.	VEL

					platforming in progress.		
Q1	3	Digital gifting	Digital device support to community groups and partners, as part of Trust device refresh programme.	Citizens	Pilot completed in 2023/24.	Establishment of x4 community collaborations.	VEL
Q1	3 & 5	Digital Champions	Develop and launch 'Digital Champions' framework and recruit participants.	Colleagues Patients Donors Citizens	Scoping in progress. Digital champion profile defined.	Multi-disciplinary community of champions and supportive tools/e-learning content.	VEL DCW
Q1	4	Digital Services Management Tool	Procurement and launch of new IT Service Management tool, with accessible access for all users.	Colleagues	Procurement complete. Service design phase in progress.	Launch of new service to all Trust colleagues/users.	VEL
Q2	3	Digital Personas	Development of digital personas, including: - characteristics - national system requirements - clinical system requirements - appropriate digital devices/tools	Colleagues	First layer in progress.	VEL to consider M365 personas alongside.	VEL
Q2	5	Mobile apps user research	Review of existing Trust supported mobile apps and discovery work, to identify any new use cases.	Patients Donors Partners			VEL CDPS
Q1 – Q4	6	Working collaboratively with HEIW, support and train work force to feel more digitally confident and aware	Review the digital skills audit and would develop and create a suitable training package.	Colleagues	In progress.	Promote the access to the HEIW hosted Digital Skills Capability Framework.	DCW VEL HEIW

		of the importance of Digital Inclusion.					
Q2	6	Digital Days	Develop a concept of Digital Days and establish a pilot e.g. Skills Saturdays Concept - a patient/donor needs support with technology, they would be able to get that support in house in Velindre, this would be supported by volunteers. DCW would be able to provide the relevant training and support to set this up as this follows a model that has been used by a number partner organisation in a several counties.	Patients Donors Citizens	Not Started	Programme of internal and external skills events.	DCW VEL
Q2	2	Digital Telephony	Launch of new accessible patient and donor facing telephony services.	Patients Donors Citizens	Not started	Launch of new telephony service, with monitoring metrics and user experience feedback loops in place.	VEL
Q2	4	Service design mapping workshops	Publication of scheduled service design mapping sessions (across Trust-wide services).	Colleagues Patients Donors Citizens	Digital leads upskilling in progress.	Timely and relevant workshops, to support service mapping demand, across all user communities.	VEL
Q2	6	Digital Hackathons	Conduct a series of hackathons, to explore and develop at pace prototypes of new digitally included services.	Colleagues Citizens Patients Donors	Not started	Delivery of x2 hackathons, bringing multi-disciplinary teams together to explore user needs.	VEL DCW
		Digital 'Lunch 'n Learns'	Delivery of a rich programme of short, bite-sized digital sessions.	Colleagues	Pilot sessions developed.	Accessible sessions, across a wide cross-	VEL

Q2	5				Scoping in progress.	section of formats/channels, with user feedback and user-centred programme of events.	
Q2	2	New Bone Marrow Donor website	Re-development of new bone marrow donor facing website, with improved search engine optimisation, rich digital content and user experience.	Donors	Not started.	Launch of new and improved bone marrow donor website. Annual increase in bone marrow registrations.	VEL
Q2	5	New Digital Ecosystem sub-group	Establish a multi-disciplinary sub-group, including external partners/suppliers.	Colleagues	Not started.	Launch of new group with full Digital Programme governance.	VEL
Q2	1	New Joiners, Movers & Levers (JML) digital colleague service	Development and launch of robust JML service, ensuring the movement of colleagues is managed, controlled and considers the needs of end users, in a timely and relevant manner.	Colleagues	Scoping in progress.	Launch and adoption of new JML service.	VEL
Q3	5	Provide digital inclusion training for Cardiff University medical students	DCW would like to provide digital inclusion training for 300 students to ensure they understand what digital inclusion is, the importance of it and how they can support the patients they work with to be digital included and confident.	Patients	Not started	Digital Inclusion training module, as part of student induction/onboarding programme.	VEL
Q3	1	Single Sign On	Implementation of user authentication solution, to manage login/logout processes, for multiple systems simultaneously.	Colleagues	Procurement in progress.	Safe and secure access to 'core'	VEL DHCW

