

Public Audit Committee

Tue 03 March 2026, 10:00 - 13:00

Velindre HQ, Nantgarw

Agenda

10:00 - 10:00
0 min

1. STANDARD BUSINESS

Led by Gareth Jones, Chair

1.1. Apologies

Led by Gareth Jones, Chair

1.2. Declarations of Interest

Led by Gareth Jones, Chair

1.3. Minutes of the Public Part A Audit Committee meeting held on 2 December 2025

Led by Gareth Jones, Chair

 1.3 DRAFT MINUTES - PART A PUBLIC AUDIT COMMITTEE - 2 December 2025 (V2).pdf (12 pages)

1.4. Action Log

Led by Gareth Jones, Chair

 1.4 PUBLIC AUDIT COMMITTEE ACTION LOG - MARCH 2026.pdf (2 pages)

10:00 - 10:00
0 min

2. INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

Led by Non Gwilym, Interim Director of Corporate Governance & Matthew Bunce, Executive Director of Finance

2.1. Audit Action Tracker Report – February updates

Led by Matthew Bunce, Executive Director of Finance

-  2.1a Audit Action Tracker cover paper - Feb updates.pdf (10 pages)
-  2.1b Appendix 1. February updates Red (overdue) Purple (Partially complete - overdue).pdf (1 pages)
-  2.1c Appendix 2. February updates - Full report.pdf (9 pages)
-  2.1d Appendix 3. Audit Action Tracker AMaT transition guidance.pdf (6 pages)

2.2. Trust Risk Register

Led by Non Gwilym, Interim Director of Corporate Governance

-  2.2a Public TRR Cover Paper - Audit Committee - March 2026 - V02.pdf (8 pages)
-  2.2b Public TRR Appendix - EMB - 23.02.2026 - V01.pdf (7 pages)

2.3. Board Assurance Framework

Led by Non Gwilym, Interim Director of Corporate Governance

-  2.3a BAF Cover Paper - AUDIT - FEBRUARY -2026 V01.pdf (8 pages)
-  2.3b BAF Overview February 2026 -AUDIT COMMITTEE -V02.pdf (7 pages)
-  2.3c BAF 01 - SERVICE CAPACITY- V04.pdf (7 pages)
-  2.3d BAF 02 - QUALITY -V04.pdf (6 pages)
-  2.3e BAF 03 - RDI -V03.pdf (7 pages)
-  2.3f BAF 04 - UNIVERSITY STATUS.pdf (3 pages)

-  2.3g BAF 05 - SUSTAINABILITY V04.pdf (4 pages)
-  2.3h BAF 06 -CULTURE.pdf (5 pages)
-  2.3i BAF 07 - DIGITAL.pdf (5 pages)
-  2.3j BAF 08 - GOVERNANCE.pdf (5 pages)
-  2.3k BAF 09 - FINANCE.pdf (15 pages)
-  2.3l BAF 10 - PORTFOLIO.pdf (4 pages)
-  2.3m BAF11 - WORKFORCE.pdf (6 pages)

10:00 - 10:00
0 min

3. EXTERNAL AUDIT

3.1. Audit Progress Report

Led by Kate Febry, Audit Lead (Performance), Audit Wales & Steve Wyndham, Audit Manager (Finance), Audit Wales

-  3.1 VUNHST Audit Cmt 202603 Audit Update.pdf (10 pages)

3.2. Examining decision-making for the new Velindre Cancer Centre report

Led by Alastair McQuaid and James Powell, Audit Wales

-  3.2 Examining decision-making for the new Velindre Cancer Centre report .pdf (63 pages)

10:00 - 10:00
0 min

4. INTERNAL AUDIT

Led by Stephen Chaney, Head of Internal Audit

4.1. Internal Audit Progress Report

Led by Stephen Chaney, Head of Internal Audit

-  4.1a VEL 2526 Cover Paper - 2025.26 Progress Report - Mar-26 AC v2.pdf (4 pages)
-  4.1b Velindre Progress Report March 2026.pdf (6 pages)

4.2. Receipt of Individual Reports

4.2.1. Medical Job Planning (limited assurance)

-  4.2.1a VEL-2526-02 Cover Paper - Internal Audit - Medical Job Planning.pdf (6 pages)
-  4.2.1b VUNHST 2526-02 Final Medical Job Planning Internal Audit Report .pdf (11 pages)

4.2.2. Commissioning Arrangements

-  4.2.2a VEL-2526-08 Cover Paper - Internal Audit - Commissioning Arrangements.pdf (6 pages)
-  4.2.2b VEL-2526-08 Final Internal Audit Report Commissioning Arrangements.pdf (9 pages)

4.2.3. nVCC Integrated Planning (reasonable)

-  4.2.3a VEL-SSU-2526-14 Cover Paper - Internal Audit - nVCC Integrated Planning.pdf (6 pages)
-  4.2.3b VEL-SSU-2526-14 nVCC Integrated Planning Final Report.pdf (13 pages)

4.2.4. AI / Robotics (reasonable)

-  4.2.4a VEL-2526-10 Cover Paper - Internal Audit - AI and Robotics.pdf (6 pages)
-  4.2.4b VEL2526 10 AI RPA Final Internal Audit Report.pdf (13 pages)

10:00 - 10:00
0 min

5. COUNTER FRAUD

Led by Henry Bales, Lead Local Counter Fraud Specialist

5.1. Progress Report Quarter 4 2025/26

Led by Henry Bales, Lead Local Counter Fraud Specialist

-  5.1a VELINDRE P4 COUNTER FRAUD PROGRESS REPORT - PUBLIC - COVER SHEET (AC).pdf (7 pages)
-  5.1b VELINDRE P4 COUNTER FRAUD PROGRESS REPORT - PUBLIC.pdf (7 pages)

5.2. Counter Fraud Annual Plan

Led by Henry Bales, Lead Local Counter Fraud Specialist

-  5.2a COUNTER FRAUD ANNUAL PLAN 26-27 COVER SHEET.pdf (7 pages)
-  5.2b COUNTER FRAUD ANNUAL PLAN 26-27.pdf (9 pages)

10:00 - 10:00 6. GOVERNANCE

0 min

Led by Non Gwilym, Interim Director of Corporate Governance

6.1. Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria

Led by Non Gwilym, Interim Director of Corporate Governance

-  6.1 AUDIT_DOI Gifts Sponsorship Hospitality and Honoraria_MAR 2026 v1.pdf (9 pages)

10:00 - 10:00 7. FINANCE

0 min

Led by Matthew Bunce, Executive Director of Finance

7.1. Private Patient Service Plan & Debt Position

Led by Dave Osbourne, Head of Finance Business Development

-  7.1a Audit Committee - Aged Debt Private Patient Service Mar 26.pdf (6 pages)
-  7.1b Appendix 1 - PP Aged Debt Mar 26.pdf (1 pages)
-  7.1c Audit Committee Private Patient Report Mar 26.pdf (7 pages)
-  7.1d PP Action Plan Audit Committee Mar 26.pdf (7 pages)

7.2. Losses and Special Payments Report

Angela Evans, Financial Accountant

-  7.2 Loses and Secial Payments report Mar 26.pdf (11 pages)

7.3. Technical Update paper

Angela Evans, Financial Accountant

-  7.3 Technical Update Paper Mar 26.pdf (7 pages)

7.4. Procurement Compliance Report & Action Plan update

Led by Matthew Bunce, Executive Director of Finance

To follow

10:00 - 10:00 8. CONSENT AGENDA

0 min

8.1. For approval

8.1.1. Standards of Good Governance and Probity Policy (GC03)

-  8.1.1a GC03 Standards of Good Governance and Probity - AUDIT Cover MAR 2026.pdf (4 pages)
-  8.1.1b APPENDIX 1 - DRAFT GC03 Standards of Good Governance and Probity v2.pdf (47 pages)
-  8.1.1c APPENDIX 2 - EQIA - GC 03 Standards of Good Governance & Probity.pdf (12 pages)

10:00 - 10:00 9. HIGHLIGHT REPORT TO THE TRUST BOARD

0 min

- For Alert / Escalation
- For Assurance
- For Advising
- For Information

10:00 - 10:00 0 min **10. ANY OTHER BUSINESS**

10:00 - 10:00 0 min **11. DATE & TIME OF NEXT MEETING**
Tuesday, 12th May 2026 @ 10:00

10:00 - 10:00 0 min **12. CLOSE**

**MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
TUESDAY 2 DECEMBER AT 10:00AM**

PRESENT:		
Gareth Jones	Chair and Independent Member	
Vicky Morris	Independent Member	
John Union	Independent Member	
ATTENDEES:		
Matthew Bunce	Executive Director of Finance	
Non Gwilym	Interim Director of Corporate Governance	
Stephen Chaney	Head of Internal Audit (NWSSP - Audit and Assurance Services)	
Eifion Jones	Deputy Head of Internal Audit	
Melanie Goodman	Audit Manager (NWSSP - Audit and Assurance Services)	
Steve Wyndham	Audit Wales	
Kate Febry	Audit Wales	
Henry Bales	Counter Fraud Manager	
Rachel Wetherill	Financial Services and Accounting Manager	
Dave Osbourne	Head of Finance Business Development	
Edwin Massey	Welsh Blood Service Medical Director	
Sara Walters	Clinical Audit Manager	
Niké Hooper-Collins	Secretariat	
1.0.0	Standard Business	Action
	Led by Gareth Jones, Chair, and Independent Member	
	Introduction Gareth Jones introduced, and welcomed to the Audit Committee meeting, John Union, following his recent appointment as Finance Independent Member.	
1.1.0	Apologies Led by Gareth Jones, Chair and Independent Member Apologies were received from: - Jacinta Abraham, Executive Medical Director - Carys Morgan, Clinical Director – Oncology - Richard Harries, Director, Audit Wales - Tentative - Ceri Doyle, Corporate Independent Member - Tentative	
1.2.0	Declarations of Interest Led by Gareth Jones, Chair and Independent Member There were no declarations of interest made.	
1.3.0	Draft Minutes from the Public Part A Audit Committee meeting held on 2 September 2025 Led by Gareth Jones, Chair and Independent Member. The minutes of the last meeting were reviewed for accuracy. The Audit Committee APPROVED the minutes of the meeting held on 2 September 2025.	

	1.4.0 Action Log Led by Gareth Jones, Chair and Independent Member. The Committee reviewed of the action log, discussing specific actions, their status, and updates. Action 90: This concerns clarifying the scope for the structured assessment and internal audit processes. The first part (regarding Audit Wales) has been completed: a meeting with Audit Wales clarified the scope and management of issues around the structured assessment, and this work is underway. The second part (regarding Internal Audit) remains open: a similar discussion with internal audit colleagues is still required. **Action** The Committee agreed to close the Audit Wales element and create a new action for the Internal Audit discussion, with a target to report back by the next audit Committee meeting in March. The Chair will be kept updated on progress before March, and the action log will reflect ongoing updates. Action 94: Progress made; though it remains open with a target date for update at the March meeting. Action 95: Kate Hannam explained that a new risk was raised but it didn't score high enough to reach the trust risk register; proposed to close. Action 96: Remains open until assurance is provided that strategic risks are mapped against goals and objectives; date to be revised in line with IMTP timescales. The Committee APPROVED the closure of 6 actions and NOTED the updates provided in the meeting and captured in the minutes.	NG
2.0.0	INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING Led by Matthew Bunce, Executive Director of Finance & Non Gwilym, Interim Director of Corporate Governance	
2.1.0	Audit Action Tracker – AMaT November Update Review of all outstanding audit actions from Internal & External Audit Led by Matthew Bunce, Executive Director of Finance A report was presented outlining progress on audit actions arising from both internal and external audit recommendations. Clarification was provided on the colour-coding of actions: “red” indicates that all actions linked to a recommendation are overdue, while “purple” means that some actions have been completed but others remain outstanding. System limitations were acknowledged, and a user guide will be circulated to support future understanding. Six requests for deadline extensions were reviewed, each accompanied by justification. The Committee agreed to approve extensions where sufficient rationale and revised dates were provided, with most new deadlines aligned to the next Audit Committee meeting in March 2026. For actions without a clear extension request, follow-up will take place by email outside the meeting.	

	Action Mathew Bunce to email action owners and Executive leads regarding the information above. Concerns were raised about the volume of overdue actions and the need for stronger senior oversight. It was noted that although progress has improved compared to previous years, delays are still occurring due to resource pressures and reliance on external bodies (such as national digital services) **Action** Secreteriat to alert issues with DHCW dependencies in the highlight report to the Trust Board. The Committee APPROVED closure of completed actions, AGREED to the proposed extensions (with some dates amended to align with the next meeting).	MB NHC
2.2.0	Clinical Audit Annual Plan 2025/26 Led by Sara Walters, Clinical Audit Manager and Edwin Massey, Medical Director The Clinical Audit Plan covers both Velindre Cancer Services (VCS) and the Welsh Blood Service (WBS), with overall progress reported as positive. In WBS, all planned audits remain on schedule, although the introduction of a new audit related to a point-of-care testing system has resulted in two lower-priority audits being deferred. Across VCS, strong progress has been achieved. All audits are now registered on AMaT, discussed regularly at relevant meetings, and supported by the appointment of a new clinical audit lead. Ward and departmental audits have fully transitioned onto AMaT, which has improved reporting and monitoring. Benchmarking continues to be challenging, particularly for national cancer audits, due to limitations in direct comparability with other centres. Work is underway to improve collaboration and benchmarking with external partners. Significant digital challenges were highlighted, specifically the difficulty in linking audit data across the patient pathway because of IT system limitations and dependencies on Digital Health and Care Wales (DHCW). These issues pose a clinical risk and are being escalated nationally. The Committee stressed the need for clearer assurance and agreed that future clinical audit plans must include action plans and timelines for areas where outcomes are not being met. **Action** The Committee requested mapping of benchmarking processes and follow-up on digital risks, ensuring these are captured as actions for future reporting. Edwin Massey & Sara Walters are invited back to the March Audit Committee to present. The Committee NOTED the Clinical Audit Plan 2025/26, with the expectation that future plans include action plans for any identified issues.	EM & SW
2.3.0	Trust Risk Register Led by Non Gwilym, Interim Director of Corporate Governance The Committee was informed that there were errors in the presentation of the risk register, including incorrect colour coding and missing symbols, and a commitment was made to	

republish corrected papers. A query was raised regarding progress on the system replacement (Datix), and it was confirmed that regular meetings are taking place, although no further update was available at the time.

Two new risks were highlighted:

- **Risk 3795 (WBS):** Concerns about patient safety due to independent result entry and authorisation, linked to digital system limitations and the need for involvement from the national digital body. This risk will be included in the highlight report for escalation.
- **Risk 3751 (COVID):** A concern was raised about the practicality of escalating all decisions to executive directors. It was clarified that the risk relates to gaps in clinical digital leadership and requires rewording for accuracy.

****Action**** The risk associated with clinical digital leadership (Risk 3751) will be rephrased to reflect the true position.

- **Risk 3795**, relating to patient safety issues in the laboratory setting and delays linked to the national LIMs programme, should be escalated to the Board and will be included in the highlight report. This risk connects to broader digital and clinical risks dependent on national digital developments.

Concerns were raised regarding missing or corrupted dates in the risk register, with a request for corrections. It was also noted that some high-scoring risks lacked sufficient commentary or updates.

****Action**** Future reports will include clearer explanations of significant risks and improved clarity overall. A request was also made for future reports to better describe the collective impact of digital risks and their connection to national digital dependencies.

An update was provided that a recent deep dive into digital risks had taken place within another Committee, and consideration will be given to how these insights can be reflected in future highlight reports.

The Committee **NOTED** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 on the Risk Register, subject to the comments raised.

NG

NG

2.4.0

Board Assurance Framework (BAF)

Led by Non Gwilym, Interim Director of Corporate Governance

The Committee was advised that the Board Assurance Framework (BAF) is a live document, updated following board meetings. The version presented may not fully reflect the most recent board decisions due to timing differences between meetings.

Attention was given to ensuring that actions address gaps in control, with plans to strengthen this approach in future reporting periods.

A new summary of strategic risks for each section of the BAF has been added to the cover paper, first presented to the Strategic Development Committee.

A request was made for clearer indication in the cover paper of which version of the BAF is being presented, particularly within the governance section.

	Future iterations of the BAF will include actions relating to gaps in assurance and controls, especially as development of the IMTP progresses. The Committee NOTED the current status of the Board Assurance Framework.	
2.5.0	Risk Management Arrangements at WBS & VCS Led by Alan Prosser, Welsh Blood Service Director & Kate Hannam, VCS Divisional Director Welsh Blood Service (WBS): A description was provided of a robust risk management process embedded within the quality management system, using FMEA (Failure Mode Effect and Analysis) for risk assessment, with escalation to Datix for high-scoring risks. Risks are reviewed regularly at senior leadership meetings, with clear ownership and governance arrangements in place. A query was raised about whether sufficient time is dedicated to examining risks and whether establishing a dedicated risk management committee could strengthen assurance. It was acknowledged that this is a valid challenge, and ongoing improvements are being introduced, including better triangulation of digital-related risks. A request was made for a minor update to the escalation flow chart to ensure consistency with policy, along with clarification of the process for risks that fall below formal escalation thresholds. **Action** It was agreed to update the documentation. Velindre Cancer Service (VCS): A summary was provided outlining changes within the new divisional structure, emphasising clearer roles and responsibilities for risk management at both directorate and divisional levels. Risks are entered and reviewed monthly, with divisional meetings focusing on those scoring 12 and above, supported by a process for moderating and standardising risk scoring. The Quality, Safety, and Patient Experience sub-committee reviews all risks, and the divisional board considers those scoring 12 and above. It was noted that improvements have been made in the consistency of risk scoring, along with a need for further training and clearer risk descriptors, moving from cause-based to risk-based language. A divisional-wide workshop on risk management is scheduled for 16 December to support staff training and understanding of the process. Progress was welcomed, with emphasis placed on developing a trust-wide narrative that brings divisional risk management together to provide full organisational assurance. It was confirmed that a refreshed risk framework and policy—incorporating a unified risk appetite statement and updated scoring matrix—is under development. This work will be	AP

	informed by divisional activity and is expected to be completed ahead of the next audit committee meeting. The Committee NOTED the process for managing risk at WBS & VCS.	
3.0.0	EXTERNAL AUDIT Led by Katrina Febry and Steve Wyndham (Audit Wales)	
3.1.0	Audit Progress Report Led by Kate Febry, Audit Lead (Performance), Audit Wales & Steve Wyndham, Audit Manager (Finance), Audit Wales Financial Audit: A report was provided confirming that the financial audit is currently in a transitional phase, with the charity audit underway and progressing as expected. Planning meetings for the 2025/26 audit are scheduled for later in the month, and audit testing is anticipated to begin in January. The 2024/25 Charity Accounts audit is progressing as planned, with no significant issues or delays reported in relation to the financial audit elements. Performance Audit: It was reported that audit work is progressing well, with good engagement from the organisation, although some audits are taking longer to conclude due to ongoing discussions. The structured assessment work for the 2025 plan is now underway, focusing solely on hosting governance within the core Trust for this cycle. The Cancer review is proposed to be postponed to the 2026 audit plan, with a refund of unused time, due to delays and the need to complete backlog work. Work on Cancer reviews in six Health Boards will proceed during 2025, and findings from those reviews will inform future work at Velindre. **Action** Kate Febry to formally communicate the decision to postpone the Velindre Cancer review to the trust. The Committee RECEIVED the report and NOTED the content.	KF
3.2.0	National Fraud Initiative 2024-25 Progress Report Led by Kate Febry, Audit Lead (Performance), Audit Wales & Steve Wyndham, Audit Manager (Finance), Audit Wales A progress report was presented summarising the total number of data matches received by the Trust and confirming that payroll and procurement matches have been appropriately addressed. The review of creditor matches remains ongoing and appears to be managed by shared services.	

	A request was made for future reports to include information on the completion of creditor and procurement matches, to provide clearer assurance and enable reconciliation with tables presented by external auditors. It was noted that the tables within the report were unclear; however, a subsequent update clarified that 17 matches remain open. The importance of clearly outlining the responsibilities of local counter-fraud representatives when following up on matches was emphasised. It was confirmed that the primary focus is ensuring all matches are investigated and that outcomes—whether no issue is found or further action is required—are fully recorded. The Committee RECEIVED the report and NOTED the report for assurance.	
4.0.0	INTERNAL AUDIT Led by Stephen Chaney, Head of Internal Audit (Audit and Assurance Services)	
4.1.0	Internal Audit Progress Report Led by Stephen Chaney, Head of Internal Audit A progress report was presented, highlighting that overall engagement with audits is positive. Several audits have been completed, with others in draft, fieldwork, or early stages, and no major delivery risks are anticipated. The Committee noted concern around the low KPI for timely management responses (25%), driven mainly by delays in agreeing management actions for the medical job planning and cybersecurity audits. Although this low figure is largely due to a single overdue report, discussions and engagement with responsible leads are ongoing. Upcoming audit reports include: • Medical Job Planning • Cybersecurity • Trust Assurance Framework • AI/Robotics • Quality & Safety Governance Concerns were raised about the continued slow response rate to audit recommendations, with emphasis on the need for a stronger escalation process when Executive Directors are unable to agree on actions. It was recommended that any unresolved audit actions should be escalated to the weekly Executive meeting to ensure timely resolution. It was agreed that this issue should be reflected as advice, rather than an alert, in the Highlight Report to the Trust Board. The Committee confirmed the need for a formal escalation route for overdue or unresolved management responses, which will be included in the advice section of the Highlight Report. **Action** Secretariat to include issues with management response rate as advise in the highlighted to the Trust Board. The Committee NOTED the Internal Audit Progress report.	NHC

4.2.0	2025/26 Internal Audit Plan Led by Stephen Chaney, Head of Internal Audit The plan is a snapshot in time, and as the Board Assurance Framework (BAF) is a live document, there may be ongoing changes to risk references. The Audit Committee NOTED and RECEIVED for INFORMATION the contents of the Plan.	
4.3.0	Receipt of Individual Reports Led by Stephen Chaney, Head of Internal Audit	
4.3.1	Organisational Culture and Wellbeing Advisory Report Led by Eifion Jones, Deputy Head of Internal Audit The report focused on core trust services, not hosted arrangements, and highlighted substantial recruitment progress over the past year. Fifteen management considerations were included, with four prioritised: focusing strategy around SMART objectives, centralising budget monitoring, addressing low and inconsistent engagement with well-being initiatives, and sharing best practices internally and externally. Overall, the report found positive improvement in culture and well-being, but noted areas needing further focus based on available resources and priorities. The Committee RECEIVED the report and NOTED the report.	
4.3.2	nVCC Contract Delivery (Construction) Report Led by Melanie Goodman, Audit Manager The report noted performance issues from Project Co in quality and programme delivery, as well as issues with achieving community benefit targets and the independent tester role. The Trust was found to have robust controls to monitor, manage, and report these issues, and was compliant with its obligations under the project agreement. No key findings were raised in this report, as related issues had already been addressed in previous reports and a PwC governance review, with follow-up confirming closure of prior recommendations. The only highlighted point was the importance of ongoing monitoring of Project Co's performance. The Committee RECEIVED the report and NOTED the report.	
4.3.3	nVCC Contract Compliance Report Led by Melanie Goodman, Audit Manager It was explained that the delay in finalising the contract compliance report was due to being asked to revisit and assess improved controls that had been implemented after the initial audit fieldwork. This allowed the audit team to review more recent improvements before issuing the report. Regarding key findings, it was confirmed that although several were identified, all have now been closed, and there are no further actions required from the Trust in this area.	