Sept '24	3	PROMs App	Procurement and implementation of digital PROMs collection national Value Based Health Care	Patients Colleagues	National procurement complete and supplier framework available.	Implementation and adoption of new digital PROMs data collection.	VEL
Q3	3	SACT e-learning	Development of new e-learning modules in line with new SACT digital systems, using LMS365.	Colleagues	Not started	100% completion of e-learning modules, to support implementation of new digital systems, as part of Service transformation/readiness for nVCC.	VEL
Q3	6	Launch 'Skills Saturdays' programme	Rolling programme offering opportunities to get involved in digital sessions/skills challenges.	Colleagues Citizens	Not started	Programme of quarterly digital sessions, supported by Digital Champions / volunteers.	VEL
Q3	3	Pilot – Donor Portal in NHS Wales app	Integration via API connectivity, of core WBS services, into the NHS Wales app.	Citizens Donors	Not started	Increased visibility of WBS services, including blood donation and Bone Marrow Donor Registry.	VEL DHCW
Q3	4	Digital apprenticeships	Development of new digital apprenticeships, within digital delivery, programmes and data & insight teams.	Citizens	Scoping in progress.	Successful recruitment / onboarding of x3 new digital apprentices.	VEL CDPS Universities
Oct '24	4	PMF Digital Inclusion measures	Commence reporting of new digital inclusion measures within the PMF.	Colleagues Patients Donors Citizens	In progress.	New PMF indicators for digital inclusion.	VEL

Q4	3	Launch Noona (IRS) app	Development and implementation of mobile app to support patient radiotherapy journey and PROMs reporting.	Patients	Not started	Patient download and active users volumes of app.	VEL
Q4	1	New e-Prescribing system	Implementation of ePMA solution, with full integration into national electronic prescribing solutions and patient demographics.	Colleagues	Procurement in progress.		

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Digital Inclusion Plan
QIA completed by / on date	Carl Taylor – 22nd March 2024
QIA agreed by / on date	EMB Shape 15th April 2024

Part 2a: Clinical review and sign off of QIA

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

QIA clinically agreed by / on date	**Nicola Williams – EMB Shape 15th April**

Part 2b: Executive clinical review and sign off of QIA if required

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

Clinical Executive 1 sign off / date	Nicola Williams 15th April 2024
Clinical Executive 2 sign off / date	N/A
Clinical Executive 3 sign off / date	N/A

Part 3: Outline of the proposal / decision to be made

1. Broadly outline what is being proposed and the decision that needs to be made
Digital Inclusion is one of the key themes for the Digital Strategy. We are now mature enough with our digital inclusion agenda that we have set out the Trust's Digital

Inclusion plan for approval. This is the basis of the proposal for the Quality Impact Assessment.

The Digital Inclusion plan will also form the basis of our formal accreditation against Wales' Digital Inclusion Charter who will independently review the quality of the plan.

2. Why is the proposal / decision needed?

The Velindre Trust and the wider NHS in Wales is committed to enabling people to use digital technologies to manage their own health, wellbeing, care and enable donation. This is at the core of many of our strategies and operational plans across the Trust, such as building a sustainable donor base and a world class donor experience and moving cancer services to home. However, many of our service users who could most benefit from digital services are the least likely to be online and included. The Digital Inclusion plan is needed to support service users.