	It was also noted that similar issues had been raised in the PwC governance and capabilities review, and recent follow-up confirmed those recommendations have also been actioned. The Committee RECEIVED the report and NOTED the content.	
4.3.4	nVCC Risk Management Report Led by Melanie Goodman, Audit Manager A substantial assurance report on the nVCC project's risk management processes was presented. The project was found to have a well-developed and well-resourced risk management approach. Several key findings were raised, though these were identified as opportunities for enhancement rather than fundamental control weaknesses. Most of these have already been actioned. One outstanding action remains: the Trust is working to review its risk management procedure and incorporate further improvements identified in the audit. The Committee RECEIVED the report and NOTED the content.	
5.0.0	COUNTER FRAUD	
5.1.0	Progress Report Quarter 3 2025/26 Led by Henry Bales, Counter Fraud Manager Steady progress was reported across counter-fraud activity. Fraud awareness training compliance has reached 72%, with additional in-person sessions still to be added to the figures. Activities for International Fraud Awareness Week were successfully delivered, and no significant fraud intelligence or issues were identified during the period. All National Fraud Initiative (NFI) checks for the organisation have been completed by the counter-fraud team, with payroll matches closed and no concerns identified. Creditors and procurement matches are still being finalised by shared services. Two salary overpayments were reviewed and confirmed not to involve fraud. The Committee requested that future reports include benchmarking of training rates with other NHS bodies and ensure full consolidation of NFI outcomes, particularly those overseen by shared services. Further requests were made for: • clearer integration of shared services data in future reporting, • reconciliation between NFI tables presented by the counter-fraud team and those from external auditors, and • comprehensive reporting to ensure the Committee receives full assurance for year-end accounts. It was emphasised that the counter-fraud function must provide explicit assurance that all shared services-related work is complete and fully reported to the Committee.	

	The Committee RECEIVED the report and NOTED the content of the report and AGREED on a level 6 assurance rating.	
6.0.0	COMMITTEE EFFECTIVENESS AND ANNUAL REPORT	
6.1.0	Committee Effectiveness Survey Report Led by Non Gwilym, Interim Director of Corporate Governance It was explained that the response rate for the Committee Effectiveness Survey was low, with only 8 out of 14 participants (57%) completing the survey. Most responses came from independent members, with only two responses received from the Executive team, despite several reminders and deadline extensions. The survey highlighted challenges in Committee engagement and the breadth of topics covered, suggesting a need for improved access to information and stronger participation from Executive members. The Committee thanked the secretariat for attempting to improve the response rate. The aim for next year is to discuss improvements with the Chair, to be firmer in encouraging even more responses. The Audit Committee NOTED the report.	
7.0.0	FINANCE	
7.1.0	Private Patient Service Plan & Debt Position Led by Dave Osbourne, Head of Finance Business Development An update is noted below: • The 90-day debt target was met in two out of six months; a spike in August was due to unusually high invoice raising, but this was corrected in the following month. • Debt over 90 days remains largely stagnant, with one insurer owing approximately £330,000, of which £215,000 is over 90 days. Only £16,000 is considered high risk and may be written off due to being outside the allowable invoicing window. • Less than £5,000 has been written off as bad debt this financial year; efforts continue to recover outstanding amounts. • Service improvement actions include active negotiations with insurers on tariffs, aiming to avoid subsidising private services and recognising additional income for new service lines. • The Clinical Advisory Group (CAG) now meets monthly and has approved the consultant agreement, which includes risk share arrangements; final sign-off is pending from the Divisional Director. • Automation of debt management is delayed due to digital team capacity constraints, with external options being explored. • All improvement activities are targeted for completion by year-end, with future tariff adjustments planned as inflationary uplifts rather than full renegotiations. The Committee RECEIVED the report and NOTED the content.	
7.2.0	Losses and Special Payments Report Led by Rachel Wetherill, Financial Services and Accounting Manager	

	An update is noted below: • Total debt written off for the year is £10,242.53, with £3,500 related to private patients in the first quarter and £6,800 for the current quarter. Most write-offs are salary overpayments now statute barred or uneconomic to recover. • One payment of £84,844.02 was made for a voluntary early release scheme, approved by Welsh Government and the Remuneration Committee. • Four COT3 agreements totalling £483,254 were settled, mainly for employment tribunal cases and trainee-related losses. Two cases (combined £219,000) were recharged to host organisations; others were provided for in previous accounts, so no current year impact. • Stock losses for slow-moving and obsolete items totalled £120,000 (already provided for), with an additional £27,000 in smaller write-offs. • All items have been reviewed and authorised per the scheme of delegation, and shared services losses are now included for completeness. • There is ongoing dialogue with Welsh Government to clarify accounting treatment for settlement agreements recharged to other organisations, to ensure correct reporting in year-end accounts. The Committee RECEIVED the report and NOTED the content.	
7.3.0	Technical Update paper Led by Rachel Wetherill, Financial Services and Accounting Manager An update is noted below: • IFRS 17 (Insurance Contracts): The standard is effective from April 2025 but must be applied retrospectively. A review found no hidden insurance contracts in current income contracts for the Trust or Health Technology Wales. This review will be repeated, and any findings will be reported to the Audit Committee. • De-recognition and Impairment Review: New guidance requires high-value schemes to remain as assets under construction until brought into use and formally revalued. Discretionary schemes over £500,000 need a desktop valuation for impairment. Smaller works are treated as standard capital additions. The Trust has completed its review and confirmed no impairments for the 2025/26 accounts. • All technical updates are for noting, with no current impact on the accounts. The Committee RECEIVED the report and NOTED the content.	
7.4.0	Procurement Compliance Report Led by Matthew Bunce, Executive Director of Finance Key points include: • There were 10 breaches of standing orders and standing financial instructions (SFIs) during the reporting period; details are provided in the appendices. • The trend in breaches is improving, but continued education and awareness are planned, including updates and training sessions for divisional boards and senior leadership teams to further reduce breaches.	

	The Committee DISCUSSED the information provided in this report and AGREED the assurance rating.	
8.0.0	HIGHLIGHT REPORT TO THE TRUST BOARD	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared.	
9.0.0	ANY OTHER BUSINESS Prior Agreement by the Chair Required	
	None.	
10.0.0	DATE AND TIME OF NEXT MEETING	
	Tuesday, 3 rd March 2026 at 10:00	
11.0.0	CLOSE	
	The Committee 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).	
14.0.0	PRIVATE / PART B SESSION	
	The Committee noted that the following items would be discussed at the Private / Part B Session of the Audit Committee: • Draft Minutes from the Private Audit Committee meeting held on 2 September 2025 • Action Log Private Audit Committee • Trust Risk Register	

ACTION LOG								
MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	OPEN	IF CLOSED WHAT ACTION WAS TAKEN
24.06.25	2.2.0	90	2024 – 2025 Head of Internal Audit Opinion and Annual Report Clarification of scope of Internal and External Audit to be confirmed.	CEO, Interim Director of Corporate Governance	02.09.25	Feb 2026: Arrangements for 2026 Structured assessment confirmed. Internal & External audit plans re: hosted services governance to be confirmed as part of review implimentation plan November 2025: Structured Assessment of VUNHST underway. Agreement between AW and VUNHST (5 November) to clarify scope of structured assessment as per Annual Report 2024-25 in lieu of WG report on governance arrangements. August 2025: Discussions to progress following conclusion and sharing of Welsh Government review of the current hosting arrangements.	OPEN	
02.09.25	2.2.0	94	INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING Trust Risk Register Risk 3541: Interim Director of Corporate Governance to review risk with Chief Operating Officer.	Interim Director of Corporate Governance/Chief Operating Officer	02.12.25	01/11/2025 - The current risks score is 5 for this risk (impact 5 x likelihood 1) reduced from 15 (impact 5 x likelihood 3) The update on Datix is "Decision to maintain aseptic capacity/ model at nVCS to support production of SACT obtained by COO with EMB colleagues. Therefore delays to national TrAMS will not affect nVCS SACT aseptic production capacity".	PROPOSE TO CLOSE	Feb 26 The risk has been regularly reviewed and is at a current risk value of 5, therefore not reportable to Board, as below threshold. Propose to close the action.
02.09.25	2.2.0	95	INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING Trust Risk Register Risk 2249 to be reviewed by VCS.	Interim Director of Corporate Governance /Director VCS	02.12.25	Nov 2025 - Update from Kate Hannam The risk is now closed with the following rationale: 'Initial risk relates to ongoing risk of externally funded posts. Removed on the basis that this is an ongoing issue that continues to be reviewed. New risk to be created to capture financial sustainability of Velindre Cancer Services.'	PROPOSE TO CLOSE	
02.09.25	2.3.0	96	INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING Board Assurance Framework Executives to consider process for aligning BAF with strategic goals and objectives.	Interim Director of Corporate Governance	02.12.25	February 26 - Work has begun with the Assistant Director of Planning to review the objectives in the IMTP with the strategic risks. A workshop with Trust Board members is schedule on the 18th March. November 25 - The BAF risks will be refreshed as part of the IMTP process and clearly align with strategic objectives.	PROPOSE TO CLOSE	
02.12.25	1.4.0	101	Action log Action 90: This concerns clarifying the scope for the structured assessment and internal audit processes. The first part (regarding Audit Wales) has been completed: a meeting with Audit Wales clarified the scope and management of issues around the structured assessment, and this work is underway. The second part (regarding Internal Audit) remains open: a similar discussion with internal audit colleagues is still required. **Action** The Committee agreed to close the Audit Wales element and create a new action for the Internal Audit discussion, with a target to report back by the next audit Committee meeting in March. The Chair will be kept updated on progress before March, and the action log will reflect ongoing updates.	Interim Director of Corporate Governance	03.03.26	See action 90 update. Propse to close as it's a duplication.	PROPOSE TO CLOSE	
02.12.25	2.1.0	102	Audit Action Tracker - Extensions The report included six specific extension requests for overdue actions, with explanations provided by relevant directors. The Committee agreed to approve extensions where reasons and new dates were given, generally aligning new deadlines with the next audit Committee meeting in March 2026. For actions without clear extension requests, Matthew Bunce will follow up by email and seek approval out of Committee. **Action** Mathew Bunce to email action owners and Executive leads regarding the information above.	Executive Director of Finance	03.03.26	03.12.25: MB email sent to approve extension requests following approval Audit Committee 05.12.25: MB email request sent to action owners for further info on Red & Purple status and to consider a revised date for out of committee approval. Propose to close as this is part of ongoing monitoring of the Audit Action Tracker	PROPOSE TO CLOSE	
02.12.25	2.1.0	103	Vicky Morris raised concerns about the number of overdue actions and the need for stronger executive oversight. Matthew Bunce and Anne Carey explained that while progress has improved over previous years, some actions are delayed due to resource constraints or dependencies on external bodies (e.g. DHCW). **Action** Secreteriat to alert issues with DHCW dependencies in the highlight report to the Trust Board.	Secreteriat	03.03.26	Included in highlight report to Trust Board on 29th January 2026	PROPOSE TO CLOSE	
02.12.25	2.2.0	104	Clinical Audit Annual Plan 2025/26 Vicky Morris questioned the assurance level, suggesting that if outcomes are not as intended, a revised action plan and timeline should be included in future reports. The Committee agreed that future annual plans should include action plans to address any issues identified. **Action** The Committee requested mapping of benchmarking processes and follow-up on digital risks, ensuring these are captured as actions for future reporting. Edwin Massey & Sara Walters are invited back to the March Audit Committee to present.	Clinical Audit Manager & WBS Medical Director	03.03.26	Update 11.02.26: Sara Walters advised that it won't be ready for March committee.	OPEN	
02.12.25	2.3.0	105	Trust Risk Register Risk 3751 (COVID): Vicky Morris questioned the practicality of escalating all decisions to executive directors. Anne Carey clarified the risk is about gaps in clinical digital leadership and the need to reword the risk for accuracy. **Action** Non Gwilym agreed to rephrase risk 3751 reflect the actual position regarding digital leadership gaps.	Interim Director of Corporate Governance	03.03.26	Actions complete and taken forward for subsequent reports .	PROPOSE TO CLOSE	

02.12.25	2.3.0	106	Trust Risk Register Risk 3795: The risk to patient safety due to independent result entry and authorisation (notably in the Red Cell Laboratory and related to the LIMS system and DHCW delays) should be escalated to the Board. This risk is linked to broader digital and clinical risks that depend on the national LIMS program and ongoing discussions with Digital Health and Care Wales (DHCW). This will be included in the highlight report to Trust Board. Gareth Jones noted missing or corrupted dates in some risk entries and requested corrections and Vicky Morris pointed out that some high-scoring risks lacked sufficient commentary or updates in the appendix and cover paper. **Action** Non Gwilym committed to enhancing the clarity of future reports and ensuring that the most significant risks are described in greater detail. **Action** There was a request to better outline the collective impact of digital risks and their link to DHCW in future reports.	Interim Director of Corporate Governance	03.03.26	Actions complete and taken forward for subsequent reports.	PROPOSE TO CLOSE	
02.12.25	2.5.0	107	Risk Management Arrangements at WBS & VCS Matthew Bunce requested a minor update to the escalation flow chart for consistency with policy and suggested clarifying the process for risks below escalation thresholds. **Action** Alan Prosser agreed to update the documentation.	WBS Director	03.03.26	Email and updated document sent to MB on 30th December 2025. Content to close	PROPOSE TO CLOSE	
02.12.25	3.1.0	108	Audit Progress Report The Cancer review for Velindre is proposed to be postponed to the 2026 audit plan, with a refund for the unused time, due to delays and the need to complete backlog work. It was noted that work on Cancer reviews in six Health Boards will proceed in 2025, and findings from those will inform future work at Velindre. **Action** Kate Febry to formally communicate the decision to postpone the Velindre Cancer review to the trust.	Audit Wales, Audit Lead (Performance)	03.03.26	Update to be provided at March Committee	OPEN	
02.12.25	4.1.0	109	Internal Audit Progress Report Vicky Morris raised concern about the persistent low KPI for management responses, emphasising the need for process improvement if Executive Directors cannot agree on actions or recommendations. She suggested unresolved issues should be escalated to the weekly Executive meeting for co-ordinated resolution. Gareth Jones and Vicky Morris agreed this issue should be included as an advice item in the highlight report to the board, not as an alert. The Committee noted the need for a process to escalate unresolved management responses to the executive team for coordinated resolution, and this will be included as an advice in the highlight report to the board. **Action** Secretariat to include issues with management response rate as advise in the highlighted to the Trust Board.	Secreteriat	03.03.26	Included in highlight report to Trust Board on 29th January 2026	PROPOSE TO CLOSE	

KEY	
CLOSED	ACTION COMPLETE & CLOSED
OPEN	ACTION ON TARGET FOR COMPLETION BY AGREED DATE
OPEN	ACTION AT RISK OF NOT BEING COMPLETED BY AGREED DATE
OPEN	ACTION DATE PASSED – ACTION NOT COMPLETE

OPEN	3
PROPOSE TO CLOSE	10

AUDIT COMMITTEE	
AMaT AUDIT REPORT RECOMMENDATION ACTIONS – FEBRUARY UPDATES	
DATE OF MEETING	3 rd March 2026
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	Niké Hooper-Collins, Business Support Officer
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to Audit Committee on progress against audit report recommendations and identified management actions since the 2nd December '25 Audit Committee. The Committee is asked to discuss the status* of action below: • 12 (13%) actions that are 'in progress' (blue status) • 4 (4%) actions that 'partially complete (not overdue) (orange status) • 10 (11%) actions that are 'partially complete (overdue)' (purple status) • 5 (6%) actions that are overdue (red status) • 1 (1%) actions that have been 'fully complete (awaiting approval)' (light green status) • 57 (64%) actions have been approved and closed (dark green status)

	*Data included was captured via AMaT on 26th February. <table><tr><th>Status</th><th>Count</th><th>Percentage</th></tr><tr><td>In progress</td><td>12</td><td>13%</td></tr><tr><td>Partially complete</td><td>4</td><td>4%</td></tr><tr><td>Partially complete overdue</td><td>10</td><td>11%</td></tr><tr><td>Overdue</td><td>5</td><td>6%</td></tr><tr><td>Awaiting approval</td><td>1</td><td>1%</td></tr><tr><td>Rejected</td><td>0</td><td>0%</td></tr><tr><td>Approved</td><td>57</td><td>64%</td></tr><tr><td>Unable to complete</td><td>0</td><td>0%</td></tr></table>	Status	Count	Percentage	In progress	12	13%	Partially complete	4	4%	Partially complete overdue	10	11%	Overdue	5	6%	Awaiting approval	1	1%	Rejected	0	0%	Approved	57	64%	Unable to complete	0	0%
Status	Count	Percentage																										
In progress	12	13%																										
Partially complete	4	4%																										
Partially complete overdue	10	11%																										
Overdue	5	6%																										
Awaiting approval	1	1%																										
Rejected	0	0%																										
Approved	57	64%																										
Unable to complete	0	0%																										
RECOMMENDATION / ACTIONS	EMB are asked to DISCUSS the contents of the report and the assurance it provides regarding the activities undertaken to address audit actions in response to audit report recommendations and associated risks. The Committee is asked to DISCUSS and ADVISE how to manage requests to re-allocate actions between Executive leads.																											

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
EMB	23.02.2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Director leads were asked to review their overdue actions (Red & Purple) and provide written explanations for why action target dates had not been met and request extension dates to each action for inclusion in the Audit Committee papers for Members consideration. The COO flagged an issue in relation to Assurance – Digital/2025/92 Digital Health & Care Record Draft Internal Audit Report 2024/25 for which there are 3 overdue actions (red) relating to evidence of Implementation of Phase 2 PID and agreed funding for the Phase 2 Project are not within the control of the Trust. These can only be delivered by DH&CW and WG and so are	

actions the Trust is 'Unable to Complete'. The COO asked for advice on how these actions could be handled. It was recommended that the COO speak to the Trust the Trusts Deputy Head of Internal Audit for guidance.

7 LEVELS OF ASSURANCE

The assurance assessment is based on whether the audit action tracking process provides assurance that audit recommendations, agreed management actions and expected outcomes are being realised to remove or mitigate control weakness or risks. The assessment is Level 4, as whilst there is evidence of delivery of the majority of the actions and evidence of achievement of desired outcomes, there remains issues around non delivery of some actions by agreed target dates, which may impact on achievement of desired outcomes.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES

1.	Appendix 1. February updates Red (overdue) & Purple (Partially complete - overdue)
2.	Appendix 2. February updates - Full report – All Actions
3.	Appendix 3. User guidance notes

1. SITUATION

Over the past six months there has been a transition of the monitoring process for implementation of Internal & External Audit Actions to the AMaT system from the Microsoft Excel and manual e-mail system.

2. BACKGROUND

The AMaT system is used to record recommendations from Internal and External Audit and monitor the progress in implementing agreed actions.

To aid forward planning, the following timetable provides the deadlines for updating audit actions on AMaT, and the Committee meetings these updates will be presented at.

AMaT Audit Action Update Month	Deadline for Action Updates	EMB Publication date	EMB Meeting Date	Audit Committee Date
February 2026	12 th February	16 th February	23 rd February	3 rd March

3. ASSESSMENT

Below is a summary of the number of actions and details of the Audit Report overdue actions (red & purple status) can be found at Appendix 1 and all actions for each Audit Report can be found at Appendix 2.

We continue to work closely with colleagues to provide support during this transition phase and welcome any feedback which will help to improve this report in the future. The guidance notes at Appendix 3 provides details of the differences between the coloured statuses and phrases. This document is regularly updated and is distributed each month, when requesting updates.

Inspections are recorded under the following origins:

Internal Audit Actions

Origin	No. of Actions
Internal Audit Assurance – Standard	61
Internal Audit Assurance – Capital	13
Internal Audit Assurance – Digital	5
Internal Audit Advisory – Standard	5
Internal Audit Advisory – Capital	0
Internal Audit Advisory – Digital	0
Total	84

External Audit Actions

Origin	No. of Actions
Audit Wales	5

All 5 Audit Wales actions relating to the Year End Accounts 2023/24 have been completed and approved and closed by the Audit Committee.

All Audit Actions

Origin	No. of Actions
All	89

All Action Status by Prioritisation Timescale

Priority	Total	Overdue	Partially complete (overdue)	Partially Complete	In Progress	Unable to complete	Fully complete (Awaiting approval)	Fully complete (Approved)
Red	5	1						4
Amber	78	3	8	3	11		2	49
Green	7	1	2	1			2	1
Total Actions	89	5	10	4	12	0	1	57
%* Actions	100%	6%	11%	4%	13%	0%	1%	64%

*The total figures above are 1% out, due to the rounding down on the data taken directly from AMaT.

Overdue Actions: Implementation date passed management action not complete

Priority	Overdue	Partially complete (overdue)	Total
Red	1		1
Amber	3	8	11
Green	1	2	3
Total	5	10	15

Actions Status by Executive Lead

Executive Lead	Total	Overdue	Partially complete (Overdue)	Partially Complete	In Progress	Unable to complete	Fully complete (Awaiting approval)	Fully complete (Approved)	Overdue (Red & Purple)
Executive Director of Finance	24				5			18	0%
Interim CEO / Director of Strategic Transformation, Planning & Digital	14		1					13	6.6%
Chief Digital Officer	1		1						6.6%
Director of Governance	13		6					7	40%
Director of Nursing, AHPs & Health Science	10		1	1	2			6	6.6%
Director of Place, Portfolio & Performance	13				5			8	0%
Director of OD and Workforce	1							1	0%
Executive Medical Director	1							1	0%
SRO n VCC / Project Director n VCC	2			1			1		%
Chief Operating Officer	10	5	1	2				3	40%
Total	89	5	10	4	12	0	1	57	100%

Director of Nursing, AHPs & Health Science has stated that actions 2.2 & 2.3 relating to the Quality Dashboard development (Partially Complete – overdue - purple) in VEL-2425 Duty of Quality – Final Internal Audit Report need to be transferred to Carl Taylor / Carl James as Director lead.

2	Dashboard	The reporting is ineffective and lacks openness/ transparency.	Agreed Action:
	'Always on' quality reporting had not been achieved. The development of the Quality Dashboard had been delayed due to competing internal pressures (e.g. high number of urgent priorities and ongoing manpower issues). This was also reflected in the current self-assessment, which was rated at level four on a seven-level assurance scale.		2.1 To complete and fully implement the Trust quality dashboard using agreed measures within the data and insights team. 2.2 Align fully with Always on Reporting. 2.3 Instigate an annual review cycle aligned with new emerging quality & safety risks.
	The work to develop the Quality Dashboard was estimated to require a medium size project with the delivery timeframe of approximately 24 weeks. It had initially linked to the delivery of the automation schedule of the Performance Management Framework (PMF).	Expected Evidence of Implementation: VUHNST Quality Dashboard and Always on Reporting via website	
		Medium Priority	Officer: Head of Data & Insights
	Theme: Performance Monitoring	Control Design	Target Implementation Date: 30 th June 2025

The Director of Governance has 6 partially complete overdue (purple) actions.

6 Purple Actions:

3 actions (Assurance/2024/69/MD1/1 & MD2/1 & MD3/1) were discussed at the GAR meeting is on 19 February 2026 as part of phase 2 work and will be reported through the governance cycle in due course. Extension to completion dates requested.

1 action (Assurance/2025/77/MD6/1): Further work is underway and another meeting to be arranged to review the link of the Board Assurance Framework (BAF) with the strategic objectives. Extension to completion date requested.

1 action (Assurance/2025/77/MD7/1): Divisional risks are reported through the Trust Risk Register papers to committees. Management of SLT risk papers would need to sit with divisional leads. Extension to completion date requested.

1 action (Assurance/2025/77/MD9/1): Discussion took place at QSP regarding deep dives in the BAF. A timetable will be included in the QSP cycle. Extension to completion date requested.

The COO has 5 overdue (Red) actions and 1 partially complete overdue (purple) action.

As set out in the EMB update section of the report the COO flagged an issue in relation to Assurance – Digital/2025/92 Digital Health & Care Record Draft Internal Audit Report 2024/25 for which there are 3 overdue actions (red) relating to evidence of Implementation of Phase 2 PID and agreed funding for the Phase 2 Project are not within the control of the Trust. These can only be delivered by DH&CW and WG and so are actions the Trust is 'Unable to Complete'. Advice to be sought from the Trust Deputy Head of Internal Audit.

The other two overdue actions (Assurance/2024/73) WBS Futures Governance Final Internal Audit Report will be completed as part of the Trust overall Governance Review which will include ToR of EMB & SDC to include specific reference to WBS Futures and review of the Risk Management Policy & Procedures including the draft PPRIM Procedure. Whilst the outcome of the governance review is awaited WBS Futures

management are seeking Trust Board approval for any aspects of the WBS Futures risk management approach that deviates from the Trust's approved Risk Management Policy and Procedure. Extension to completion dates requested.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Audit Committee are asked to **NOTE** the update on all actions below and agree extensions to action completion dates for the 6 overdue actions (Red Status) and 10 Partially Complete overdue actions (Purple Status):

- 12 (13%) actions that are 'in progress' (blue status)
- 4 (4%) actions that 'partially complete (not overdue) (orange status)
- 10 (11%) actions that are 'partially complete (overdue)' (purple status)
- 5 (6%) actions that are overdue (red status)
- 1 (1%) actions that have been 'fully complete (awaiting approval)' (light green status)
- 57 (64%) actions have been approved and closed (dark green status)

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	Internal & External Audit reviews can relate to any of the 10 strategic risks within the BAF
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒

	Efficient ☒ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	Internal and External Audit reviews do not have an adverse / beneficial impact on any individuals with protected characteristics
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Internal & External Audit reviews can relate to any of the Trust risks
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Inspection Title	Inspection Date	Recommendation	Reference Number	Action	Person Responsible	Last Person	Last Date	Original Due Date	Current Due Date	Date Last Updated	Action Rating	Progress Status	Risks	Review	Comments/Updates	Evidence	
Internal Audit Assurance - Capital(2024/21)	10.11.2025	Medium Priority - Procedure review While the Risk & Opportunity Management Procedure was found to be comprehensive and clear in most places, with general compliance confirmed in the sample testing, we have identified some areas (of relatively minor impact) where procedures may require clarification, or reinforcement, to improve compliance with the intended controls. The PMO should review the findings /evidence in this report and determine which would be necessary / beneficial (weighing up the relative costs and benefits) to do so forward. Where the Risk Procedure requires amendment, this should be updated and re-circulated accordingly. Where findings relate to non-compliance with procedures which are deemed to be required, these should be highlighted to the relevant parties and improved compliance supported.	Internal Audit Assurance - Capital(2024/21)/MDU/1	Agreed Action: The PMO will consider all the findings as part of their current review of the Risk & Opportunity Management Procedure. The updated Procedure will be circulated when approved. Expected Evidence of Implementation: Updated Risk Procedure approved by the Project Leadership Team.	Caitin Watts-Allen	Caitin Watts-Allen	08.01.2026	31.01.2026	31.01.2026	13.02.2026	Amber	Fully complete (Awaiting approval)			08.01.26: Added to AMAT 13.02.26: All actions are complete. 2. PMO have considered the findings and updated the procedure document. 2. Updated procedure document was approved at SLT and circulated on 26th November 2025. 3.As above.		
Internal Audit Assurance(2024/61)	Duty of Candour Final Internal Audit Report 2024/25	14.05.2025	Medium priority - Knowledge The duty of candour training completion rate was 65.7% in February 2025 (previously 62.9% in January 2025), significantly below the Welsh Government target rate of 85%. Many incidents were initially recorded in Data with a higher severity classification than was confirmed upon subsequent review. Although a report was available in Data to the guidance, the drop down menu from where the severity was selected was simplified and did not provide the same level of detailed explanation for the categories. We note that the Levels of Harm Framework (phase B) clearly outlines the specific conditions that must be met to trigger the Duty of Candour.	Internal Audit Assurance(2025/61)/MDU/1	Agreed Action: 1. To work in collaboration with Education & Development and identify staff who are non-compliant with Duty of Candour training on ESR, send a notification to prompt evening completion. 1.2 Raise the accountability of the Levels of Harm Framework in the Data OPII menu (Annex B) at the National OPII Data Group. Expected Evidence of Implementation: 1.1 Improved Duty of Candour training compliance data - monitored through Integrated Quality & Safety Group. 1.2 Evidence of discussions of the Level of Harm Framework decisions made at national meeting.	Tina Jenkins	Nicole Willis	24.07.2025	31.07.2025	31.07.2025	03.09.2025	Amber	Fully complete (Approved)			24 July 2025: Added to AMAT 07/09/2025: Communications circulated to improve Duty of Candour training compliance in July 2025 had increased to 72.8% this is just below the mandatory training target of 75% this will continue to be monitored through Integrated Quality and Safety Group monthly. Duty of Candour Training Communication, Training Compliance and email asking to Agencies about the levels of harm framework at national meeting updated. Audit report shared with national meeting. Any changes to Data Entry require a Data for Wales decision. We are unable to make local amendments to the system.	20250603145007_23aaccvparamanact sentracxrgpdsd02025.docx
Internal Audit Assurance(2024/62)	Welsh Blood Service Infrastructure Programme Final Internal Audit Report 2024/25	08.05.2025	Medium priority - Attendance at Programme Board Meetings As noted in the overview, the Programme Board meetings were generally well attended, with the minutes from April to October 2024 reflecting a comprehensive agenda, meaningful discussions, and appropriate approvals. However, it was noted that the meetings to be specific, attendance by several specific roles, as outlined in the Terms of Reference, was required. In three instances, the Assistant Director of Estates was absent. Although no approvals or decisions were noted during these meetings, the absence of adequate representation risks limiting the diversity of perspectives necessary for robust oversight.	Internal Audit Assurance(2025/62)/MDU/1	Due to operational pressures at the time, availability was impacted. However, the meetings held did not involve any approvals or decision-making. That said, the Terms of Reference remain clear, and every effort will be made to ensure continued attendance to fulfil these obligations. Expected Evidence of Implementation: Efforts demonstrating regular attendance at Programme Board meetings by those specific roles outlined as required to be in attendance by the Tuf for the Programme Board.	Sarah Richards	Lauren Fear	25.07.2025	30.09.2025	31.12.2025	16.02.2026	Green	Fully complete (Approved)			We request that the deadline for this action is extended to December 2025 to allow time for the newly implemented attendance approach to embed and demonstrate sustained improvement. Extension request approved at Audit Committee on 2nd Dec. 2025. Due date updated by Nikki Hooper Collins and emailed audit owner.	2025050124337_33meetingnote50800 21.pdf
Internal Audit Assurance(2024/63)	Finance and Service Sustainability Value Based Healthcare Final Internal Audit Report 2024/25	30.05.2025	High priority - Objectives and measurable benefits The three pillars of the programme had clear overarching objectives and purposes, there was a lack of clarity regarding the specific objectives which underpinned the Food Mission Project. Additionally, some of the objectives of the three pillars of the vBHC Programme lacked SMART objectives which meant there was a lack of clarity when it came to measuring the benefits. A documented process for implementing the SST Dashboards was in place, but there is further opportunity to develop KPI reporting which would help with the programme's performance going forward. Recognising that productivity has been compromised due to cross function team working and vacancies, there would be benefit in undertaking a review to determine the potential impact on delivery based on the current performance - and to determine mitigating action as appropriate.	Internal Audit Assurance(2025/63)/MDU/1	Agreed Action: The objectives for each workstream within the vBHC programme will be re-appraised for ability to reference as SMART objectives. Programme level aims may not be directly measurable, however, each sub-project should have KPIs set against them. Assessment of resource within the Value Intelligence Centre including funded provision from the cross functional teams as a gap analysis against the expected requirements of the programme for this financial year to be completed together with the Assistant Director of Digital and Data & Insights. Expected Evidence of Implementation: A revised set of objectives for each workstream KPIs in place and visible (where appropriate) for the SST Dashboard project and other key projects. Completed assessment of resource gap analysis with mitigating actions.	Gwair Evans	Matthew Bunce	25.07.2025	31.10.2025	31.10.2025	24.11.2025	Red	Fully complete (Approved)			25 July 2025: Added to AMAT 08/07/2025: KPIs added to each objective for this financial year for the VC. To be brought to the next steering group meeting 3rd Sept 13/12/2025 All Assurance Management Objectives are tracked via the WBS Futures Dashboard and are "SMART". VC KPIs to align with each objective were approved at the vBHC Steering group, some of these will require development to measure. These are objectives for this current financial year. The SMART framework will be applied to the objectives for the next financial year, where it is possible to do so. Food Mission objectives remain as originally defined.	2025111333408_programmadashboa referwbsfutures.docx
Internal Audit Assurance(2024/71)	Board Assurance & Risk Management Final Internal Audit Report 2024/25	03.03.2025	Medium priority - Alignment with MTPI in the TAF Dashboard presented to the December 2024 Audit Committee, it noted: • TAFDS and TAFDR: Both linked to multiple strategic goals but only referred to MTPI actions for one goal each. • TAFDS and TAFDR: MTPI priority improvement actions had been completed for 2024/25 only. Reporting would be improved if, prior to presenting the TAF Dashboard at meetings, that they checked to ensure all identified strategic risks are aligned with the corresponding operational risks and MTPI actions for related strategic goals.	Internal Audit Assurance(2025/71)/MDU/1	Agreed Action: Management response: 1.121 reviewed the Executive Leads in place since November 2024 to review. 2. New process for incorporating MTPI into TAF and vice versa for 2025-26 to improve reporting. Expected Evidence of Implementation: • TAF 2025-26 report template to incorporate MTPI. • MTPI 2025-26 to reference strategic risks in TAF. • Consolidated approach live from April 2025 via 121 meetings with Risk and Assurance Manager. TAF reported to Executive Management Board, Quality Safety and Performance Committee and Audit Committee prior to Trust Board.	Non Gwynn	Non Gwynn	18.07.2025	01.04.2025	01.04.2025	17.10.2025	Amber	Fully complete (Approved)			April 2025: The TAF paper for Trust Board Cycle May 2025 will be a new template referencing the ten newly agreed strategic risks. The new format will include actions mapped in from the MTPI, all operational risks above the reporting threshold and risk trend data. July 2025: The proposed new format for the TAF was submitted to EMB on 29.05.2025. EMB were in support of the proposed reporting documentation but agreed that further discussion was needed regarding the strategic risks. June 2025: The new TAF format will be submitted to Trust Board in the July cycle following further discussion of the strategic risks at a workshop on 16.06.2025. 18 July 2025: Added to AMAT	20250603145346_sentracxrgpdsd02025.docx
Internal Audit Assurance(2024/69)	Governance, Assurance and Risk Programme Final Internal Audit Report	14.07.2024	Medium priority - Matter Arising - GAR Programme approval (Design) 1.1 Larger service improvement programmes (including those that fall under ROPF) should receive approval at an appropriate forum at the initiation stage.	Internal Audit Assurance(2025/69)/MDU/1	Management Response: 1.1 Future phases of the Governance, Assurance and Risk programme of work will be formally approved at Trust Board, following endorsement by Audit Committee and Executive Management Board. For Phase 2, this to be considered in the Audit Committee and Trust Board in July 2024.	Melanie Fredey	Non Gwynn	17.07.2025	25.03.2025	25.03.2025	08.01.2026	Amber	Partially complete (Ongoing)		The December 2024 Audit Committee agreed to the Extension 25 March 2025 July 2024: No update August 2024: GAR Phase two to be reviewed by EMB mid September for Audit and Trust Board consideration in November 2024. September 2024: Request Extension to 12 December 2024 due to review of GAR Phase 2 Programme incorporating EMB and IM feedback taken by Interim DOCS. Approved Phase 2 to be noted by Trust Board in January 2025. October 2024: No update November 2024: Request Extension to 12 December 2024 due to review of GAR Phase 2 Programme incorporating EMB and IM feedback taken by Interim DOCS. Approved Phase 2 to be noted by Trust Board in January 2025. December 2024: GAR Group Terms of Reference reviewed and approved by Group on 18 November. Tuf clearly states that the reporting lines for GAR Group and programme is EMB and ROPF. ROPF reporting arrangements under review. Propose to review status of action when said reporting lines are confirmed. Request to extend deadline until March Audit Committee to provide time for clarity on ROPF reporting arrangements. January 2025: No update February 2025: GAR reporting arrangements agreed. ROPF reporting arrangements under review. Propose to review status of action when said reporting lines are confirmed. Request to extend deadline until March Audit Committee to provide time for clarity on ROPF reporting arrangements. March 2025: No update April 2025: The next Governance, Assurance and Risk (GAR) meeting is in May 2025. Following the meeting an paper will be sent through the governance cycle following the meeting. May 2025: Review of Phase 1 of GAR undertaken in February March 2025. Updated programme presented to GAR group meeting. New GAR Tuf considered by group at 15 May meeting. Governance rules for GAR programme monitoring confirmed at GAR Group and Audit Committee. 17 July 2025: Added to AMAT 15 August 2025: Following discussion at the GAR meeting in March it was agreed that the TCR would be agreed outside of the meeting. 30 October 2025: An update paper will be going to EMB in October, then to Audit Committee in December 21 November 2025: It was agreed at the GAR meeting in 10 November 2025 to formally close phase one of the GAR programme. Phase 2 is in development. An update paper went to EMB in October and will be going to Audit Committee in December. 01 December 2025: The next GAR meeting will be on 19th February 2026, phase 2 of the work will be discussed at that meeting.	20250603145346_23aaccvparamanact sentracxrgpdsd02025.docx	
Internal Audit Assurance(2024/78)	Duty of Quality Final Internal Audit Report 2024/25	13.05.2025	Medium priority - Measures In total 87 quality and safety measures were assessed for reporting purposes at the HUB level monthly. While the current reporting structure was comprehensive, some redundant controls were noted, including overlap with the Trust's Performance Management Framework reporting to the Board (e.g. 44 measures were the same), as well as the submission of identical reports to multiple forums / groups. The Trust website includes monthly Performance Reports - how We're Doing' since August 2024, the report included seven sub-measures for Welsh Blood Service (WBS) and eight for Velindre Cancer Centre Services (VCS). However, this reporting format did not include consistent metrics, with the exception of the satisfaction score. There was no scoring reported for corporate services, while these services may not have external customers / clients a review should be completed to identify any metrics required. There was also no separation provided regarding how the satisfaction score is calculated or how it relates to the underlying service measures (particularly when at report). service measures include 100%, yet the satisfaction score is below 100%). Furthermore, some of the reports observed during the audit did not reference linkage to 'data of quality'.	Internal Audit Assurance(2025/78)/MDU/1	Agreed Action: 1.1 To work in collaboration with the performance team to ensure streamline consistent reporting across the Trust. 1.2 Remediate Control Failure: From April 2025 all quality & safety integrated reports now have an introductory section including the linkage to the duty of quality. 1.3 To provide an explanation of the % rating for overall percentage compliance for people experience measures, against the national target of 85%. Expected Evidence of Implementation: Revised Fully Integrated Quality & Safety Reports and always on reporting via website.	Tina Jenkins	Tina Jenkins	25.07.2025	01.08.2025	01.08.2025	17.10.2025	Amber	Fully complete (Approved)			May 2025: 1.1 VCS and corporate hub reps met with Peter Gwynn and reporting aligned. 1.2 All quality & safety integrated reports now have an introductory section including the linkage to the duty of quality. 1.3 Agreed that an explanation of the % rating for overall percentage compliance for people experience measures, against the national target of 85%, to be included in all quarterly reports from quarter 2 2025/2026. Also included in email report. 25 July 2025: Added to AMAT	20250603145410_23aaccvparamanact sentracxrgpdsd02025.docx
Internal Audit Assurance(2024/76)	Performance Management Framework (PMF) Final Internal Audit Report 2024/25	25.03.2025	Medium priority - Metrics Reviews The current performance metrics do not subject to a regular, comprehensive review (e.g., at least annually) to ensure their continued relevance, including the evaluation of calculation methods and targets.	Internal Audit Assurance(2025/76)/MDU/1	Management comment: Following completion of the transition from the current 'Teams method' of PMF performance report production to the new '6 automated' method based on April data, the PMF will be presented with the full range of WBS, VCS and Corporate KPIs. This would be the best time for a 'stock take' of the performance metrics to ensure relevance for the coming financial year 2025/26. Agreed Action: • Carry out comprehensive review of VCS, WBS and Corporate KPIs. Expected Evidence of Implementation: • Formal report to EMB, QSP Committee and Trust Board.	Peter Gwynn	Carl James	18.07.2025	29.04.2025	29.04.2025	08.01.2026	Amber	Fully complete (Approved)			April 2025: Currently requesting VCS, WBS Divisional and Corporate Leads to confirm full list of performance measures applicable from April 2025 plus those in development for 2025/26, any changes in calculation methodology and planned reporting date. This will be reported as part of monthly PMF report to EMB QSP and Trust Board. May 2025: A range of 19 new and revised WBS KPIs have been agreed by EMB and QSP Committee and incorporated into regular PMF reports now going to EMB 30 June and QSP Chair 17 July and Trust Board 31 July 2025. Similarly, VCS KPIs have been reviewed with additional KPI measures added, particularly in the Quality and Safety area. This is an on going process to ensure the continued relevance of KPI metrics in our PMF Scorecards so this action completed. 18 July 2025: Added to AMAT. A report in May 2025. This action is completed. 25 November 2025: Peter Gwynn email confirmation	
Internal Audit Assurance(2024/91)	Integrated Radiotherapy Solution (Implementation Phase) Final Internal Audit Report 2024/25	29.06.2025	Completeness of Action Log Implementation Board Action Log activity for Q1 2025 appeared to be low (3 actions across January and February 2025) in relation to the 18 current and future monthly Activities and Deliverables noted across the 4 workstream Highlight Reports for January 2025. Whilst we do not directly correlate, they do indicate a significant level of programme activity, and this may indicate that actions or related discussion at the Implementation Board that could mitigate actions, are not being noted on the Action Log.	Internal Audit Assurance(2025/91)/MDU/1	Agreed Action: Actioned since audit feedback: Actions planned and completed at workstream level at the IIS Business Implementation Group are captured and reflected on Implementation Board plan. Expected Evidence of Implementation: More detail provided at Implementation Board to provide assurance of progress or transparency for any actions which require support / mitigation or intervention.	Gerisela Burris	Gerisela Burris	06.09.2025	30.06.2025	30.06.2025	24.11.2025	Amber	Fully complete (Approved)			06.09.25: Added to AMAT 18/07/2025: Actions agreed at the Board meeting is reflected in the minutes and followed up in the following Board meeting. In addition, there are a number of key actions relating to the contract included in the Escalated Issues Log which are reviewed at each Board meeting to assess progress.	20251124170036_projectsplantracx.pdf, 20251124170206_3implementationboard discussiontracx.pdf, 20251124172138_rvisskingshewember202 3.pdf
Internal Audit Assurance(2024/75)	Energy Management Final Internal Audit Report	05.12.2024	Medium priority - Data Capture Sub-meter analysis 2. Automation of data capture and processing provides the opportunity for improved data analysis. This view is particularly beneficial in better understanding consumption patterns for linear accelerators. Risk & Impact: Management may be inadequate, or mis-informed e.g. positive and negative variances may be offset when reporting, resulting in inefficiencies not being identified or controlled.	Internal Audit Assurance(2025/75)/MDU/1	December 2024: No update January 2025: No update February 2025: Currently employing a Trust Energy Officer to support management of consumption. Interviews: February. BMS Energy contract currently being M4. March 2025: No update April 2025: Energy and Environment Officer now in post. Enhance BMS monitoring in place. May 2025: Energy and Environment Officer now in post. Enhance BMS monitoring in place. Internal energy audits underway. June 2025: Energy and Environment Officer now in post. Enhance BMS monitoring in place. Internal energy audits underway. 18 July 2025: Added to AMAT	Jonathan Fear	Lauren Fear	18.07.2025	30.04.2027	30.04.2027	06.08.2025	Amber	In progress				
Internal Audit Assurance - Digital(2024/92)	Digital Health & Care Record: Draft Internal Audit Report 2024/25	29.07.2025	Reporting We note that the originally approved project closure report was revisited and reopened six months after its formal endorsement. At the time of the feedback the reporting had not yet completed the full governance reporting cycle within the Trust. Furthermore, the latest reporting was slightly out of date. While the closure document reflects a snapshot moment of the project, e.g. when it was closed down, the benefit analysis does not encounter the impact for the last six months since it was first reviewed.	Internal Audit Assurance - Digital(2025/92)/MDU/1	Agreed Action: Complete the governance cycle for the DHCR Phase 1 Project Closure through the Executive Management Board. The DHCR benefits realisation review will be scheduled for Nov '25 which will complete a three-year benefits-review cycle. Expected Evidence of Implementation: • EMB DHCR Closure report • EMB minutes approval of closure • EMB Benefits Realisation 3 year report • EMB minutes noting of benefits.	Anne Carey	Anne Carey	05.09.2025	30.09.2025	30.09.2025	08.01.2026	Amber	Fully complete (Approved)			05.09.25: Added to AMAT The closure report when to EMB. The list of outstanding actions have been prioritised for Phase 2 and are with DHCR. There are on-going discussion with the National Cancer Leadership team regarding what is required as part of Phase 2 with VNNHS7 involvement.	
Internal Audit Assurance - Capital(2024/93)	NVCC Governance Final Internal Audit Report 2024/25	19.08.2025	Updating of key documents Elements of the Project Initiation Document (PID) and Terms of Reference (ToR) required updating to reflect current arrangements. Examples of potential areas for updating included: a. Project Board ToR did not reflect current designated financial authority following approval of the RMC. b. Project Board ToR did not reflect actual practice in terms of standard agenda items. c. Consideration could be given to attendance of the Equipment Workstream lead at Project Board, noting the workstream is currently not represented. d. Workstream ToRs did not contain approval by Project Board. e. Noting recent changes in reporting arrangements to Project Board, Workstream ToRs would also benefit from wider review. f. The PID did not make reference to performance management process / KPI arrangements. (Note, the operation of contract performance management is being separately reviewed at the Management of Adverse Adversity review).	Internal Audit Assurance - Capital(2025/93)/MDU/1	Agreed Action: a. The Project Board ToR will be updated to reflect the points raised and taken back through the project board for approval by November 2025. b. As above c. Consideration has been given to the presence of the equipment lead at the Project Board. The Project Director will invite the equipment lead to meetings only where he/she deems it appropriate. d. Workstream ToR documents will be updated to reflect Project Board approval in November 2025. e. Annual review of Project Board ToR will be undertaken in September 2025. f. PID to be revised to reflect recent changes and taken back through the Project Board in November 2025. Expected Evidence of Implementation: Attach 1. Revised Project Board Terms of Reference (ToR) 2. Revised PID	Caitin Watts-Allen	Caitin Watts-Allen	05.09.2025	30.11.2025	30.11.2025	08.01.2026	Amber	Fully complete (Approved)			05.09.25: Added to AMAT 25.11.25: Revised Project Board Terms of Reference, and Revised PID will be discussed at November Project Board on 26th November. Action can now be closed.	
Internal Audit Assurance(2024/74)	Acute Oncology Service Final Internal Audit Report	06.11.2024	Medium priority - AOS Standard Operating Procedures (Design) 1.1 Timely implementation of the 52/ACU QCC RMP action to review existing AOS policies and SOPs in a timely manner, to include: • Adding expiry / next review dates to all SOPs. • Ensuring SOPs are updated and communicated promptly when new guidance is issued. • Improving SOP availability and searchability on the Trust intranet. • Developing mechanisms to provide and report ongoing assurance over SOP compliance (such as compliance audits, clinical audits, etc) and address findings / share learning. • Due consideration of the findings of the gap analysis against AOs standards (recommendation 1.1).	Internal Audit Assurance(2025/74)/MDU/1	1.1 Recommendation agreed. See AOS Internal Audit Report Action Plan for full details. December 2024: No update January 2025: No update February 2025: No update March 2025: No update April 2025: No update May 2025: No update June 2025: No update July 2025: No update August 2025: No update September 2025: No update October 2025: No update November 2025: No update December 2025: No update January 2026: No update February 2026: No update March 2026: No update April 2026: No update May 2026: No update June 2026: No update July 2026: No update August 2026: No update September 2026: No update October 2026: No update November 2026: No update December 2026: No update January 2027: No update February 2027: No update March 2027: No update April 2027: No update May 2027: No update June 2027: No update July 2027: No update August 2027: No update September 2027: No update October 2027: No update November 2027: No update December 2027: No update January 2028: No update February 2028: No update March 2028: No update April 2028: No update May 2028: No update June 2028: No update July 2028: No update August 2028: No update September 2028: No update October 2028: No update November 2028: No update December 2028: No update January 2029: No update February 2029: No update March 2029: No update April 2029: No update May 2029: No update June 2029: No update July 2029: No update August 2029: No update September 2029: No update October 2029: No update November 2029: No update December 2029: No update January 2030: No update February 2030: No update March 2030: No update April 2030: No update May 2030: No update June 2030: No update July 2030: No update August 2030: No update September 2030: No update October 2030: No update November 2030: No update December 2030: No update January 2031: No update February 2031: No update March 2031: No update April 2031: No update May 2031: No update June 2031: No update July 2031: No update August 2031: No update September 2031: No update October 2031: No update November 2031: No update December 2031: No update January 2032: No update February 2032: No update March 2032: No update April 2032: No update May 2032: No update June 2032: No update July 2032: No update August 2032: No update September 2032: No update October 2032: No update November 2032: No update December 2032: No update January 2033: No update February 2033: No update March 2033: No update April 2033: No update May 2033: No update June 2033: No update July 2033: No update August 2033: No update September 2033: No update October 2033: No update November 2033: No update December 2033: No update January 2034: No update February 2034: No update March 2034: No update April 2034: No update May 2034: No update June 2034: No update July 2034: No update August 2034: No update September 2034: No update October 2034: No update November 2034: No update December 2034: No update January 2035: No update February 2035: No update March 2035: No update April 2035: No update May 2035: No update June 2035: No update July 2035: No update August 2035: No update September 2035: No update October 2035: No update November 2035: No update December 2035: No update January 2036: No update February 2036: No update March 2036: No update April 2036: No update May 2036: No update June 2036: No update July 2036: No update August 2036: No update September 2036: No update October 2036: No update November 2036: No update December 2036: No update January 2037: No update February 2037: No update March 2037: No update April 2037: No update May 2037: No update June 2037: No update July 2037: No update August 2037: No update September 2037: No update October 2037: No update November 2037: No update December 2037: No update January 2038: No update February 2038: No update March 2038: No update April 2038: No update May 2038: No update June 2038: No update July 2038: No update August 2038: No update September 2038: No update October 2038: No update November 2038: No update December 2038: No update January 2039: No update February 2039: No update March 2039: No update April 2039: No update May 2039: No update June 2039: No update July 2039: No update August 2039: No update September 2039: No update October 2039: No update November 2039: No update December 2039: No update January 2040: No update February 2040: No update March 2040: No update April 2040: No update May 2040: No update June 2040: No update July 2040: No update August 2040: No update September 2040: No update October 2040: No update November 2040: No update December 2040: No update January 2041: No update February 2041: No update March 2041: No update April 2041: No update May 2041: No update June 2041: No update July 2041: No update August 2041: No update September 2041: No update October 2041: No update November 2041: No update December 2041: No update January 2042: No update February 2042: No update March 2042: No update April 2042: No update May 2042: No update June 2042: No update July 2042: No update August 2042: No update September 2042: No update October 2042: No update November 2042: No update December 2042: No update January 2043: No update February 2043: No update March 2043: No update April 2043: No update May 2043: No update June 2043: No update July 2043: No update August 2043: No update September 2043: No update October 2043: No update November 2043: No update December 2043: No update January 2044: No update February 2044: No update March 2044: No update April 2044: No update May 2044: No update June 2044: No update July 2044: No update August 2044: No update September 2044: No update October 2044: No update November 2044: No update December 2044: No update January 2045: No update February 2045: No update March 2045: No update April 2045: No update May 2045: No update June 2045: No update July 2045: No update August 2045: No update September 2045: No update October 2045: No update November 2045: No update December 2045: No update January 2046: No update February 2046: No update March 2046: No update April 2046: No update May 2046: No update June 2046: No update July 2046: No update August 2046: No update September 2046: No update October 2046: No update November 2046: No update December 2046: No update January 2047: No update February 2047: No update March 2047: No update April 2047: No update May 2047: No update June 2047: No update July 2047: No update August 2047: No update September 2047: No update October 2047: No update November 2047: No update December 2047: No update January 2048: No update February 2048: No update March 2048: No update April 2048: No update May 2048: No update June 2048: No update July 2048: No update August 2048: No update September 2048: No update October 2048: No update November 2048: No update December 2048: No update January 2049: No update February 2049: No update March 2049: No update April 2049: No update May 2049: No update June 2049: No update July 2049: No update August 2049: No update September 2049: No update October 2049: No update November 2049: No update December 2049: No update January 2050: No update February 2050: No update March 2050: No update April 2050: No update May 2050: No update June 2050: No update July 2050: No update August 2050: No update September 2050: No update October 2050: No update November 2050: No update December 2050: No update January 2051: No update February 2051: No update March 2051: No update April 2051: No update May 2051: No update June 2051: No update July 2051: No update August 2051: No update September 2051: No update October 2051: No update November 2051: No update December 2051: No update January 2052: No update February 2052: No update March 2052: No update April 2052: No update May 2052: No update June 2052: No update July 2052: No update August 2052: No update September 2052: No update October 2052: No update November 2052: No update December 2052: No update January 2053: No update February 2053: No update March 2053: No update April 2053: No update May 2053: No update June 2053: No update July 2053: No update August 2053: No update September 2053: No update October 2053: No update November 2053: No update December 2053: No update January 2054: No update February 2054: No update March 2054: No update April 2054: No update May 2054: No update June 2054: No update July 2054: No update August 2054: No update September 2054: No update October 2054: No update November 2054: No update December 2054: No update January 2055: No update February 2055: No update March 2055: No update April 2055: No update May 2055: No update June 2055: No update July 2055: No update August 2055: No update September 2055: No update October 2055: No update November 2055: No update December 2055: No update January 2056: No update February 2056: No update March 2056: No update April 2056: No update May 2056: No update June 2056: No update July 2056: No update August 2056: No update September 2056: No update October 2056: No update November 2056: No update December 2056: No update January 2057: No update February 2057: No update March 2057: No update April 2057: No update May 2057: No update June 2057: No update July 2057: No update August 2057: No update September 2057: No update October 2057: No update November 2057: No update December 2057: No update January 2058: No update February 2058: No update March 2058: No update April 2058: No update May 2058: No update June 2058: No update July 2058: No update August 2058: No update September 2058: No update October 2058: No update November 2058: No update December 2058: No update January 2059: No update February 2059: No update March 2059: No												