3. What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities)

Overall, 7% of adults in Wales are digitally excluded, but some sections of the population are more likely to be digitally excluded than others

The 2017-18 National Survey for Wales shows that those who are digitally excluded are more likely to be:

- Older (40% of people over 75 use the internet, compared with 97% of 16–49-year-olds)
- Have a disability or long-term condition (74% of people with a disability or long-term condition use the internet, compared with 90% of those without)
- Less well educated (53% of those with no qualifications use the internet, compared with 95% of those with higher education qualifications)

Digital Communities Wales (DCW). DCW is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. In 2019 Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales with an overview of the user of digital technology for health in Wales (Figure 1) which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

https://audit.wales/sites/default/files/publications/digital-inclusion-eng.pdf
Reference: National Survey for Wales https://www.gov.wales/sites/default/files/statistics-and-research/2019-01/national-survey-wales-internet-use-digital-skills-2017-18.pdf
https://dhcw.nhs.wales/files/publications/digital-inc-guide-0619-english-pdf/

4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected

The following stakeholder groups are set out in the plan proposal:

- Patients (and supporting teams)
- Donors
- Velindre Workforce
- Citizens (as the Digital Inclusion will have wider societal benefit)

5. How have you engaged with the people affected?
If you have not yet engaged, what are your plans?

We have been engaged with Digital Communities Wales on the preparation for the Digital Inclusion plan who lead on this agenda for Wales and have engaged wider with stakeholder groups.

6. What are the main benefits of this proposal / decision?

The main benefits from the Digital Inclusion Plan that have been set out in the Digital Strategy are below, the plan will run over multiple years, we have set out 24/25 at this stage.

- Digitally connect our donors, patients, and carers and staff to our services 24/7
- Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require.
- Deliver the technology which supports the provision of more services at home and as locally as possible.
- Provide our staff with the technology to work from a wide range of locations across Wales.
- Reduce digital exclusion of people across Wales.

7. What are the main risks of implementing this proposal / decision?

The main risks of implementing the Digital Inclusion plan:

- Placing more emphasis on digital channels for our stakeholder groups. This will need to be managed carefully and we will still follow the Welsh Service Design Standards (5. Make sure everyone can use the service)

https://digitalpublicservices.gov.wales/guidance-and-standards/digital-service-standards-wales

The disbenefit of not implementing the Digital Inclusion plan is that the Trust will not contribute to the Digital Inclusion agenda in a co-ordinated or measured way and patient experience improvement opportunities will be missed.

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?
The proposal is in alignment with the Trust Vision and Purpose: • **Our Vision:** Excellent Care, Inspirational Learning, Healthier People • **Our Purpose:** To Improve Lives The proposal is also aligned with the following Trust strategic goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations The plan also fulfils the Digital Inclusion theme of the Trust's Digital Strategy
9. Is the proposal / decision planned to be temporary or permanent?
The Digital Inclusion plan is set out for 24/25. Work on Digital Inclusion is intended to be a permanent part of the Digital Strategy set out to 2023.

Part 4: Quality Impact Assessment

- This assessment tool should be completed for all strategic decisions.
- The response should be **proportionate** to reflect the significance, scale, risk, impact on delivery of strategic objectives and drivers of the proposal being made.
- Consider how the proposal / decision impacts on each of the Health and Care Quality Standards.

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Safe	• Proposal is not directly related to patient/donor safety	Neutral
Timely	• Increasing Digital inclusion will improve stakeholders' ability to access digital services in a timely manner through improved access and skills when interacting with Digital services.	Positive
Effective	• The Digital Inclusion plan will support the effective and efficient delivery of services. • VUNHST is committed to enabling stakeholders to use digital technologies to manage their own health, wellbeing, care and donations. Increasing Digital Inclusion will mean that we do this in an effective and efficient way and do not drive further exclusion.	Positive
Efficient		Positive
Equitable	• The Digital Inclusion plan will provide our stakeholders with a more equal opportunity to access our services. Over 7% of adults in Wales are digitally excluded.	Positive
Person-centred	• Increasing Digital Inclusion for our stakeholders should improve the well-being as the digitally excluded are often those most in need of access to our services • The range of ways that stakeholders can access services will be widened through the Digital Inclusion plan.	Positive