Internal Audit - Assurance(2024/7)	Financial and Service Sustainability: Budgetary Control and Savings Plans	10.07.2024	Medium priority - Matter Arising 1: Savings plans – implementation plans and monitoring (operations). 1.1 Progress for the delivery of savings plans should include SMART actions to implement the plans. The responsible leads for savings plans should receive timely written reports on savings delivery, including progress on implementing supporting actions.	Internal Audit- Assurance(2024/7)/MD2/1 Assurance(2024/7)/MD2/1	1.1 The overall savings plan will continue to be reported at a Trust level via the Trust Board report and via the Finance and Investment Enhanced Monitoring presented to EMB. Discretionary savings will be reported via the month and report and / or dashboards which will include progress and supporting actions if required. SMART actions will be used during the development of next year's savings plan alongside the MTFF.	Matthew Bunce Matthew Bunce	18.07.2025	31.03.2025	11.03.2025	17.10.2025	Amber	Fully complete (Approved)		July 2024: On target to be achieved by the target date. Trust savings continue to reported monthly via the Trust Board and Finance and Investment Enhanced Monitoring presented to EMB. Discretionary savings are on target, reported via the month and report and / or dashboards which will include progress and supporting actions if required. SMART actions should then be required will be used during the development of next year's savings plan alongside the MTFF. August 2024: First action is completed. The Trust savings plan for 2024-25 is live and will continue to be monitored reported via the Trust Board Report and Finance and Investment Enhanced Monitoring presented to EMB. Discretionary savings are currently on target and will be reported via the month and report and / or dashboards which will include progress and supporting actions if required. SMART actions should then be required will be used during the development of next year's savings plan alongside the MTFF. September 2024: Ongoing challenges will need to be overcome in order to meet the need to deliver SMART action plans in readiness for the development of the 25/26 MTFF savings plan. October 2024: Delivery programme to develop SMART action plans in readiness for the 2025/26 MTFF savings plan. November 2024: Divisions to use SMART action plans as part of the 2025/26 MTFF saving plan development. December 2024: The MTFF process for 2025-26 is underway with the savings plan development expected to be in line with the release of the Financial Planning assumption to be released from WBS on the 20th December. January 2025: No update. February 2025: 2025-26 VCS savings planning nearing completion. SLT leads have been assigned to each saving and they will be responsible for the completion of SMART action plans. These should be finalised by end Feb. 2025 so WBS savings planning meeting completion with SMART actions plans being developed by SLT to be finalised by end Feb. March 2025: No update. April 2025: SLT leads assigned to each saving across VCS and RBH. Development of plans currently underway, however, given intricacies within VCS, deadline extended until end of April 2025. May 2025: SMART action plans have been developed for all savings to demonstrate how they are to be implemented. These plans will continue to be monitored as part of the month and report and dashboard which will include progress against target. Where deviation from plan is anticipated corrective action will be required. June 2025: SMART action plans complete - June 2025. These will continue to be subject to ongoing monitoring. 18 July 2025: Added to AMAI	202509145312_12awpaperparameters centricupdate02025.docx
Internal Audit - Assurance(2024/7)	Medicines Management Final Internal Audit Report	17.09.2024	Low priority - Matter Arising 2: SOPs – competency requirements and legislation (Design) 2.1 Medicines management SOPs should include competency requirements and the relevant legislation the SOP addresses / is governed by.	Internal Audit Assurance(2024/7)/MD2/1 Assurance(2024/7)/MD2/1	1.1 SOPs will be reviewed and updated as part of the Q pulse implementation project work for the Directorate as part of the VCC wide Q pulse implementation project. Timeline reflects dependence of VCC Pharmacy on VCC wide Q pulse project plans.	Anthony Cadejan Jasinta Abraham	17.07.2025	01.10.2025	01.10.2025	01.10.2025	Green	Fully complete (Approved)		September 2024: Q pulse project remains on track to deliver Phase 1 in November 2024 (most recent highlight report August 2024). SOP templates will be delivered as part of this phase. October 2024: No update. November 2024: Remains on track. Standard SOP format issued by project group. Access to software for Pharmacy is imminent. December 2024: Whilst there are delays in the Q pulse project for VCS impacting the transition to QMS, the Medicines Management actions are on track for delivery by the target date. January 2025: No update. February 2025: Medicines management actions remain on target. March 2025 update will include progress KPIs. March 2025: No update. April 2025: Out of the 330 SOPs for Pharmacy and Medicines Management 32% are in progress of being reviewed, updated and transferred across to the new template. Business Support Manager is working with the Leads of each service to progress this work to ensure compliance with the timescales, which remain on target for completion by October 2025. May 2025: Following review and update of SOPs are part of the review an additional 20 SOP's in the Homecare and Procurement Service have been identified. Increasing the overall total to 250 SOP's across Pharmacy and Medicines Management. 35% are current in the process of being reviewed and pending sign off via the agreed governance route. An increase of 3 %. With 50% of the overall 250 SOPs transferred on to the new template in readiness for Q pulse implementation. 12% of the SOP's are fully completed. June 2025: Accounting for additional SOPs identified, as of 11 June 2025 of the SOP's, are current in the process of being reviewed and pending sign off via the agreed governance route which 4% increase on the position at the end of May 2025. 15% of the SOPs finalised and ready for uploading to Q pulse. Given the focus on this project within the Pharmacy remit we are confident of seeing significant progress over the next 2 months and remain on target for delivery to the deadline. 17 July 2025: Added to AMAI 30 Sept 2025: Confirmation has been received by all clinical sub-sections that all SOPs have been updated and are in the format required for uploading onto Q pulse. Q pulse roll out at VCS has been delayed, however as all SOPs are ready to be uploaded, the action is now closed.	
Audit Wales(2023/94	Audit of Accounts Report Addendum- Velindre University NHS Trust 2024-25	11.08.2025	Matter arising 1 – There was some non-compliance with the Welsh Governance's guidance on interim senior officer appointments (Implementation Phase) Final Internal Audit Report 2024/25	Audit Wales(2023/94)/MD2/2	The process in relation to application of the requirements set out in WHC/2024-033 for all senior appointments has been clarified with Welsh Government. The Director and Deputy Director of Workforce and CIO are fully updated and are applying these requirements for impacted posts in 23/26.	Sarah Morley Sarah Morley	21.09.2025	01.09.2025	01.09.2025	19.10.2025	Red	Fully complete (Approved)		21.09.25: Added to AMAI Fully implemented when report was received - This recommendation has been complied with when making subsequent interim appointments	2025020115702_au02walesaddendum afhwalesdatamattersreport.pdf
Internal Audit - Assurance(2024/9)	Integrated Radiotherapy Solution (Implementation Phase) Final Internal Audit Report 2024/25	29.06.2025	Key Activities and Deliverables not Prioritised by Risk Level Key Activities and Deliverables on the workstream highlight Reports were not ordered or prioritised in relation to associated risk level. It was however acknowledged that improvement to the design and inclusion of key risks had been added to recent reports for presentation in April 2025.	Internal Audit Assurance(2024/9)/MD2/1	Agreed Action: Allocated joint audit feedback - Maintain risk reporting implemented April 2025 with additional risk focus. Monthly liaison with project managers ensure risks / deliverables are allocated in priority order on highlight reports. Complete Evidence of Implementation: New Workstream Highlight Reports show key risks and prioritisation.	Daniela Burris Daniela Burris	05.09.2025	30.06.2025	30.06.2025	24.11.2025	Amber	Fully complete (Approved)		05.09.25: Added to AMAI 24/11/25 - Evidence provided by Daniela Burris (Digital Programme Manager) and Rachael Hennessy and authorisation to close action - Evidence uploaded of Radiation Services Highlight Report Nov 2025	20251124178151_programmehighlightreportreferencetofuture.pdf
Internal Audit Assurance – Capital(2023/93)	WVCC Governance Final Internal Audit Report 2024/25	19.08.2025	Embedding of new processes The Trust has closed out the recommendations made within the PWC Governance and Capabilities review, in line with the timeline agreed with WBS of year end and March 2025. However, whilst this had achieved the delivery of the products developed by the external consultants, training to support the transfer of skills was ongoing, and the products were not yet fully applied or embedded into the business-as-usual processes of the project. The project now needs to focus on the embedding of the PWC recommended actions into business as usual, ensuring processes are in place for further development/improvement where necessary. The IRG has requested that audit activity	Internal Audit Assurance – Capital(2023/93)/MD2/1	Agreed Action: The recruitment into the new Project Control roles concluded in May 2025. PwC completed an assurance assessment of their report recommendations on behalf of VUNWST Chief Executive Officer. The assessment confirmed: Evidence provided for the assurance assessment demonstrated that all enablers, to address the PwC recommendation, were in place. The project team are in the process of embedding the new ways of working, fully supported by key advisors Currie & Brown and Corbridge & Theobald. The embedding cycle process will be tested by follow up Audit. Expected Evidence of Implementation: 1. Project Handbook 2. Risk & Issues Strategy 3. Consulting Framework 4. Any coaching guides (in progress) 5. Training & Development Pathways for controls team. 6. Project Controls team engagement 7. Future Internal Audit assessment	Catrin Watts-Alton Catrin Watts-Alton	05.09.2025	31.03.2026	31.03.2026	13.02.2026	Amber	Partially complete		05.09.25: Added to AMAI 13.02.26: Update as below: •Project Handbook – in place •Risk & Issues Strategy – in place •Competency Framework – in place (produced by GAT) •Any coaching guides (in progress) – awaiting Phase B sign off •Training & Development Pathways for controls team – in place •Project Controls team engagement – in place •Future Internal Audit assessment – in progress, to include Governance, Risk & Issues & Scheduling to date. Change Control expected March 2026	
Internal Audit - Assurance(2024/78	Duty of Quality Final Internal Audit Report 2024/25	11.05.2025	Medium priority - Dashboard Always of quality reporting had not been achieved. The development of the Quality Dashboard had been delayed due to competing internal pressures (e.g. high number of urgent priorities and ongoing manpower issues). This was also reflected in the current self-assessment, which was rated at level four on a seven-level assurance scale. The work to develop the Quality Dashboard was estimated to require a medium size project with the delivery timeframe of approximately 24 weeks. It had initially linked to the delivery of the automation schedule of the Performance Management Framework (PMF).	Internal Audit Assurance(2024/78)/MD2/1	Agreed Action: 2.1 To complete and fully reporting the Trust quality dashboard using agreed measures within the data and insights team. 2.2 Align fully with Always on Reporting. 2.3 To integrate an annual review cycle aligned with new emerging quality & safety risks. Expected Evidence of Implementation: VUNWST Quality Dashboard and Always on Reporting via website	Kate Mackenzie Nicola Wella	26.07.2025	30.06.2025	30.06.2025	16.10.2025	Amber	Partially complete (Overdue)		May 2025: No update 25 July 2025: Added to AMAI 09/10/25: update requested 26 Oct 2025: Update MAMC, Action 2 - responsible person is Kate Mackenzie. Actions 2.1 & 2.2 are responsible person for Tina Jenkins. Update: 21 Sep CEO & Exec Nurse Director agreed process for developing dashboard, prioritising mortality and PROMs metrics. Plan for development being prepared	
Audit Wales(2023/94	Audit of Accounts Report Addendum- Velindre University NHS Trust 2024-25	11.08.2025	Matter arising 2 – There were an excessive number of misstatements included in the Draft Remuneration Report presented for audit. As noted in our audit plan and audit of accounts report the remuneration report is considered material by nature by us and so we have a much lower materiality threshold in regard to the disclosure rate. In common with our previous year's audit, we found a significant number of errors and omissions made in the draft remuneration report. These errors and omissions relate to: • Changes in rates not being disclosed; • Dates of rate changes incorrectly stated; • Staff being disclosed in the wrong salary bands; and • One officer's salary being oversteered due to an overpayment of salary being included without there being any reference to the occurrence of an overpayment. Most of the errors we consider have occurred due to Finance either having sufficient sight of the decisions made by the Remuneration Committee or enough information being provided by Human Resources.	Audit Wales(2023/94)/MD2/1	Last year we recommended that liaison is improved between Finance and Human Resources. Although we have been informed that there has been closer working between Finance and Human Resources, there is still room for improvement, we therefore recommend that this is further strengthened with consideration being given to provide the officer preparing the Remuneration Report with access to the Remuneration Committee papers and minutes. This should reduce the number of errors and omissions which should reduce the amount of time it takes to audit the Remuneration Report in future years. Management response: The Head of Financial Operations has met with both the Director and Deputy Director of Workforce & CIO to discuss this audit finding and have agreed the following: The Director/Deputy Director of Workforce & CIO and the Head of Financial Operations will meet regularly throughout the year to discuss the requirements of the Remuneration Report and to ensure accuracy of reporting. The Director/ Deputy Director of Workforce & CIO will play these Remuneration Committee papers and reviews with the Head of Financial Operations, where applicable to the Remuneration Reports. The Assistant Director of Estates will arrange to meet with the Assistant Director of Social Capital/AID to discuss an audit programme and associated costs for inclusion with the next OBC/PRC. Expected Evidence of Implementation: MAP included with OBC/PRC	Tacey Hughes Tacey Hughes	23.09.2025	23.09.2025	23.09.2025	19.10.2025	Red	Fully complete (Approved)		23.09.25: Added to AMAI Fully implemented or report received	20250913105322_au02walesaddendum afhwalesdatamattersreport.pdf
Internal Audit - Assurance(2023/82	Welsh Blood Service Infrastructure Programme Final Internal Audit Report 2024/25	08.05.2025	Medium priority - Inclusion of Integrated Audit within combined OBC/PRC Noting WBS are now in the process of preparing a combined OBC/PRC, consideration should be given to the development and inclusion of an Integrated Assurance Agreement Plan (IAP).	Internal Audit Assurance(2025/82)/MD2/1	Agreed Action: 2.1 To develop the current learning from events process to ensure that all staff involved in a Duty of Candour investigation are provided an opportunity for feedback and learning. Expected Evidence of Implementation: 2.1 Evidence of post-learning event reports and meeting notes of follow up to make it safe meetings.	Jonathan Fear Learan Fear	21.07.2025	30.03.2026	30.03.2026	06.08.2025	Amber	In progress		25 July 2025: Added to AMAI	
Internal Audit - Assurance(2024/9)	Duty of Candour Final Internal Audit Report 2024/25	14.05.2025	Medium priority - Information sharing Inter-organisational communication typically occurs during the initial information gathering and investigation phases to establish responsibilities. However, once the Duty of Candour was triggered and responsibilities were identified, further communication with the involved parties did not routinely carry on in practice. In cases where responsibilities related with the Trust, the internal procedures were completed, and the case was subsequently closed off within the incident reporting system. The planned and implemented actions were not consistently communicated to the parties involved.	Internal Audit Assurance(2024/9)/MD2/1	Agreed Action: 2.1 To develop the current learning from events process to ensure that all staff involved in a Duty of Candour investigation are provided an opportunity for feedback and learning. Expected Evidence of Implementation: 2.1 Evidence of post-learning event reports and meeting notes of follow up to make it safe meetings.	Chris Kelly Nicola Wella	24.07.2025	30.09.2025	31.03.2026	18.02.2026	Amber	In progress		24 July 2025: Added to AMAI 07/08/2025: Email sent to Quality and Safety Teams in Corporate and VCS to discuss further. 30/09/2025 Wales & Safe meetings are held following every DoC incident or potential DoC incident with all staff involved contributing to the meeting. Further work is being considered in line with new learning framework, of these past investigation learning is shared. 20/11/2026: Date changed as agreed with Tina Jenkins, action sent to VCS to consider as part of the Quality & Safety Review. Plan to be agreed. 18/02/2026: Chris Kelly understanding wider work on the Learning Framework, this is included in this work	
Internal Audit - Assurance(2023/93)	Finance and Service Sustainability: Value Based Healthcare Final Internal Audit Report 2024/25	10.05.2025	Medium priority - Reporting and escalation There was opportunity to streamline the reporting process to reduce duplication of papers to the multiple forums, ensuring reports are tailored to the specific requirements/ focus of the forum.	Internal Audit Assurance(2024/9)/MD2/1	Agreed Action: Review the current reporting schedule for both committees, if it aligns then discuss arrangements with the Head of Governance and Chair of the relevant committees, to consider whether the same updates can be provided to VSC and to GSP for the purposes of reducing duplication. The reports go to the different committees for different reasons, the GSP report and SCD reports have a different area of focus which will become more clear as the programme evolves. Expected Evidence of Implementation: Evidence of efforts to align reporting data	Gwael Evans Matthew Bunce	25.07.2025	30.09.2025	30.09.2025	19.10.2025	Amber	Fully complete (Approved)		25 July 2025: Added to AMAI 19/10/25: Request sent to key Barrow a Corporate Governance Manager to align the cycle of business such that reports go to both committees at the same time on a twice annual basis. Scope for the content of the reports to differ where appropriate due to the different remit of each committee. Key is in agreement with this request. Most recent submissions did align and were issued during the same month.	20251019494811_corporategovernance overview02024.docx, 20251019494811_valuereport02024.docx
Internal Audit - Assurance(2024/6)	Governance, Assurance and Risk Programme Final Internal Audit Report 2024/25	14.07.2024	Medium priority - Matter Arising 4: Measuring Programme objective achievement (operation). 4.1 The identified existing mechanisms (paragraph 3.1.3) should be used to provide an indication of Programme objective achievement, which should then be reported to the Audit Committee.	Internal Audit Assurance(2024/6)/MD2/1	4.1 In line with start of dashboard reporting, as per action 3.1 above, this will include an assessment of objective achievement to data, using mechanisms which are already in place (as per paragraph 3.1.3)	Melanie Frenday Non Gwilym	17.07.2025	25.03.2025	25.03.2025	09.10.2026	Amber	Partially complete (Overdue)		The December 2024 Audit Committee agreed to the Extension 25 March 2025 July 2024: No update August 2024: This will be delivered as part of Phase 2 of the GAR programme. September 2024: No update October 2024: No update November 2024: Request Extended to 12 December 2024 due to review of GAR Phase 2 Programme incorporating OMB and BM feedback taken by Interim DOCCS. Approved Phase 2 to be noted by Trust Board in January 2025. December 2024: GAR Group currently understanding a review of completed actions of Phase 1 of programme. Additional actions identified. Consolidated programme to be discussed at next GAR Group meeting on 30 January and will include a mechanism to ensure programme objective achievement. Proposal also shared with Audit Committee reviews a paper to outline progress against action, following January 2025 meeting. January 2025: No update February 2025: Review of Phase 1 continuing with GAR project team and Independent Members. Additional actions from internal audit, committees and other areas are being mapped onto the GAR Project and will be taken forward into Phase 2. Monthly GAR meetings continue with a new focus on objectives and outputs. March 2025: No update April 2025: Following the next GAR meeting in May 2025 the dashboard and update of objective achievement will be shared the governance cycle, including Audit Committee. May 2025: Reporting achievement against refreshed GAR programme now included in the new template. Governance route confirmed as described in 1.1. 17 July 2025: Added to AMAI 15 August 2025: Regular monitoring of the GAR programme progress is carried out and updated. 30 October 2025: The next GAR meeting is on 05.11.2025 when progress will reviewed, then reported through the governance cycle. 21 November 2025: The GAR meeting held on 10.11.2025 (original date of the meeting was 05.11.2025) discussed phase one of the programme and agreed to formally close the phase. Phase one is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 09 January 2026: the next GAR meeting is on 19 February 2026, phase 2 will be discussed at the meeting and reported through the governance cycle in due course.	
Internal Audit - Assurance(2024/7)	WBS Future Governance Final Internal Audit Report	06.11.2024	Medium priority - Future Alignment of WBS Future Programme (Design) 3.1 incorporate mechanisms in the WBS future change management process to maintain alignment between the WBS future programme and the WBS 5 Year Strategy and MTFF Action Plan. This could include oversight/endorsement of the changes by the FIG and Delivery Board prior to formal approval through the existing WBS project approval mechanisms.	Internal Audit Assurance(2024/7)/MD2/1 Assurance(2024/7)/MD2/1	1.1 Implement an oversight mechanism in the WBS future change management process that ensures FIG oversight and Delivery Board endorsement of any changes to ensure they align with the WBS 5 Year Strategy and MTFF Action Plan before they become formal mechanisms. This includes: 1. Defining Oversight Roles – clearly outlining responsibilities of the FIG and Delivery Board in reviewing and endorsing changes completed as part of the Task review. 2. Establish Review Procedures – develop a standardised process for submitting changes to FIG & Delivery Board for review. 3. Alignment Checks – implement a process to ensure all proposed changes align with WBS 5 Year Strategy and MTFF Action Plan. Documentation strengthened to ensure this alignment as part of the change submission.	Sarah Richards Anne Carey	18.07.2025	31.03.2025	31.03.2025	03.09.2025	Amber	Fully complete (Approved)		December 2024: No update January 2025: No update February 2025: 1. Define Oversight Roles – clearly outlining responsibilities of the FIG and Delivery Board in reviewing and endorsing changes (completed as part of the Task review). 2. Establish Review Procedures – development of a standardised change management process is well underway and final proposal to be shared with Delivery Board in March 2025. 3. Alignment Checks – development of a framework to ensure all proposed changes align with WBS 5 Year Strategy and MTFF Action Plan is underway and will be shared with Delivery Board in March 2025. March: No update April 2025: 1. Complete 2. Establish Review Procedures – development of a standardised change management process is nearing completion and final proposal to be shared with Delivery Board at meeting in May 2025. 3. Alignment Checks – development of a framework to ensure all proposed changes align with WBS 5 Year Strategy and MTFF Action Plan is nearing completion and will be shared with Delivery Board at meeting in May 2025. May 2025: 1. Complete 2. Establish Review Procedures – The May meeting of the Delivery Board was cancelled due to scheduling conflicts. The final change management proposal will now be presented at the June 2025 Delivery Board meeting. 3. Alignment Checks – The May meeting of the Delivery Board was cancelled due to scheduling conflicts. The framework for alignment with WBS Future & MTFF will now be presented at the June 2025 Delivery Board meeting. June 2025: No update July 2025: Added to AMAI 18 July 2025: The Change Management proposal, approved at the June 2025 Delivery Board meeting, has now been successfully implemented. This ensures robust oversight of change activity and alignment of all proposed changes with the Welsh Blood Service's 5-Year Strategy and MTFF Action Plan.	202509144047_12awpaperparameters centricupdate02025.docx
Internal Audit - Assurance(2024/74	Acute Oncology Service Final Internal Audit Report	06.11.2024	Medium priority - Implementation of the ACS Improvement Project Recommendations (Operation) 2.1 Timely development and delivery of • The planned ACS core team business case following the Trust's governance processes for review and approval. • An ACS improvement Implementation Plan, including SMART actions, clear timelines and responsible individuals, with progress reporting to the Integrated Care Operational Group. The seven levels of assurance should be applied to the progress reports. • Clear, measurable targets to ensure realisation of the ACS improvement programme benefits, with regular progress reporting to an appropriate forum.	Internal Audit Assurance(2024/74)/MD2/1	2.1 Recommendation agreed. See ACS Internal Audit Report Action Plan for full details. ACS Action Plan: 2.1 Develop ACS business case and Improvement Plan and identify measurable benefits. • Ahead improvement project recommendations and prioritise with ACS team senior nursing team accounting for areas of priority reporting to the Integrated Care Operational Group. The seven levels of assurance should be applied to the progress reports. • Develop a Business Case that outlines the costs and benefits for introducing a ACS operational team - in order to take forward the long-term programme of recommendations that will continue to develop the ACP workstream within ACS and the ACP roles within the services that support the delivery of the ACS patient pathway e.g. within SACT, palliative care and Radiotherapy ensuring correct governance structures are in place, after the phased delivery of the recommendations listed within the report is in line with the short/medium and long-term priorities. Progress the recommendations to ensure that they meet the service specifications and recommendations of the Welsh Cancer Network/ Royal College of Physicians reports. • Review the proposed ACS ACS SMO model and realise the associated benefits; align the ongoing work in the region with developments at VCC ensuring 'one line of sight' for equitable patient care; continue the relationship with the Velindre Oncology Academy to enhance and the skill set of core ACS teams; continue to scope the feasibility and opportunities to enhance acute patient pathways with LRBs and primary care; develop the ongoing activities of the previous Safe Care Collaborative (SCC) projects namely SACT Treatment Helpline and Molecular Social Care Commission (MSCC). • Enhance assurance at executive level, through the correct reporting channels that the ACS service model is safe, equitable and compliant. • Redefine the current ACS Working Group membership and Terms of Reference into an ACS Site Specific Team (SST) that reports to the regional ACS Board and VCC Senior Leadership Team. • Develop a suite of ACS QPIs underpinned by robust metrics that reports through the Trust Performance Management Framework and aligns with the regional/ National/ Cancer Data Standards for Wales & ACS. • Work with the regional ACS Operational Manager, working collaboratively to improve and optimise regional acute oncology patient	Ceri Stubbs Ceri Stubbs	18.07.2025	31.03.2025	03.03.2026	12.02.2026	Amber	Partially complete		Organisational restructuring impacting on achieving actions in January 2025: No update February 2025: 2.1.8.2.2 Not yet set for completion yet do form overarching action, however some of the included action points under 2.1.8.2.2 are being progressed such as : running ACP working group to ensure the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned with business support for SST leads in April 2025. 2.4. Core QPI and KPIs against the ACS service specification and SEW regional business case have been agreed by SEW programme board in December 2024. This work was supported by the operational manager and Business Analyst for the regional ACS programme (based on VCC digital services). LRBs have started to report this related suite of KPIs from January 2025. An VCC white case OPIs/KPIs will be recorded and reported in line with LRBs. Differences in service configuration mean that further work is required to standardise data and this work is being worked on and will be discussed at the next meeting of the GAR group. The update will be reported through the governance cycle. 2.1.8.1: Still approved the ACS SST SST had appointed from January 2025, TOR have been drafted for review first meeting to be planned	