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Leadership	• Improving the digital and data skills of our leaders will help create the conditions for an effective Quality Management System	Positive
Workforce	• The Trust's workforce is one of our stakeholder groups identified within the plan • The Digital Inclusion includes items specifically aimed at improving the digital skills and data confidence of our workforce which will benefit quality (e.g work with HEIW)	Positive
Culture	• Proposal is not directly related to the culture of the Trust	Neutral
Information	• Improved Digital Inclusion will make digital information more accessible to the identified stakeholders and build confidence in using the information	Positive
Learning, improvement and research	• Proposal is not directly related to learning/improvement and research	Neutral
Whole systems approach	• The Digital Inclusion plan will help the Trust to work in our wider communities. • Improving digital inclusion will be a positive benefit for our stakeholders that will give them access to digital services wider than just healthcare • Gifting digital equipment (e.g. WiFi, laptops) will provide wider access	Positive

Part 5: Summary of the Quality Impact Assessment

Based on the assessment in Section 2, what are the key messages, risks and recommendations for the clinical review and sign-off process?

Digital Inclusion continues to be a key challenge in Wales and impacts on Health outcomes, with digitally excluded amongst the heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services. The Digital Inclusion plan is the Trust's plan for addressing this important area. The Digital Inclusion plan is not clinical in nature. It forms part of the Digital Strategy which been approved by Trust Board.
What are the proposed monitoring arrangements and frequency of QIA Review?
In Digital Inclusion Plan includes a set of measures that will be introduced into the Performance Management Framework over the period of the plan. Reporting on progress against the plan will go to Digital Programme Board and follow its agreed reporting arrangements from there. An annual submission will also be made to Digital Communities Wales as the accrediting body. It is proposed that Digital Inclusion plan is reviewed on an annual basis.

STRATEGIC DEVELOPMENT COMMITTEE

STRATEGIC DEVELOPMENT COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	15/05/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Carl James, Executive Director of Strategic transformation, Planning & Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	In accordance with the Strategic Development Committee Cycle of Business, the latest version of the Strategic Development Committee Terms of Reference have been brought to the Strategic Development Committee for review.
RECOMMENDATION / ACTIONS	The Strategic Development Committee is asked to review the Strategic Development Committee Terms of Reference. The Strategic Development Committee is

	asked to **ENDORSE FOR TRUST BOARD APPROVAL**.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	15/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive Management Board – Shape **ENDORSED FOR APPROVAL.**	

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

APPENDICES	
1	Strategic Development Committee Terms of Reference – with track changes

1. SITUATION

In accordance with the Strategic Development Committee Cycle of Business, the latest version of the Strategic Development Committee Terms of Reference has been brought to the Strategic Development Committee for review.

2. SUMMARY OF MATTERS FOR CONSIDERATION

The Strategic Development Committee Terms of Reference has been updated as appropriate since the previous version but today is opened to the Strategic Development Committee for any comments or recommended changes.

If endorsed by Strategic Development Committee, the updated Terms of Reference will go to Trust Board for approval.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Choose an item

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Not applicable

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	**Choose an item**
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item
	Not Applicable
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	January 2022
Next Review Due:	April 2025

1. INTRODUCTION

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

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

2. PURPOSE

2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - Strategic direction
  - Strategic planning and related matters
  - Strategic Workforce
  - Strategic Capital
  - Organisational development
  - Digital services, estates and other enabler services
  - Sustainable development and the implementation of strategy through the spirit and intention of the well-being of future generations act
  - Investment in accordance with Value-based healthcare

- **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

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

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:

- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

- Review Strategic workforce plans to ensure alignment with service requirements.

- Regularly review whether the Trust is developing a strategic approach, which provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium-Term Plan (IMTP) in accordance with above.

- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.

- Review Trust developments involving significant investment or modernisation.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

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

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

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

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

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

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders

with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

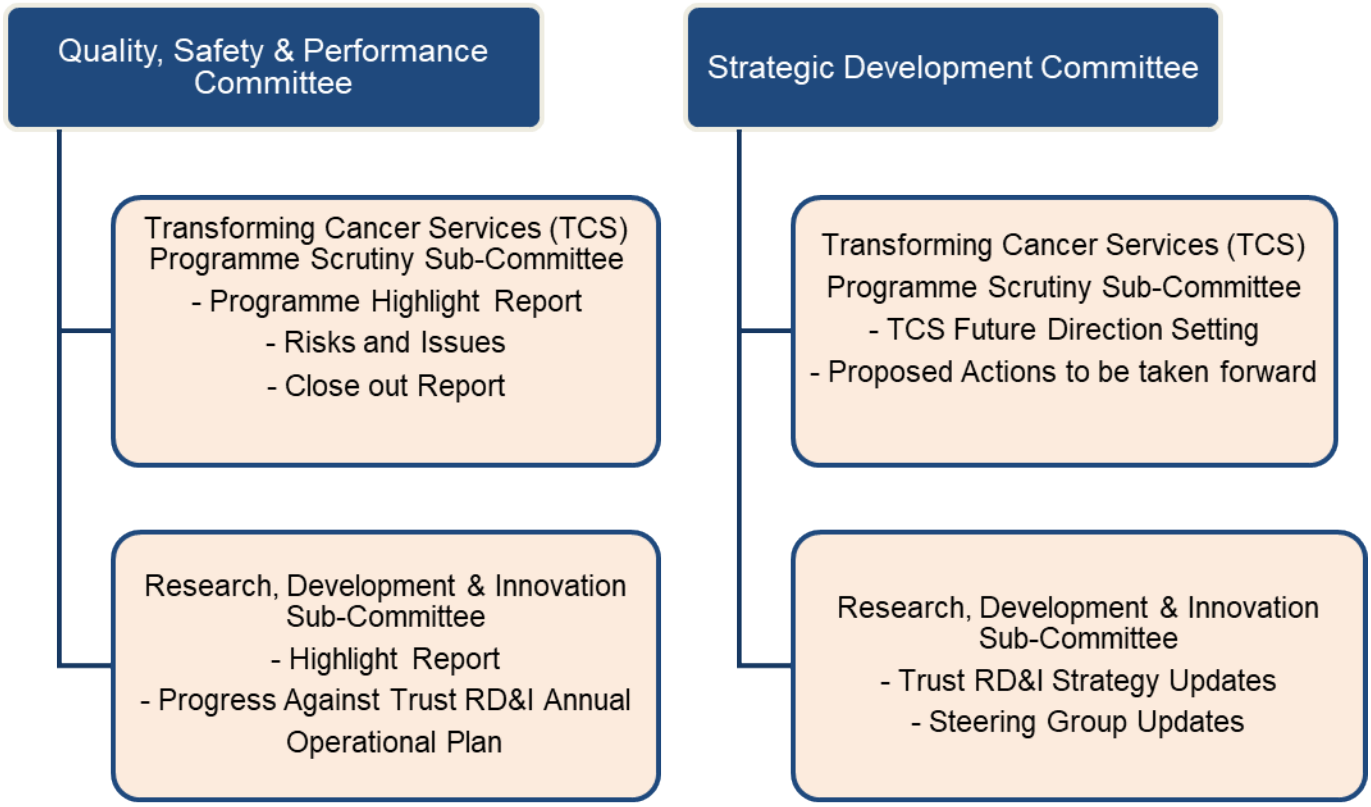
3.4 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for

decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

4.1 Members

A minimum of two (2) members comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 Attendees:

- Chief Executive Officer
- Director of Strategic, Transformation, Planning & Digital
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Divisional Directors
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Commercial and Strategic Partnerships
- Chief Digital Officer

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3 Secretariat

As determined by the Director of Corporate Governance and Chief of Staff.

4.4 Member Appointments

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

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

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

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

4.5 Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 Quorum

At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 Frequency of Meetings

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 **Withdrawal of individuals in attendance**

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

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its staff, patients, donors and citizens through the effective governance of the Organisation.

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

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

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

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

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.

- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

7.2 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

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

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

STRATEGIC DEVELOPMENT COMMITTEE

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS

DATE OF MEETING	15/05/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Carl James, Executive Director of Strategic transformation, Planning & Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	In accordance with the Strategic Development Committee Cycle of Business, the latest version of the Strategic Development Committee Cycle of Business have been brought to the Strategic Development Committee for review.
RECOMMENDATION / ACTIONS	The Strategic Development Committee is asked to review and **APPROVE** the Strategic Development Committee Cycle of Business.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	15/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive Management Board – Shape **ENDORSED FOR APPROVAL**	

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

APPENDICES	
1	Strategic Development Committee Cycle of Business – with track changes
2	Strategic Development Committee Cyle of Business – accepted track changes

1. SITUATION

In accordance with the Strategic Development Committee Cycle of Business, the latest version of the Cycle of Business has been brought to the Strategic Development Committee for review.