Internal Audit Advisory – Standard/2023/80	Contract Management Final Advisory Report 2024/25	24.06.2025	Objective 1: There is a clear framework of policies, procedures and processes for contract management, with roles and responsibilities clearly defined. The Trust's Standing Financial Instructions (SFI) includes a section on contract management, section 11.16.1 outlines that the relevant budget holder is responsible for overseeing and managing each contract on behalf of the Trust to ensure that implicit obligations are met. This includes: • Maintaining accurate records; • Monitoring contract performance measures; • Engaging suppliers to ensure performance delivery; • Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and • Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder. In addition to the above, there is an All Wales Procurement e-manual, which contains contract management guidance, available via the Trust 'Oracle' system home page. In discussion with staff, this document is not a regular point of reference. However, even combined, these documents do not provide good coverage of the main elements of a contract management model and leave many aspects unaddressed. Currently the Trust does not have policies and procedures that describe the contract management model that contract managers are to use. Toward that aim, we were advised that one of the Trust's key contracts is being managed using a model designed around the processes set out in the SFI, Standing Order (SO) and additionally the NAO Good Practice Contract Management Framework. There is an intention that going forward this will be adopted as the Trust's contract management model.	Internal Audit Advisory – Standard/2025/80/201/1	Management Consideration 1: Standing operating procedure for Trust-wide contract management The Trust should develop a standing operating procedure to detail the expectations, responsibilities, accountabilities and processes to be followed by personnel charged with contract management and based on current best practice.	Mark Muller	Mark Muller	24.07.2025	02.07.2025	11.03.2026	08.10.2025	Amber	In progress			Update 01.10.25: Following a review of the advisory actions, we are implementing a collaborative working group with colleagues across the Trust to ensure we deliver an efficient and effective response on all five actions, with processes developed as required. MB has requested guidance and expertise from Shared Services and we will then aim to develop a timetable during this financial year to successfully deliver our outputs accordingly.	
Internal Audit Advisory – Standard/2023/80	Contract Management Final Advisory Report 2024/25	24.06.2025	Objective 2: Contract registers are used as the basis for effective contract management and procurement planning. A contract register is important as it provides: • Contract Tracking to track important dates, such as start and end dates, renewal periods, and milestones associated with each contract. • Compliance and Risk Management: to ensure that the organisation stays compliant with contract terms and legal requirements, and to help identify any potential risks by keeping a record of contract clauses, obligations, and renewal terms. • Audit Trail: provided for each contract, including amendments and performance evaluations. This makes it easier to track changes and decisions related to a contract. • Centralised Repository: allowing easier access for teams like legal, procurement, and finance when they need to refer to specific terms, obligations, or other contract details. • Improved Communication: enhances communication across departments, as everyone involved can refer to the register to ensure that they are aware of their obligations and responsibilities under various contracts. • Budget and Financial Tracking: for financial management to track contract values, payment terms and other financial aspects to ensure proper budgeting and forecasting. • The Social Partnership and Public Procurement (Wales) Act 2023 includes that a contracting authority must create, maintain, and publish a contract register. The Social Partnership and Public Procurement (Wales) Act 2023 states that a contracting authority must create, maintain, and publish a contract register. Within our sampled contracts, no contract managers indicated a directorate contract register was currently in place, nor is there a Trust wide register- sample testing was based on Electronic Contract Management module of the Bravo e-tendering system -however this testing is not comprehensive and does not include all the information provided above. We note from our audit work on the nVCC project, that a contract register was in place for the advisor appointments.	Internal Audit Advisory – Standard/2025/80/202/1	Management Consideration 2: Contracts register A Trust-wide contract register should be developed to record and manage contract records and information.	Mark Muller	Mark Muller	24.07.2025	02.09.2025	11.03.2026	08.10.2025	Amber	In progress			Update 01.10.25: Following a review of the advisory actions, we are implementing a collaborative working group with colleagues across the Trust to ensure we deliver an efficient and effective response on all five actions, with processes developed as required. MB has requested guidance and expertise from Shared Services and we will then aim to develop a timetable during this financial year to successfully deliver our outputs accordingly.	
Internal Audit Advisory – Standard/2023/80	Contract Management Final Advisory Report 2024/25	24.06.2025	Objective 3: Contract managers have access to relevant training and development. This audit, and similar reviews at other NHS Wales Organisations, observed that contract management was undertaken by combination of: • dedicated contract managers; • to fulfil an existing element of a job description / role; and • as an unspecified additional responsibility. The demands on staff was dependent on the specific performance monitoring requirements of the contract and varied significantly. For the sampled contracts, there was no evidence of an assessment of the capacity / capability requirements to fulfil the role and / or the identification of any training requirements to address any gaps. Similarly, no specific contract monitoring training had been provided for the contract managers within our sample. The Trust's SFI's include within Section 11.16.3 that "Advice on best practice on Contract Management is available from NNSSP Procurement Services."	Internal Audit Advisory – Standard/2025/80/203/1	Management Consideration 3: Training A mechanism should be established to ensure senior managers identify any specific training requirements to support operational contract management – reflecting the capacity / capability of individuals and the requirements of the specific contracts. The Trust should engage with other NHS Wales Organisations to develop contract management training, to ensure staff are equipped with the tools and skills to manage the key stages and lifecycles of contracts.	Mark Muller	Matthew Bunce	24.07.2025	02.09.2025	11.03.2026	08.10.2025	Amber	In progress			Update 01.10.25: Following a review of the advisory actions, we are implementing a collaborative working group with colleagues across the Trust to ensure we deliver an efficient and effective response on all five actions, with processes developed as required. MB has requested guidance and expertise from Shared Services and we will then aim to develop a timetable during this financial year to successfully deliver our outputs accordingly.	
Internal Audit Advisory – Standard/2023/80	Contract Management Final Advisory Report 2024/25	24.06.2025	Objective 4: Service levels/deliverables are specified in the contract, with standard terms and conditions applied, and are linked to service needs and monitored by the assigned contract manager/crm user. Standing Financial Instructions (SFI 1.1) require that "The relevant budget holder, shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met." A sample of the contracts were selected from the contract management module of the Bravo e-tendering system, and this was undertaken in conjunction with reviews taking place at other NHS Wales organisations to provide consistency of service/contract type where possible. Common themes across these reviews have been identified which will need a consistent approach to be addressed on an All Wales basis, in conjunction with NNSSP's Procurement Services. Evidence from Trust contract managers demonstrated ongoing contract management and operational understanding of the requirements of such, where exceptions have been identified below these were accompanied by mitigations. Through discussion and review of documentation with contract managers we identified the following: Designated responsible officer/contract ownership Whilst the audit was directed to certain individuals by the Trust procurement lead, for the contracts sampled in the audit, not all those had been formally assigned responsibility for contract monitoring. Within our sample of contracts, we identified one manager who performed a dedicated contract management role, others were operational staff. The recording of the Senior Responsible Officer and budget holder within contract documentation varied in the documentation reviewed, and this, alongside the differences in the contract leads recorded within Brava, indicates a need for the Trust to progress its own contract register, and ensure this is updated to reflect changes in ownership (see Objective 2). Contract documentation Within our sample, there were several contracts where a signed 'Trust' contract was not available. Trust managers noted that those had not been provided by Procurement Services, but prior to audit feedback had not identified this gap. We noted that in some cases a suppliers completed ITT user requirement specification (URS) documentation was used as a reference document for contract management purposes (deliverables specification, targets and KPIs, performance monitoring) but there is a risk in doing so that changes or amendments that arise in finalising the contract and therefore are not reflected in the URS document are overlooked.	Internal Audit Advisory – Standard/2025/80/204/1	Management Consideration 4: Contracts In respect of contracts: • Responsibility for monitoring the contract should be formally assigned and the expected responsibilities should be accepted (for example utilising a formal appointment form). Consideration should also be given to instances where responsibility may be handed on to other individuals i.e. when the officer responsible for the tender process will not be the assigned contract manager for ongoing performance review. • The Trust should ensure that final, signed, full contract documents are obtained from Procurement Services and retained centrally, with the contract register updated accordingly. • The Trust should ensure that performance measures are in place within contracts, that there are appropriate regular contract performance meetings taking place to monitor the achievement of these and that there is a process to address any underperformance identified.	Mark Muller	Mark Muller	24.07.2025	02.09.2025	11.03.2026	08.10.2025	Amber	In progress			Update 01.10.25: Following a review of the advisory actions, we are implementing a collaborative working group with colleagues across the Trust to ensure we deliver an efficient and effective response on all five actions, with processes developed as required. MB has requested guidance and expertise from Shared Services and we will then aim to develop a timetable during this financial year to successfully deliver our outputs accordingly.	
Internal Audit Advisory – Standard/2023/80	Contract Management Final Advisory Report 2024/25	24.06.2025	Objective 5: Contract performance and risk is reported and managed within the Trust's governance structure. The SFI's relating to contract management (section 11.16) do not provide information on the expected minimum reporting, accountability and escalation arrangements in relation to contracts and this is not specified in any other Trust document. Risk Management is not an explicit element of the contract monitoring by the contract manager, although the threat to service delivery from contract business interruption is appropriated by contract managers. Risk to the service receiving the contracted activity posed by the contract is however always managed by the receiving service and we were advised that Service risk management (although not in the scope of this audit) is active across the Trust through the DATS platform, cited by all contract managers in the sample we examined. Performance monitoring is structured around metrics agreed between the service and the provider but, as noted above, is not always specified in the contract itself. Reporting was found to be exception based and escalation routes determined by the established pathways of the service/divisions in question.	Internal Audit Advisory – Standard/2025/80/205/1	Management Consideration 5: Reporting, escalation and risk management arrangements Explicit internal monitoring / reporting arrangements should be defined at the outset of the contract taking into account the risk, value, complexity and strategic importance of the contract.	Mark Muller	Mark Muller	24.07.2025	02.09.2025	11.03.2026	08.10.2025	Amber	In progress			Update 01.10.25: Following a review of the advisory actions, we are implementing a collaborative working group with colleagues across the Trust to ensure we deliver an efficient and effective response on all five actions, with processes developed as required. MB has requested guidance and expertise from Shared Services and we will then aim to develop a timetable during this financial year to successfully deliver our outputs accordingly.	