2. ASSESSMENT

Proposed additional changes to the Cycle of Business

The additional changes proposed to the Strategic Development Committee Cycle of Business at this stage of the review process, have been incorporated into the document – ref. ***Appendix 2 and 3***.

For ease of reference the proposed changes are:

- ***Revised nomenclature:***

The naming conventions used to describe a number of the items reported to the Strategic Development Committee have been strengthened to more accurately reflect the nature and purpose of the report. This includes the following items:

Existing Naming Convention	**Proposed Naming Convention**
Trust Strategy Update	Trust Strategy
Estates Strategy Update	Estates Strategy
Digital Strategy Update	Digital Strategy
Workforce Strategy Update	Workforce Strategy
Comms Strategy Update	Communication and Engagement Strategy
Strategic areas of focus	Strategic updates in other ways

- ***Removal of items of business:***

The Capital Plan has been proposed to be removed from the Cycle of Business. The Capital Plan is reviewed by Executive Management Board at different intervals throughout the year.

It is being proposed to remove the Health and Wellbeing Framework to be removed from the Strategic Development Committee Cycle of Business as this is reported through Quality, Safety and Performance Committee. Quality, Safety and Performance Committee receive the Health and Wellbeing Framework report as well as all its associated themes.

The following strategies are proposed as being removed from the Strategic Development Committee Cycle of Business as they covered within another strategy recently launched.

Existing Naming Convention	**Proposed within a revised strategy**
Trust and digital strategy update	Digital Strategy

Estates and Sustainability Strategy Update	Estates Strategy Sustainability Strategy
Workforce and Comms Strategy Update	Workforce Strategy

- ***New items of business:***

Sustainability Strategy and Clinical and Scientific Strategy have been added to the Strategic Development Committee to report on an annual basis.

The following items have not previously been reported to Strategic Development Committee. To ensure the necessary scrutiny and assurance arrangements, it is proposed that a highlight report is provided to the Strategic Development Committee at each meeting.

- Strategic Workforce Plans
- Velindre Futures Highlight Report
- Welsh Blood Futures Highlight Report
- Digital Programme Highlight Report
- Strategic Capital Board Highlight Report

3. SUMMARY OF MATTERS FOR CONSIDERATION

The Strategic Development Committee Cycle of Business has been updated as appropriate since the previous version but today is opened to the Strategic Development Committee for any comments or recommended changes.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒

• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒ Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Choose an item Not applicable

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	**Choose an item**
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item
	Not Applicable
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS 2024 – 2025

Key: = Annual Report
= Highlight Report
= Exception Report
= Assurance Report

Item of Business	Exec. Lead	Author	Session	Reporting Frequency	April 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
RISK MANAGEMENT & SAFE SERVICES																
Trust Assurance Framework	Director of Corporate Governance	Head of Corporate Governance	Public	Each Meeting	✓		✓		~~✓~~		✓		✓		✓	✓
PLANNING & PERFORMANCE																
Integrated Medium Term Plan	Executive Director of Strategic Transformation, Planning & Digital	~~Director of WBS/VCC~~Deputy Director of Planning & Performance	Public	As Required						~~✓~~			~~✓ Endorse - for sign off in Jan 2023 ✓~~		✓	✓
~~Capital Plan~~	~~Executive Director of Finance~~	~~Director of WBS/VCC~~	~~Public~~	~~As Required~~						~~✓~~					~~✓ Endorse - for sign off in March~~	
STRATEGY DEVELOPMENT																
Trust Strategy ~~Update~~	Executive Director of Strategic Transformation, Planning & Digital	Deputy Director of Planning & Performance	Public	~~As Required~~ Annually	✓								~~✓~~		~~✓ Endorse - for sign off in March~~	
Estates Strategy ~~Update~~	Executive Director of Strategic Transformation, Planning & Digital	Assistant Director of Estates, Environment & Capital Development	Public	~~As Required~~ Annually			✓						~~✓~~		~~✓ Endorse - for sign off in March~~	
Sustainability Strategy	Executive Director of Strategic Transformation, Planning & Digital	Assistant Director of Estates, Environment & Capital Development	Public	Annually							✓					
Digital Strategy ~~Update~~	Executive Director of Strategic Transformation, Planning & Digital	Chief Digital Officer	Public	~~As Required~~ Annually									✓		~~✓ Endorse - for sign off in March~~	
~~Workforce~~ People Strategy ~~Update~~	Executive Director of OD & Workforce	Deputy Director of OD and Workforce	Public	~~As Required~~ Annually									✓		~~✓ Endorse - for sign off in March~~	
~~Comms Strategy Update~~ Communication & Engagement Strategy	Director of Corporate Governance	Director of Corporate Governance	Public	~~As Required~~ Annually									~~✓~~		~~✓ Endorse - for sign off in March~~ ✓	
Clinical & Scientific Strategy	Executive Director of Nursing, AHP's & Healthcare Scientists	Executive Director of Nursing, AHP's & Healthcare Scientists	Public	Annually											✓	

Commented [LF(-DoCGa1]: To reflect outcome of open action

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS 2024 – 2025

Key: = Annual Report
= Highlight Report
= Exception Report
= Assurance Report

Item of Business	Exec. Lead	Author	Session	Reporting Frequency	April 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
SCRUTINY IMPLEMENTATION STRATEGIC ASSURANCE																
Trust & Digital Strategy Update	Director of Strategic Transformation, Planning & Digital		Public	Bi-Annually		✓							✓			
Estates & Sustainability Strategy Update	Director of Strategic Transformation, Planning & Digital		Public	Bi-Annually				✓					✓			
Workforce & Comms Strategy Update	Executive Director of OD & Workforce & Director of Corporate Governance		Public	Bi-Annually						✓					✓	
Strategic Areas of Focus Strategic Updates in other ways	All	All	Public	Each meeting		✓		✓		✓	✓		✓		✓	
Health & Wellbeing Framework	Executive Director of OD & Workforce		Public	Annually						✓						
Value Based Healthcare Programme of Work	Executive Director of Finance	Chris Moreton, Deputy Director of Finance	Public	Each meeting	✓	✓	✓	✓		✓	✓		✓✓		✓✓	✓
Strategic Workforce Plans	Executive Director of OD & Workforce	Deputy Director of OD & Workforce	Public	Every Other Meeting			✓						✓			✓
TCS Programme Sub-Committee Highlight Report	Executive Director of Strategic Transformation, Planning & Digital	Secretariat	Public	As Required												
RD& I Sub Committee Highlight Report	Executive Medical Director	Secretariat	Public	As Required												
Velindre Futures	Director of Velindre Cancer Services	Director of Velindre Cancer Services	Public	Each meeting	✓		✓				✓		✓		✓	✓
Welsh Blood Futures	Director of Welsh Blood Services	Director of Welsh Blood Services	Public	Each meeting	✓		✓				✓		✓		✓	✓
Digital Programme Highlight Report	Executive Director of Transformation, Planning and Digital	Chief Digital Officer	Public	Each meeting	✓		✓				✓		✓		✓	✓
Strategic Capital Board Highlight Report	Executive Director of Transformation, Planning and Digital	Secretariat	Public	Each meeting	✓		✓				✓		✓		✓	✓
COMMITTEE EFFECTIVENESS																

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS 2024 – 2025

Key: **= Annual Report**
= Highlight Report
= Exception Report
= Assurance Report

Item of Business	Exec. Lead	Author	Session	Reporting Frequency	April 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Strategic Development Committee Terms of Reference and Operating Arrangements	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually											✓	✓
Strategic Development Committee Programme of Business	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually											✓	✓
Strategic Development Committee Effectiveness Survey Report	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually			✓									
Strategic Development Committee Annual Report for Trust Board	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually			✓									