Inspection code	Inspection title	Inspection origins	Recommendation description	Recommendation reference number
		Audit Wales		
		Internal Audit Assurance - Standard		
		Internal Audit Assurance - Capital		
		Internal Audit Assurance - Digital		
		Internal Audit Advisory – Standard		

Reference numbers	Action description	Service type	Divisions	Business units	Specialities	Sites	Responsible person	Date raised from	Date raised to

Audit Action Tracker: Audit Management and Action (AMaT) Transition Guidance

Transfer and Set up

Whilst we are continuing to use feedback to improve the system, process & reporting and respond to queries from staff we have set out the key expectations of the Audit Committee as well as frequently asked questions in this Guidance. This guidance is intended to be a working document that will be distributed following each Audit Committee when new actions are assigned. The AMaT system inspection guidance is included after this guidance.



AMaT Inspections
Handout v3.pdf

Please note that all actions will be assigned to one of the Inspection origins below, these will need to be used when using search filters*:

- Internal Audit Assurance – Standard
- Internal Audit Assurance – Capital
- Internal Audit Assurance – Digital
- Internal Audit Advisory – Standard
- Internal Audit Advisory - Capital
- Internal Audit Advisory – Digital
- Audit Wales

*We have requested additional Origin options to enable further filtering of audit reports, which will also be in keeping with Internal Audit 'domain' categories used in their reporting.

Use of Terminology

Please find snap shots below of the old terminology seen on the Excel workbook and new terminology you will see on AMaT so you can adjust to the recording of actions, priority and status.

OLD Priority rating

Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

NEW Importance rating – This will appear at the bottom of each Action page. The only change you will notice is that the Medium Priority actions will be assigned to **Amber**

Inspection action importance rating: * ?



Key for status

Please familiarise yourself with the change of text below

OLD Status

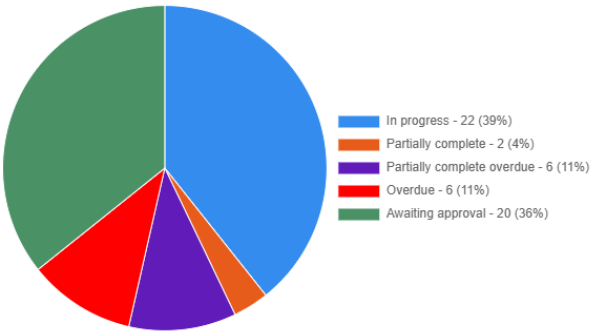
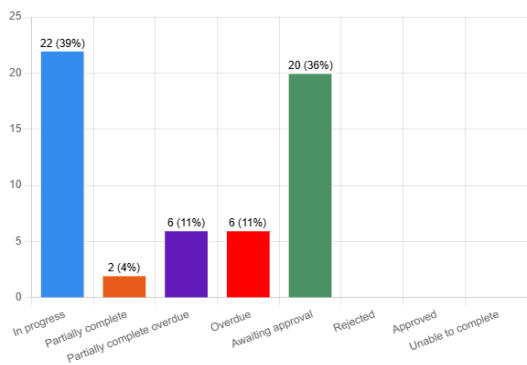
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
	Orange - Action not on target for completion by agreed date
	Red - Implementation date passed - management action not complete
	Blue - Action closed previous meeting

NEW Status – This can be selected on the **Action** tab using the **Progress Status** drop down menu, you won't see the colour coding at this stage but it relates to the reporting section below.

	Fully complete (Approved)
	Fully complete (Awaiting approval)
	Partially Complete
	Unable to complete
	In Progress
	Overdue
	Partially complete (overdue)

N.B. The colour coding will only appear in the **Reporting** option and can be displayed as a bar or pie chart, only wording will appear when selecting the status from the drop down.

Examples



F.A.Q's Please note that anything in **Red Bold** in the answers below indicates the terminology used or steps needed as a guide.

How do I access the system?

When actions are assigned to you or your work area, individuals will be granted access and you will receive an email notification from Rachael Kipling, Rebecca Quinlan or Sara Walters informing you.

You can access in two ways:

- You can access the system via a single sign in at the link below and it appears at the top of the 'Find it fast' links on the Velindre web page

<https://velindre.amat.co.uk/trust/>

- Or you can click on the link that will appear on your email notification from AMaT.

How can I see my actions?

When you access AMaT your 'To do list' will pop up. This can also be found at the top right-hand corner. There will be 2 tabs 'For your organisation' and 'To do list', however, this will only capture Overdue actions.

Another way is by searching the **Inspection actions**. Search by **Responsible person** and click **Get results**

HOME

Dashboards

Your inspections

Inspection actions

Reporting

Actions dashboard

Actions table

Inspection actions dashboard

Filter actions

Inspection code:

Inspection title:

Inspection origin:

2 inspection origins selected

Recommendation:

Action:

Site:

Any site

Service:

Any service

Responsible person:

Matthew Bunce

Rating type:

Any rating type

Progress status:

Any status

Priority type:

Any priority type

Risks:

Risks (all)

Barriers:

Barriers (all)

By service / site:

Organisation wide

Date raised from:

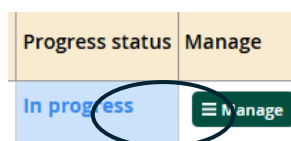
Date raised to:

View my actions only

Get results

Clear

How do I update an action?



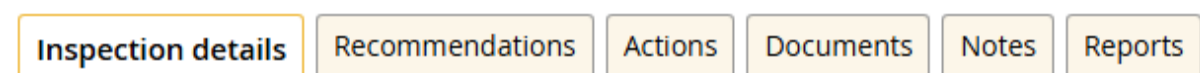
Click on **Manage** then **View & edit**

Once you are on the next screen the heading will say **Edit action** and you will be able to add your update in the **Comments/Updates** box.

You will see that all previous information has been transferred across from the Excel workbook. Please note, for a fuller vision of the **Action** and **Comments/Updates** box you can enlarge by dragging the lower right-hand corner.

Can I view other recommendations and actions under the Inspection title?

Yes. Actions may be assigned to different individuals, though you may wish to have an oversight of all **Recommendations** and **Actions** by using the top tabs.



How do I request an extension?

When updating your action please click the **Barriers/problems preventing implementation** which will bring up a text box. Please insert the text 'Extension Request' and a proposed date. This will communicated to the next Audit Committee for approval.

Barriers/problems preventing implementation

Are there any potential barriers/problems to prevent the implementation of this action? ☒

Barriers: *

What happens when an action is Fully Complete (awaiting approval)?

When selecting a **Fully Complete (awaiting approval)** status, you must try to attach evidence to verify that an action has been completed.

N.B. This can only be done before changing / saving the status.

Internal Audit reports often include details of expected evidence, other examples include policy documents, project and delivery plans, or agendas of meetings that have taken place.

Uploaded evidence

No files have currently been uploaded.

Upload new file

Fully Complete (awaiting approval) actions will then be presented to the next Audit Committee to seek formal agreement to close these actions and the administrator will do so in a batch.

Audit Committee	
TRUST RISK REGISTER UPDATE	
DATE OF MEETING	03 March 2026
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, Risk and Assurance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The report: • highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 and above for all other domains. • allows the Audit Committee to have effective oversight and assurance of the way in which risks are being managed across the Trust. • provides the Audit Committee with a summary of activity related to the status of the risks and associated movement. • Provides an update on the sub-threshold risks in the Trust.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • NOTE the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 on the Risk



	Register. • NOTE the update on the Datix risk system replacement. • NOTE the update on sub-threshold risks.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	DATE
Velindre Cancer Service Divisional Team	Data shared
Welsh Blood Service Senior Leadership Team (WBS SLT)	Data Shared
Data has been validated in divisions.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	
1	Trust Risk Register

1. SITUATION

This report informs the Committee of the status of reportable risks in line with the Trust Board approved risk appetite levels and policy. The baseline information is drawn from Datix, with additional information provided by the Velindre Cancer Service (VCS) and the Welsh Blood Service (WBS) monthly risk analysis reports.

The reporting in Appendix 1 is based on changes to the register since the 29 January Trust Board meeting.

Risks reported in this paper are:

1. risks in the safety/quality domain with a risk level of 12 and above.
2. risks in the non-safety domain risk level of 15 and above.

2. ASSESSMENT

2.1 Trust Risk Register

The Trust Risk Register is available as Appendix 1.

2.2 There are five new risks on to the Trust Risk Register:

Risk 3716

'There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.'

The risk is being managed with a current control in a process in the Standard Operating Procedure. Extra care to be taken when manually transferring results to SERIF to ensure that only current and not historic results are transferred.

Risk 3856

'There is risk to Quality as a result of the installation of data nodes to support the temperature monitoring of 2 new walk-in freezers, leading to disruption of routine services and the implementation of Plasma for Medicines.'

Risk is being treated to reduce risk level.

On completion of identified works, installation support from environmental monitoring provider (Contronics) to update data node number.

Risk 3801

"There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise."

Phase 2 Project remains in the system integration testing phase awaiting resolution of the final outstanding issue. This issue has been outstanding since 20th November, with no confirmed timeline from DHCW for resolution. Until this issue is resolved, the project progress to User Acceptance Testing and Validation (end to end testing by the lab SME).

Risk 3643

"There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service."

Risk reduction is reliant on implementation of replacement LIMS. Timelines controlled by DHCW as part of national WLIMS2.0 implementation programme.

Risk 3685

"There is a risk to leadership stability and capacity due to a number of interim positions on the Executive Management Board and a key vacancy."

Timescales for recruiting into permanent roles are being developed. Confirmation of interim positions in accordance with Welsh Health Circulars is ongoing. Decision making processes and accountabilities are under review.

2.3 No risks have been closed or reduced below the reporting threshold since the last reporting cycle.

2.4 As a result, the current Public Trust Risk Register is showing:

- A total of 18 risks reporting onto the public Trust Risk Register.
- Eight risks with a score of 12 or above reported in the safety/quality domain.
 - o Two on the VCS register
 - o Six on the WBS register
- Ten with a score over 15 or above reported in other domains.
 - o One on the VCS register
 - o Three on WBS register
 - o Six on the Corporate risk register.

3.0 Risk Themes

The Trust Risk Register presented for the committee highlights a continued risk profile across several clinical, operational, digital and corporate areas. While targeted actions and mitigation workstreams are underway across all domains, the overall position demonstrates some ongoing systemic pressures.

Across Velindre Cancer Service (VCS), the dominant risk theme continues to centre on capacity constraints in both SACT treatment delivery and associated administrative functions. Mitigating actions—including development of a surge capacity plan, recruitment to key posts and pathway transformation—are progressing, but the service remains under significant pressure.

Within the Welsh Blood Service (WBS), the risk profile is strongly influenced by the continued reliance on ageing or non-integrated digital systems. Several risks remain at or above threshold because manual workarounds and legacy IT platforms continue to pose threats to accuracy, quality and performance in laboratory operations. Critical mitigations have a key dependency with Digital Health Care Wales. Project slippage in digital programmes continues to create uncertainty for key services.

Overall, the risk environment remains highly influenced by capacity constraints, dependency on national digital programmes, and legacy infrastructure. While progress is

being made across multiple transformation and workforce streams, the Board's continued focus on strategic mitigation, assurance, and cross-system engagement remains key.

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

Datix System Replacement

The contract with Datix 14 runs until November 2027.

Meetings on the relevant issues have taken place of risk peers across NHS Wales during the reporting period. There is an appetite to agree a specification for the new system collaboratively. Intelligence around systems will be shared, as will sessions booked for demonstrations from providers. The collegiate approach was favoured by Health Boards and Trusts represented at the meeting.

The last Trust's Task and Finish group agreed to:

- Continue to work on the specification requirements, taking into account the peer group work undertaken across NHS Wales.
- Create a plan procurement notice (PPN) as a part of the procurement process to enable engagement with potential system suppliers to develop the Trust's requirement and procurement approach and identify potential suppliers. The proposed date for this activity will be in mid March 2026.

Risk Management Framework Review

EMB will consider the review of the Trust's Risk Strategy in February. This will include a refreshed risk appetite statement. Supporting procedural documents have been reviewed by the Risk and Assurance Manager will be finalised over the coming weeks.

5. Sub-threshold Risk Update

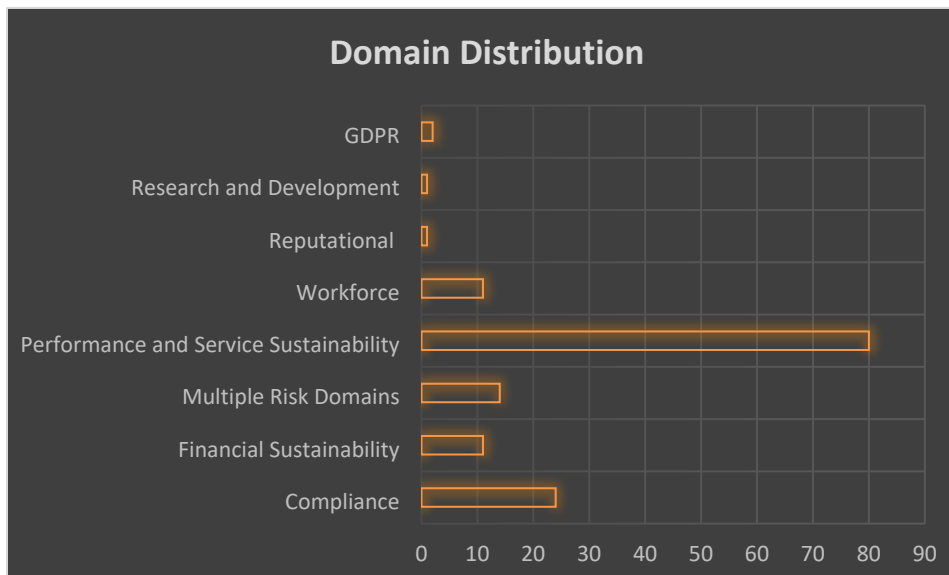
A review of sub-threshold risks was carried out in August 2025. In September 2025, Audit Committee agreed to review the sub threshold risks on a six-month cycle.

The most recent review was undertaken by the Risk and Assurance Manager in January-February 2026 sub-threshold risks are defined as those recorded on Datix scored below the reporting threshold for escalation to the Trust Board - 12 in the safety domain and 15 for all other risk domains.

In line with established governance arrangements, Quality and Safety related risks have been excluded from this review, as they are monitored and managed through the Quality and Safety Hubs, with escalation through the Integrated Quality and Safety Group as appropriate. In addition, risks associated with Welsh Blood Service (WBS) venues have

been excluded, as these are recognised as tolerated risks for the duration of each venue's operational lifespan. The aim of the review is to ensure that remaining sub-threshold risks are being appropriately monitored, reviewed, and mitigated in line with the Trust's risk management policy.

The number of risks audited totalled 144. Of this total, 58 risks (40%) have a current risk rating the same as the target risk, in which case the risk is tolerated. 21 (14.5%) audited risks have an out-of-date review – this demonstrates a reduction of 25.5% in out of date reviews since August 2026. The risk reviews are regularly monitored and managed with risk leads. Many of overdue reviews are noting February review dates 2026, actions have been created and shared with risk leads to manage and update risk reviews.



Risk review dates may become overdue due to competing operational pressures, changes in ownership, or limited capacity to carry out reviews. This can impact the accuracy of the risk register by preventing timely identification of changes in risk exposure or effectiveness of controls. To address overdue risk reviews, the Risk and Assurance Manager continues to work with risk leads to implement clear review schedules, which are supported by automated reminders. Each risk has a risk lead who will be needed to carry out timely updates, with compliance monitored through routine reporting. Training and guidance will reinforce the importance of reviews, while integration into governance meetings will ensure regular oversight.

To strengthen management of sub-threshold risks, the following actions are in process:

- Clear Review Schedules – Each risk has an agreed review frequency, with automated reminders and escalation where deadlines are missed. This is also backed up with support from divisional staff and the Risk and Assurance Manager.

- Ownership and Accountability – Risk leads are responsible for timely updates, with compliance monitored through routine reporting.
- Training and Support – Risk leads receive support and guidance to reinforce the importance of timely reviews and effective risk management. Following the approval of the Risk Management Framework training will be reviewed and updated to include review of risks.
- Governance Integration – Sub-threshold risk oversight will be embedded into existing governance meetings to provide regular assurance and ensure overdue reviews are addressed.
- Monitoring and Reporting – Progress is tracked supported by the Risk and Assurance Manager for oversight.

This plan will ensure sub-threshold risks are effectively managed, the accuracy of the risk register is maintained, and the Trust Board receives appropriate assurance.

6. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee is asked to **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	
Please tick all relevant goals: Outstanding for quality, safety and experience ☒	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.



SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report. There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. There are no specific legal implications related to the activity outlined in this report.

7. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	The risks are detailed in the paper.

TRUST RISK REGISTER

Executive Management Board – February 2026 reporting cycle

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

To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

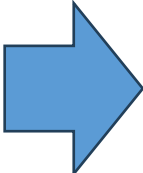
SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING & EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service											
12+ Risks in the Quality and Safety domains											
1	3747 01.08.25	VCS	Safety	Interim General Manager	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment	20 (4x5)	12 (3x4)	6 (3x2) Target date: 30.06.2026		A Surge Capacity Action Plan will be developed to explore opportunities and implement actions at pace to support mitigation of the current and future capacity gap. This will include exploration of additional capacity across Pharmacy, nursing and pre SACT assessment in the short term. The SACT expansion business case is currently in development, and this will be updated to reflect the current growth of 14%. This will ensure sustainable additional capacity is planned for and the VCS has the appropriate workforce across all areas to deliver this capacity safely and efficiently. In addition, there will be a focus to expedite high benefit protocols which will support even balance of activity across the week to ensure optimisation of all available capacity. This will include implementation of new ways of working and transformation of the current SACT Pathway.	Update 05.02.2026 Capacity and demand being worked through to feed into business case. Implementation of SACT steering group to drive work forward.