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS 2024 – 2025

Key: = Annual Report
= Highlight Report
= Exception Report
= Assurance Report

Item of Business	Exec. Lead	Author	Session	Reporting Frequency	April 2024	Jun 2024	Oct 2024	Dec 2024	Feb 2025	Mar 2025
RISK MANAGEMENT & SAFE SERVICES										
Trust Assurance Framework	Director of Corporate Governance	Head of Corporate Governance	Public	Each Meeting	✓	✓	✓	✓	✓	✓
PLANNING & PERFORMANCE										
Integrated Medium Term Plan	Executive Director of Strategic Transformation, Planning & Digital	Deputy Director of Planning & Performance	Public	As Required				✓	✓	✓
STRATEGY DEVELOPMENT										
Trust Strategy	Executive Director of Strategic Transformation, Planning & Digital	Deputy Director of Planning & Performance	Public	Annually	✓					
Estates Strategy	Executive Director of Strategic Transformation, Planning & Digital	Assistant Director of Estates, Environment & Capital Development	Public	Annually		✓				
Sustainability Strategy	Executive Director of Strategic Transformation, Planning & Digital	Assistant Director of Estates, Environment & Capital Development	Public	Annually			✓			
Digital Strategy	Executive Director of Strategic Transformation, Planning & Digital	Chief Digital Officer	Public	Annually				✓		
People Strategy	Executive Director of OD & Workforce	Deputy Director of OD and Workforce	Public	Annually				✓		
Communication & Engagement Strategy	Director of Corporate Governance	Director of Corporate Governance	Public	Annually					✓	
Clinical & Scientific Strategy	Executive Director of Nursing, AHP's & Healthcare Scientists	Executive Director of Nursing, AHP's & Healthcare Scientists	Public	Annually					✓	
STRATEGIC ASSURANCE										
Strategic Workforce Plans	Executive Director of OD & Workforce	Deputy Director of OD & Workforce	Public	Every Other Meeting		✓		✓		✓

STRATEGIC DEVELOPMENT COMMITTEE CYCLE OF BUSINESS 2024 – 2025

Key: ☐ = Annual Report
☐ = Highlight Report
☐ = Exception Report
☐ = Assurance Report

Item of Business	Exec. Lead	Author	Session	Reporting Frequency	April 2024	Jun 2024	Oct 2024	Dec 2024	Feb 2025	Mar 2025
Value Based Healthcare Programme of Work	Executive Director of Finance	Chris Moreton, Deputy Director of Finance	Public	Each meeting	✓	✓	✓	✓	✓	✓
Strategic Updates in other ways	All	All	Public	Each meeting	✓	✓	✓	✓	✓	✓
TCS Programme Sub-Committee Highlight Report	Executive Director of Strategic Transformation, Planning & Digital	Secretariat	Public	As Required						
RD& I Sub Committee Highlight Report	Executive Medical Director	Secretariat	Public	As Required						
Velindre Futures	Director of Velindre Cancer Services	Director of Velindre Cancer Services	Public	Each meeting	✓	✓	✓	✓	✓	✓
Welsh Blood Futures	Director of Welsh Blood Services	Director of Welsh Blood Services	Public	Each meeting	✓	✓	✓	✓	✓	✓
Digital Programme Highlight Report	Executive Director of Transformation, Planning and Digital	Chief Digital Officer	Public	Each meeting	✓	✓	✓	✓	✓	✓
Strategic Capital Board Highlight Report	Executive Director of Transformation, Planning and Digital	Secretariat	Public	Each meeting	✓	✓	✓	✓	✓	✓
COMMITTEE EFFECTIVENESS										
Strategic Development Committee Terms of Reference and Operating Arrangements	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually						✓
Strategic Development Committee Programme of Business	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually						✓
Strategic Development Committee Effectiveness Survey Report	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually		✓				
Strategic Development Committee Annual Report for Trust Board	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually		✓				