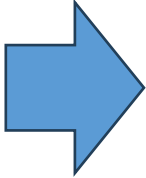
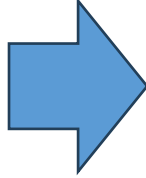
TRUST RISK REGISTER

2	3714 24.06.25	VCS	Safety	Interim general Manager	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches	16 (4x4)	15 (5x3)	6 (2x3) Target date: 01.06.26			04.02.2026 Additional workforce gap in team, now recruiting to 2 WTE vacancies, and band 5 team lead recruited (start date pending). Current booking capacity is insufficient to offset incoming demand, causing a growth in pending list for booking of SACT. Further risk to service due to departure senior managerial support (including clinical oversight and prioritisation). Delays in booking will impact on patient outcomes
15+ Risks in other domains											
3	3832 02.12.25	VCS	Safety	SACT Clinical Lead	There is a risk to staff safety administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure.	15 (3x5)	15 (3x5)	6 (3x2) Target date 31.03.26	New risk	1. SBAR, QIA, Risk Assessment to be presented at QSREB complete 2. Escalation to procurement for tender of products, following Board approval 3. Financial business case development 4. Education and training for CSTDs for rapid role out	04.02.2026 CSTD progression to trial approved by QSP Jan 26. Awaiting minutes to allow procurement to progress trial.
Welsh Blood Service											
12+ Risks in the Quality and Safety domains											
4	3418 03.07.25	WBS	Quality/ Safety	Head of Transplantation Services	There is a risk to quality, as a result of pre- and post-examination processes for all tests yielding patient results, leading to a potential adverse impact on patient care.	12 (4x3)	12 (4x3)	4 (4x1) Target date 28.03.26		1. Introduction of LIMS to mitigate the risk of manual transcription errors	16/02/2026 The risk still remains significant as the mitigating action (implementation of LIMS in Transplantation Services) is the only action that will reduce this risk score - implementation of HistoTrac remains on track for March 2026. Implementation planning for go-live currently underway.

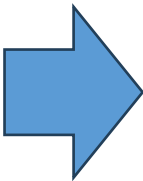
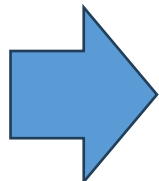
TRUST RISK REGISTER

5	3795	WBS	Quality	Head of Transfusion services	There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient.	12 (4x3)	12 (4x3)	8 (4x2) Target date 21.07.26		1. Update to report comments in progress- PAT-123 & PAT-361 in draft to inform of changes and process change requirements	16/02/2026 Risk position remains unchanged, risk reduction is reliant on implementation of replacement LIMS. Risk consideration has included current inability to work smarter due to system limitations. Further operational actions are being taken to mitigate risk where possible.
6	2774 27/10/2024	WBS	Quality/ Safety	Director of WBS	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16 (4x4)	12 (4x3)	4 (4x1) Target date: 03.03.26		1. Implement replacement IT System (Q3) 2. Discovery and planning 3. Transformation workstream - process redesign and system config 4. Data workstream - migration of legacy data 5. Application workstream - build of environments, database and interfaces	16/02/2026 The risk scoring remains unchanged until the replacement HistoTrac system is live to mitigate. No further controls/mitigations can be identified to reduce the risk prior to replacing the system Go-live Date for the WHAISIT project has been set March 2026. Implementation planning for go-live currently underway.
7	3716 *new risk	WBS	Quality	Head of Transfusion Services	There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.	12 (4x3)	12 (4x3)	8 (4x2) Target date: 11.06.2026		1.	16/02/2026 New risk reported

TRUST RISK REGISTER

8	3856 *New to TRR	WBS	Quality	Head of Transfusion Services	There is risk to Quality as a result of the installation of data nodes to support the temperature monitoring of 2 new walk-in freezers, leading to disruption of routine services and the implementation of PFM.	16 (4x4)	12 (4x3)	4 (4x1) Target date: 13.03.2026			16/02/2026 Treat risk to reduce risk level On completion of identified works, installation support from our environmental monitoring provider (Contronics) to update data node number 15 from a 8 input PCB to a 16 input PCB and install the new temperature sensors in each of the new freezers. The location of these sensors will be determined by the thermal profiling exercises which will need to be undertaken once the equipment is installed.
9	3388 07/05/2024	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16 (4x4)	16 (4x4)	2 (2x1) Target date: 22.04.26		2. Develop and validate interface between FEDIS and eMPI+WRRS when available	16/02/2026 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). DHCW have one final issue to resolve before the project can move on from System Integration Testing phase to User Acceptance Testing phase. This issue has been outstanding since 20th November, with no confirmed timeline from DHCW for resolution. There will be further slippage of the project timelines, the extent of which is currently unknown until the final issue is resolved.
15+ Risks in other domains											
10	3801 *new to TRR	WBS	Performance and Service Sustainability	Head of Transplantation Services	There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise	16 (4x4)	16 (4x4)	8 (4x2)			16/02/2026 Phase 2 Project remains in the system integration testing phase awaiting resolution of the final outstanding issue. This issue has been outstanding since 20th November, with no confirmed timeline from DHCW for resolution. Until this issue is resolved, the project progress to User Acceptance Testing and Validation (end to end testing by the lab SME).

TRUST RISK REGISTER

11	3643 11/04/2025 *new to TRR	WBS	Quality/Safety	Head of Transfusion Services	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16 (4x4)	16 (4x4)	4 (4x1)		1. Validation of upgrade/ Replacement 1. Unable upgrade SERIF due to age and lack of digital SME support. The system has been operating safely for over 20 years, current workarounds to remain in place. SBAR drafted to consider all replacement options and timelines.	16/02/2026 Risk position remains unchanged, risk reduction is reliant on implementation of replacement LIMS. Timelines controlled by DHCW as part of national WLIMS2.0 implementation programme.
12	3306 15/01/25	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	20 (5x4)	15 (5x3)	5 (5x1) Target date 07.02.26		2. Review of risk assessment required	16/02/2026 All the contingency measures i.e. hire of generator and hire of cold store have all been taken off hire and have left the service yard. No further electrical works are required at this point in time.
Corporate											
15+ Risks in other domains											
13	3685 19.01.26 *New risk	Corporate	Service Sustainability Reputational	Interim CEO/ Interim Executive Director of Workforce and Organisational Development	There is a risk to leadership stability and capacity due to a number of interim positions on the Executive Management Board and a key vacancy.	20 (4x5)	15 (3x5)	4 (2x2) Target date: 01.09.26	** New risk	1. Confirm timescales for recruiting into permanent roles (end of January 2026) 2. Confirm interim positions in accordance with Welsh Health Circulars (ongoing – aligned to Action 1) 3. Confirm decision making processes and accountabilities (ongoing – confirmed January 2026)	19.01.26 interviews for Executive Director Transformation, Planning and Digital held w/e 16 January. Appointment confirmed. Awaiting confirmation of start date.
14	3634 03.04.25	Corporate	Multiple Risk Domains - Quality - Performance and Service sustainability - Workforce	Chief Digital Officer	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16 (4x4)	16 (4x4)	6 (3x2) Target date: 01.04.26		1. Agree the final plans with the service areas - expected to be complete by the end of May 2025. 2. External partner will review the roadmap. 3. Capacity demand plan will be developed to support the roadmap.	06.02.2026 The digital diagnostic outcome reported to EMB in January 2026. Digital deep dive at EMB and SDC in November.

TRUST RISK REGISTER

15	3646 15.04.20 25	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems.	20 (4x5)	20 (4x5)	6 (2x3) Target date: 31.08.26		1. Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. 2. Agree the new launch date with WBS Futures Programme. 3. Mitigation plan in place with existing SERIF system.	06.02.2026 Current proposed go live date, although unconfirmed, is at the earliest an implementation date of August 2026
16	3656 24.04.25	Corporate	Performance and Service Sustainability	Director of Corporate Governance	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.	20 (5x4)	16 (4x4)	6 (3x2) Target date: 31.03.26		1. Annual accounts and accountability report to be approved by Trust Board. 2. Assurance mapping to be reviewed and completed by end of June 2025 3. WG review of current arrangements to be concluded by end of July 2025	16.01.2026 Annual Report presented at AGM. Assurance mapping underway in n response. Now in receipt of WG report. Approach to implementation to be confirmed.
17	3633 15.04.20 25	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	15 (3x5)	12 (3x4)	6 (3x2) Target date: 28.02.26		1. Share Integration Plan with DHCW to be clear about priorities – Complete 2. Weekly escalation meetings with the DHCW Exec Director responsible to monitor assure on progress. 3. Trust to line up third party suppliers (e.g.Thermofisher) to provide their Integration at the right time.	06.02.2026 FEDIS and WHAIS interfaces are now being built by DCHW. The service would still like to accelerate the plans if possible. WHAIS is on track to go live in February 206, without the Intergration, which will need to be delivered in a subsequent phase.
18	3632 03/04/25	Corporate	Multiple risk domains -Performance and service sustainability - Quality	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16 (4x4)	16 (4x4)	8 (4x2) Target date: 31.03.26		Risk reviewed. Likelihood reduced from 4 to 3 due to the change note for RISP, resetting the date of EPMA project starting.	06.02.2026 Electronic Prescribing and Medicines Administration (EPMA) remains on track. Radiotherapy Informatics System Procurement (RISP) has a no go decision for go live in January. Go live is being planned for April 2026. Welsh Laboratory Information Management System (WLIMS) is very high risk there is no national plan for the national transfusion module.

TRUST RISK REGISTER

SECTION 2 - Risks Decreased below Board threshold or closed since last reporting cycle. This section is for assurance purposes and is not included in the current risk count reported in the paper.

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
				No risks to report					

SECTION 3 – Risks decreased below Board threshold in this reporting period. This section is for assurance purposes and is not included in the current risk count reported in the paper.

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
				No risks to report					

Audit Committee	
BOARD ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	03 March 2026
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, Risk and Assurance Manager
PRESENTED BY	• Non Gwilym, Interim Director of Corporate Governance • Lauren Fear, Director of Place, Portfolio and Partnerships • Nicola Williams, Director of Nursing and • Anne Carey, Chief Operating Officer • Sarah Jenkins, Director of OD and Workforce • Jacinta Abraham, Medical Director • Matthew Bunce, Director of Finance • Carl Taylor, Chief Digital Officer
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Audit Committee with the latest updates to the Board Assurance Framework.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • NOTE the status of the Board Assurance Framework which has a current assurance rating of 2.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	

COMMITTEE OR GROUP		DATE
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.	
APPENDICES		
1	Board Assurance Framework Overview	
2	Board Assurance Framework Dashboards	

1. SITUATION

- 1.1 The Trust Assurance Framework (TAF) was established in 2020 and the refreshed framework, detailing eight strategic risks, was approved by Trust Board in March 2024. As part of the Integrated Medium-Term Plan (IMTP) process, the strategic risks have been considered in line with strategic goals. The revised strategic risks were considered and approved by Trust Board in March 2025.

In July 2025 the Trust Board approved renaming the Trust Assurance Framework as the Board Assurance Framework (BAF), bringing Velindre University NHS Trust in line with other NHS organisations.

2. ASSESSMENT

- 2.1 As part of the IMTP, eleven strategic risks were agreed by Trust Board in March 2025, aligned to strategic objectives.
- 2.2 Since the last Trust Board meeting, the following work has been undertaken or is in development:
- All strategic risks have been reviewed, including scrutiny of actions and assurance levels across the BAF.
 - A regular monthly review schedule is now in place with Executive Directors and wider teams.
- 2.3 Appendices show the current summary for the eleven strategic risks and the more detailed information to support, including full dashboards.

3. EXECUTIVE SUMMARIES

Part of the monthly review cycle includes Executive leads summarising the strategic risk, included here for review:

BAF01

WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group.

VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus to deliver the consistency required and to continue to build capacity. This work is being supported by the embedding of the Cancer PTL which is increasing ability to track pathways and understand bottlenecks in pathways, for focused work.

Risk score trend: The risk score has remained static since the last period.

BAF02

Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.

BAF03

The risk is currently assessed as moderate but managed, with robust strategies in place to deliver against both the Velindre Cancer Service 10-year Cancer Research Ambitions and the Welsh Blood Service Research Strategy.

The risk is being actively managed through robust governance structures reporting to the Trust's RD&I Sub-Committee and onward to the Quality, Safety & Performance and Strategic Development Committees and then to Trust Board, as appropriate. This ensures the Trust maintains alignment with the UK Policy Framework for Health and Social Care Research, The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended; and the ICH Good Clinical Practice Guidelines E6.

The oversight of the research risks by the Research Service is supported by delivery plans to manage digital transformation, regulatory preparedness, and strengthen assurance. Key residual risks remain around sustainable funding, workforce capacity, and evidencing OECl / benchmarking outcomes – these are being addressed through targeted actions.

Risk score trend: The risk score has remained static since the last period.

BAF04

Controls have been identified. All controls reporting as preventative and as being managed resulting in an improved rating of 6.

Risk score trend: The risk score has remained static since the last period.

BAF05

An assurance level of 4 for sustainability reflects that robust governance, policies are in place. The Climate Action Board provides regular oversight, supported by ISO 14001 certification (surveillance audit passed in October 2025), sustainability internal audits, and active working groups driving progress across all key themes. Clear reporting, engagement, and delivery against sustainability objectives demonstrate strong assurance and continuous improvement. Risk score trend: The risk score has remained static since the last period.

BAF06

This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 2026 on the organisational development plan to support the transition to nVCC.

Risk score trend: The risk score has remained static since the last period.

BAF07

Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position.

Risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. Go-live date for RISP agreed (April '26 from January 26) due to National/Regional image viewer capabilities. No go-live date agreed for LIMS nationally., some elements are live, however blood transfusion module does not have a go live date.

The delivery of National Programmes through DHCW re still in escalation level 3.

Key controls have been reviewed, gaps identified and action plan updated.

Risk score trend: The risk score has remained static since the last period.

BAF08

Refreshed Risk Policy on track to deliver for 3 March 2025 Audit committee.

The Trust is working with Welsh Government and NWSSP regarding the next steps for the review of NWSSP Accountabilities and Governance.

A specification for expert advice on a review of the Board's structure and development programme has been completed due to commence in the new year.

Target date has been reduced due to publication of the WG report and progress made on Risk Policy and Board Development programme.

BAF09

Executive Summary

There are a range of factors that impact on the finance sustainability and long-term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased.

Operational Summary

Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.

Risk score trend: The risk score has remained static since the last period.

BAF10

VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented, and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level.

BAF 10 was discussed at Strategic Development Committee, the controls will be tightened and updates reflected in the next reporting cycle.

Risk score trend: The risk score has remained static since the last period.

BAF11

There are many factors that impact on the current supply and shape of our workforce. These are both external, due to the economic landscape impacting the labour market and internal, within the organisation, or granular at multi-disciplinary team level. We are currently mitigating the risk in this area through effective strategic and operational workforce planning, with a focus on recruitment, retention and people development. In addition, we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams.

Risk score trend: The risk score was reviewed in October 2025 and reduce from 12 to 9. The reduction was agreed following the information submitted under the Supply and Shape assurance paper which demonstrates a number of key metric improvements in all areas mitigating the risk.

Risk score trend: The risk score has remained static since the last period.

4 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC BOARD ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY



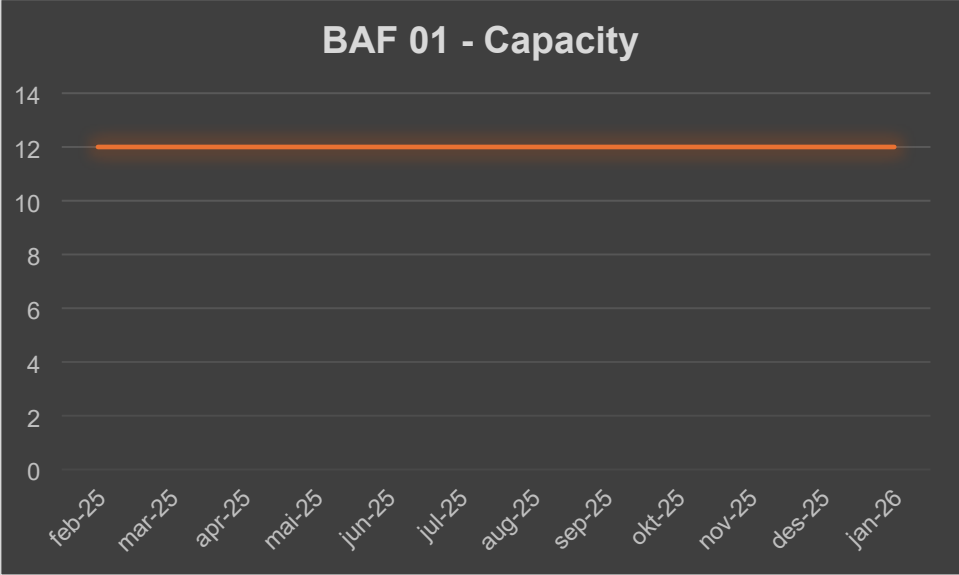
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centered ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	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

3 RISKS

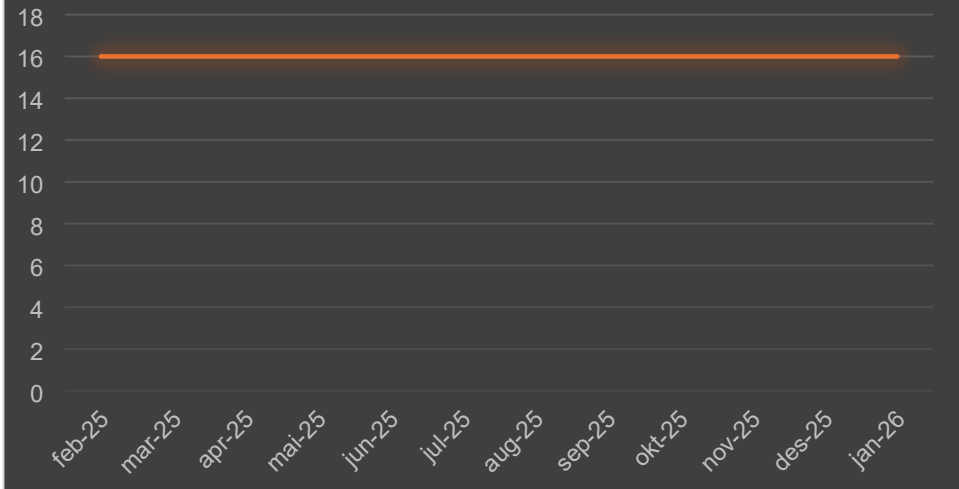
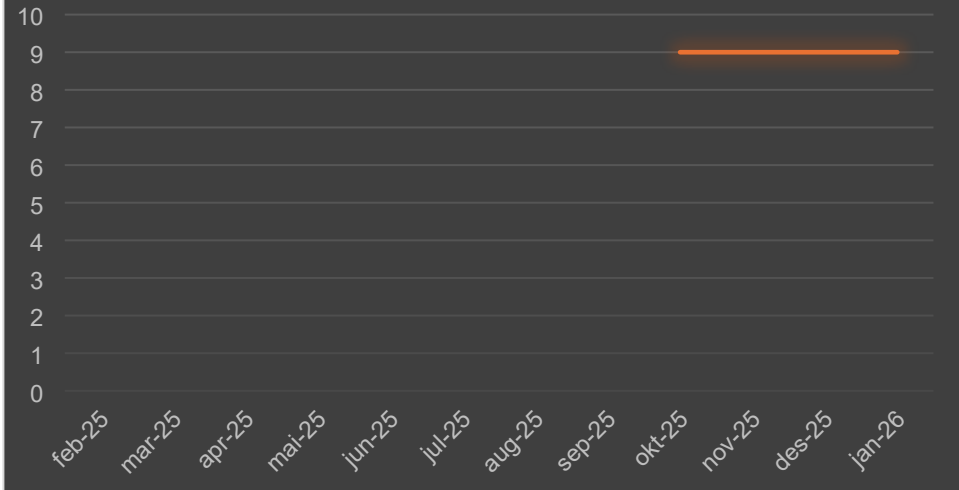
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

All risks must be evidenced and consistent with those recorded in Datix

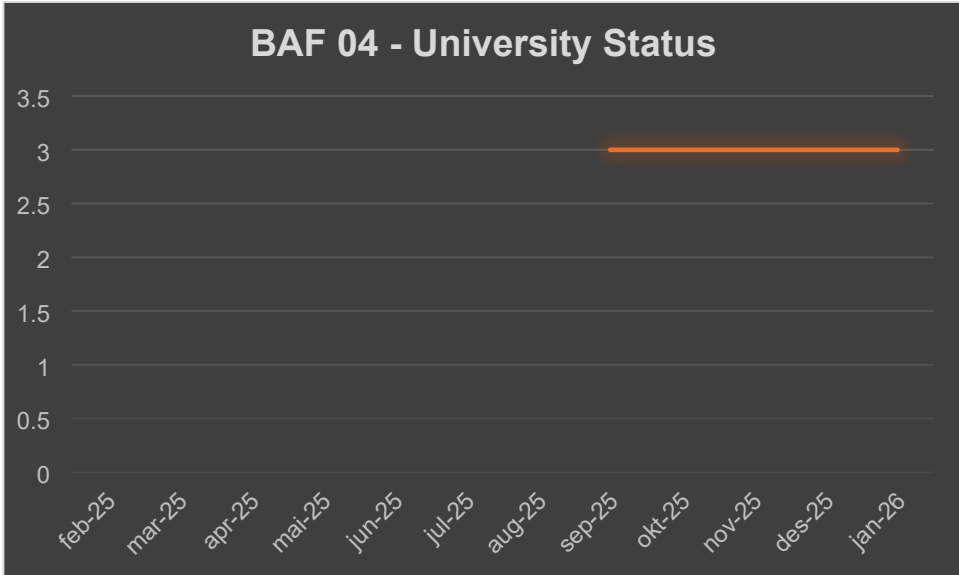
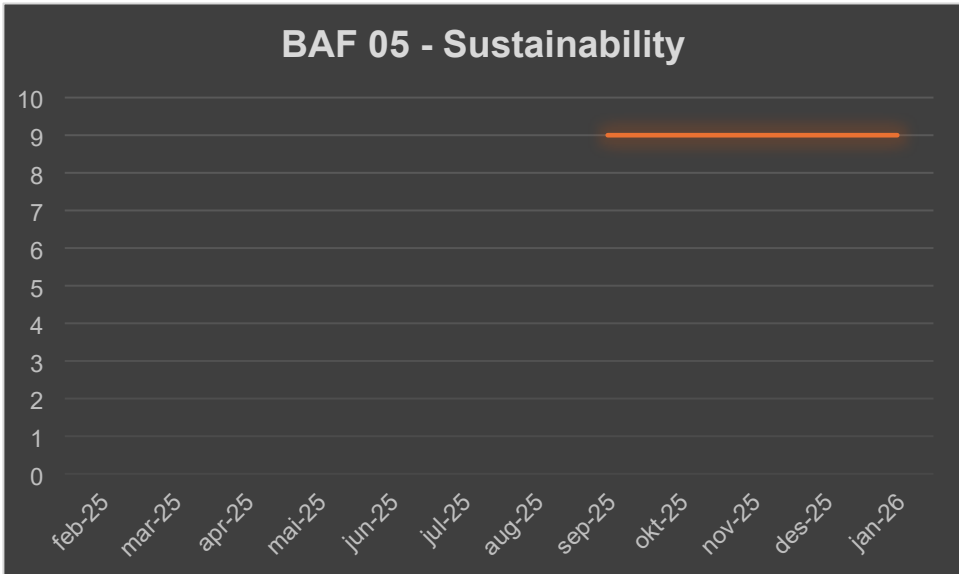
BOARD ASSURANCE FRAMEWORK

RISK ID	STRATEGIC RISK	STRATEGIC GOAL/ ENABLER	INITIAL RISK SCORE (I X L)	CURRENT RISK SCORE (I X L)	CURRENT RISK SCORE (I X L) Plus expected date	CURRENT RISK TREND	ASSURANCE RATING	TRUST RISK REGISTER CORRESPONDING RISK
01	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.	Outstanding for quality, safety and experience.	16 (4X4)	12 (4X3)	8 (4x2)	BAF 01 - Capacity 	2	- 3418 There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care. - 3678 There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient. - 3643 There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service. - 3388 There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care. - 3634 There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities. - 3747 There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment - 3714 There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches
02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities, the need for significant service transformation and external factors.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	20 (4x5)	16 (4x4)	9 (3x3)	Executive Summary: WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus. Further work is needed to deliver the consistency required and to continue to build capacity. This work is being supported by increasing ability to track pathways and understand bottlenecks in pathways, for focused work. Risk score trend: The risk score has remained static since the last period.	3	- 3418 – There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care. - 3388 - There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care. - Blood services Llantrisant. - 3832 - There is a risk to staff safety administering SACT without the use of

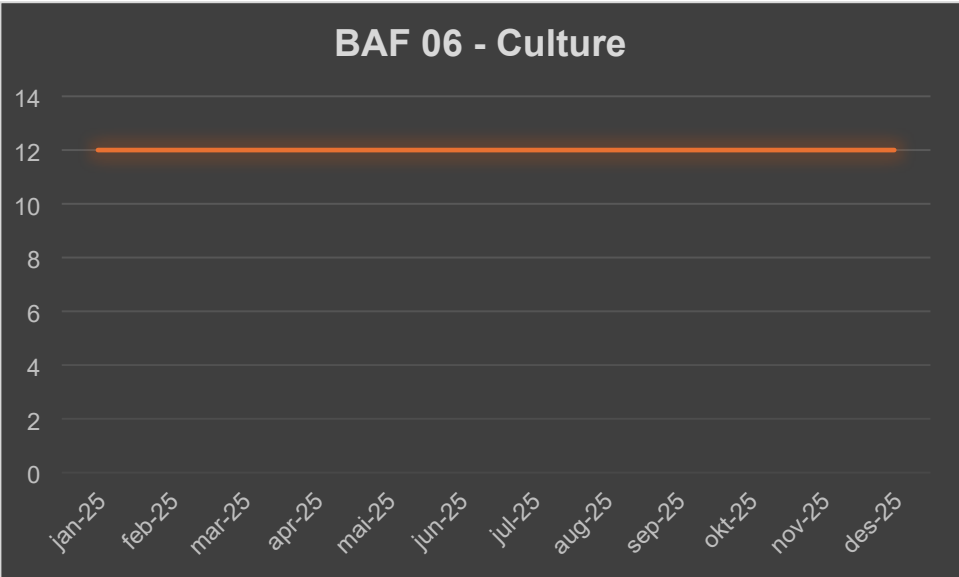
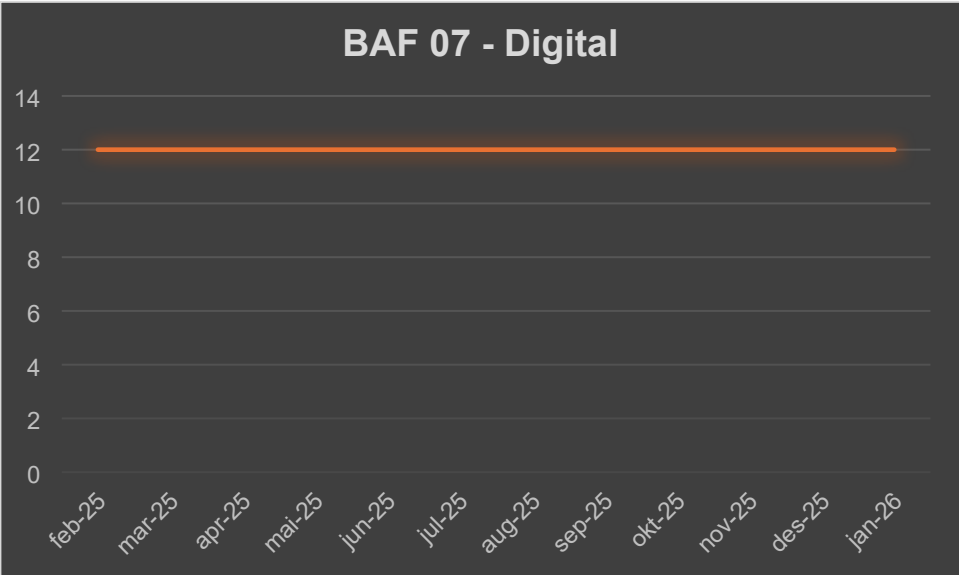
BOARD ASSURANCE FRAMEWORK

						BAF 02 - Quality <table><tr><th>Month</th><th>Score</th></tr><tr><td>feb-25</td><td>16</td></tr><tr><td>mar-25</td><td>16</td></tr><tr><td>apr-25</td><td>16</td></tr><tr><td>mai-25</td><td>16</td></tr><tr><td>jun-25</td><td>16</td></tr><tr><td>jul-25</td><td>16</td></tr><tr><td>aug-25</td><td>16</td></tr><tr><td>sep-25</td><td>16</td></tr><tr><td>okt-25</td><td>16</td></tr><tr><td>nov-25</td><td>16</td></tr><tr><td>des-25</td><td>16</td></tr><tr><td>jan-26</td><td>16</td></tr></table> April 2028 Executive Summary: Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.	Month	Score	feb-25	16	mar-25	16	apr-25	16	mai-25	16	jun-25	16	jul-25	16	aug-25	16	sep-25	16	okt-25	16	nov-25	16	des-25	16	jan-26	16		closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure. 3795 - There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient. - 2774 - There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.
Month	Score																																	
feb-25	16																																	
mar-25	16																																	
apr-25	16																																	
mai-25	16																																	
jun-25	16																																	
jul-25	16																																	
aug-25	16																																	
sep-25	16																																	
okt-25	16																																	
nov-25	16																																	
des-25	16																																	
jan-26	16																																	
03	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10-year Cancer Research Ambition and the Welsh Blood Service Research Strategies, 2. Not fully embedding innovation activities in line with the national Innovation Framework.	A beacon for research, development and innovation in our stated areas of priority.	12 (3x4)	9 (3x3)	6 (3x2)	BAF 03 - RD&I <table><tr><th>Month</th><th>Score</th></tr><tr><td>feb-25</td><td></td></tr><tr><td>mar-25</td><td></td></tr><tr><td>apr-25</td><td></td></tr><tr><td>mai-25</td><td></td></tr><tr><td>jun-25</td><td></td></tr><tr><td>jul-25</td><td></td></tr><tr><td>aug-25</td><td></td></tr><tr><td>sep-25</td><td></td></tr><tr><td>okt-25</td><td>9</td></tr><tr><td>nov-25</td><td>9</td></tr><tr><td>des-25</td><td>9</td></tr><tr><td>jan-26</td><td>9</td></tr></table> August 2030 Executive Summary: The risk is currently assessed as moderate but managed, with robust strategies in place to deliver against both the Velindre Cancer Service 10-year Cancer Research Ambitions and the Welsh Blood Service Research Strategy. The risk is being actively managed through robust governance structures reporting to the Trust's RD&I Sub-Committee and onward to the Quality, Safety & Performance and Strategic Development Committees and then to Trust Board, as appropriate. This ensures the Trust maintains alignment with the UK Policy Framework for Health and Social Care Research, The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended; and the ICH Good Clinical Practice Guidelines E6.	Month	Score	feb-25		mar-25		apr-25		mai-25		jun-25		jul-25		aug-25		sep-25		okt-25	9	nov-25	9	des-25	9	jan-26	9	5	There are no associated risks on the Trust Risk Register
Month	Score																																	
feb-25																																		
mar-25																																		
apr-25																																		
mai-25																																		
jun-25																																		
jul-25																																		
aug-25																																		
sep-25																																		
okt-25	9																																	
nov-25	9																																	
des-25	9																																	
jan-26	9																																	

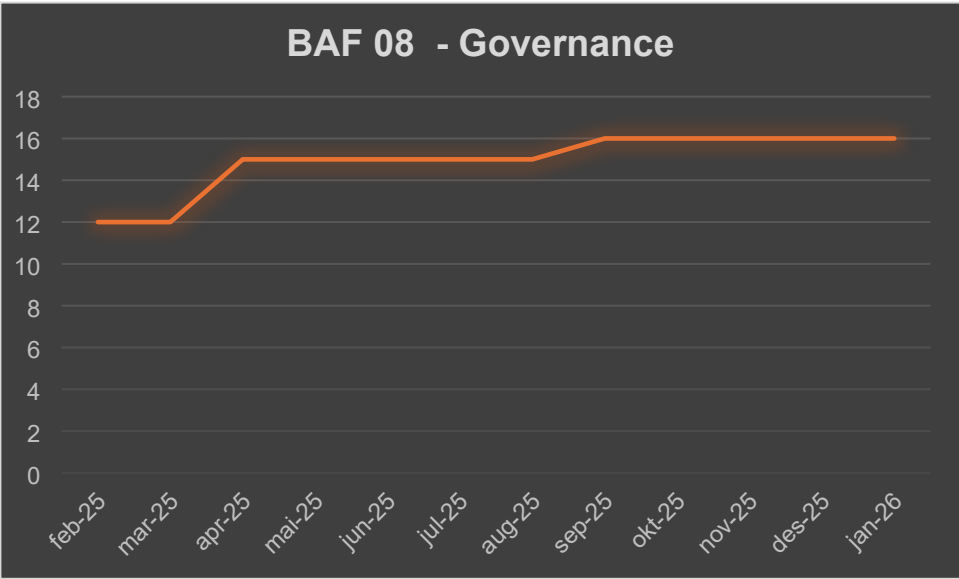
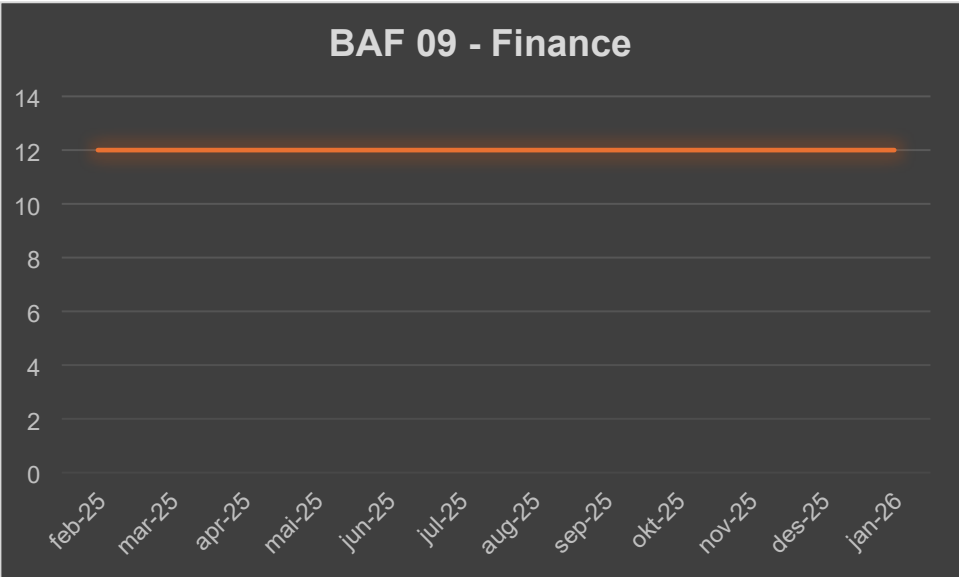
BOARD ASSURANCE FRAMEWORK

						The oversight of the research risks by the Research Service is supported by delivery plans to manage digital transformation, regulatory preparedness, and strengthen assurance. Key residual risks remain around sustainable funding, workforce capacity, and evidencing OECl / benchmarking outcomes – these are being addressed through targeted actions.																												
04	There is a strategic risk of failing to retain the Trust's University status.	An established University Trust which provides highly valued knowledge and experience for all.	3 (3x1)	3 (3x1)	3 (3x1)	BAF 04 - University Status <table><tr><th>Month</th><th>Score</th></tr><tr><td>feb-25</td><td></td></tr><tr><td>mar-25</td><td></td></tr><tr><td>apr-25</td><td></td></tr><tr><td>mai-25</td><td></td></tr><tr><td>jun-25</td><td></td></tr><tr><td>jul-25</td><td></td></tr><tr><td>aug-25</td><td></td></tr><tr><td>sep-25</td><td>3</td></tr><tr><td>okt-25</td><td>3</td></tr><tr><td>nov-25</td><td>3</td></tr><tr><td>des-25</td><td>3</td></tr><tr><td>jan-26</td><td>3</td></tr></table> March 2026 Executive Summary: Controls have been identified. All controls reporting as preventative and as being managed resulting in an improved rating of 6.	Month	Score	feb-25		mar-25		apr-25		mai-25		jun-25		jul-25		aug-25		sep-25	3	okt-25	3	nov-25	3	des-25	3	jan-26	3	6	There are no associated risks on the Trust Risk Register
Month	Score																																	
feb-25																																		
mar-25																																		
apr-25																																		
mai-25																																		
jun-25																																		
jul-25																																		
aug-25																																		
sep-25	3																																	
okt-25	3																																	
nov-25	3																																	
des-25	3																																	
jan-26	3																																	
05	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.	A sustainable organisation that plays its part in creating a better future for people across the globe	16 (4x4)	9 (3x3)	4 (2x2)	BAF 05 - Sustainability <table><tr><th>Month</th><th>Score</th></tr><tr><td>feb-25</td><td></td></tr><tr><td>mar-25</td><td></td></tr><tr><td>apr-25</td><td></td></tr><tr><td>mai-25</td><td></td></tr><tr><td>jun-25</td><td></td></tr><tr><td>jul-25</td><td></td></tr><tr><td>aug-25</td><td></td></tr><tr><td>sep-25</td><td>9</td></tr><tr><td>okt-25</td><td>9</td></tr><tr><td>nov-25</td><td>9</td></tr><tr><td>des-25</td><td>9</td></tr><tr><td>jan-26</td><td>9</td></tr></table> Executive Summary: The Trust has strong operational environmental controls and assurance through governance groups, ISO 14001, and audits. Key gaps in capital decision-making, clinical pathways, and job descriptions are being addressed through targeted actions to achieve full integration and reduce strategic risk.	Month	Score	feb-25		mar-25		apr-25		mai-25		jun-25		jul-25		aug-25		sep-25	9	okt-25	9	nov-25	9	des-25	9	jan-26	9	4	There are no associated risks on the Trust Risk Register
Month	Score																																	
feb-25																																		
mar-25																																		
apr-25																																		
mai-25																																		
jun-25																																		
jul-25																																		
aug-25																																		
sep-25	9																																	
okt-25	9																																	
nov-25	9																																	
des-25	9																																	
jan-26	9																																	

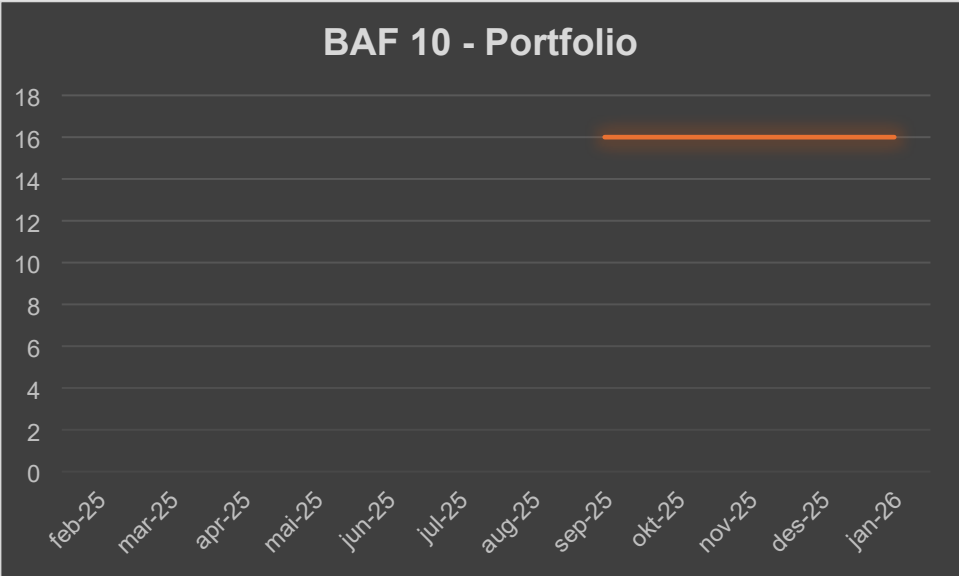
BOARD ASSURANCE FRAMEWORK

06	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes	Culture	16 (4x4)	12 (3x4)	6 (3x4)	BAF 06 - Culture 	3	There are no associated risks on the Trust Risk Register
					March 2027	Executive Summary: This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 2026 on the organisational development plan to support the transition to nVCC. Risk score trend: The risk score has remained static since the last period.		
07	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	Digital	16 (4x4)	12 (4x3)	8 (4x2)	BAF 07 - Digital 	3	- 3388 Reporting errors and limited access to FEDIS system - 3634 Demand exceeding capacity in new digital services team - 3646 Delay in go live date for LIMS Programme - 3643 Patient safety risk due to an aged Laboratory Information System - 3633 risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales - 3632 risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) - 3716 There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported. - 3801 There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise
					June 2026	Executive Summary: Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position. Assurance ratings moved to 7 levels of assurance. New risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. New go-live date for RISP agreed (Jan '26 from Jun '25) due to National/Regional image viewer capabilities. The third lines of defence have been reviewed as some were previously not independent to the Trust. The delivery of National Programmes through DHCW has been moved into escalation level 3. Risk score trend: The risk score has remained static since the last period.		

BOARD ASSURANCE FRAMEWORK

08	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.	Governance	16 (4x4))	16 (4x4)	8 (4x2)		3	– 3656 Quality of current assurance and reporting arrangements in hosted services
					May 2026	Executive Summary: Refreshed Risk Policy on track to deliver for 3 March 2025 Audit committee. The Trust is working with Welsh Government and NWSSP regarding the next steps for the review of NWSSP Accountabilities and Governance. A specification for expert advice on a review of the Board's structure and development programme has been completed due to commence in the new year. Target date has been reduced due to publication of the WG report and progress made on Risk Policy and Board Development programme.		
09	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.	Financial	16 (4x4)	12 (4x3)	8 (4x3)		4	

BOARD ASSURANCE FRAMEWORK

					April 2026	Executive Summary: There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Operational Summary Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.		
10	There is a risk that the scale and complexity of the transformation across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence	Transformation Delivery	16 (4X4)	16 (4X4)	6 (3x2)	BAF 10 - Portfolio  Executive Summary: VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented, and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level. BAF 10 was discussed at Strategic Development Committee, the controls will be tightened and updates reflected in the next reporting cycle.	3	There are no associated risk on the Trust Risk Register
11	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape	Workforce	16 (4x4)	9 (3x3)	6 (3x2)		4	- 3634 Capacity issues for digital services

BOARD ASSURANCE FRAMEWORK

						BAF 10 - Workforce <table><tr><th>Month</th><th>Risk Score</th></tr><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr><tr><td>jul-25</td><td>12</td></tr><tr><td>aug-25</td><td>12</td></tr><tr><td>sep-25</td><td>9</td></tr><tr><td>okt-25</td><td>9</td></tr><tr><td>nov-25</td><td>9</td></tr><tr><td>des-25</td><td>9</td></tr><tr><td>jan-26</td><td>9</td></tr></table>	Month	Risk Score	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	jul-25	12	aug-25	12	sep-25	9	okt-25	9	nov-25	9	des-25	9	jan-26	9		
Month	Risk Score																																	
feb-25	12																																	
mar-25	12																																	
apr-25	12																																	
mai-25	12																																	
jun-25	12																																	
jul-25	12																																	
aug-25	12																																	
sep-25	9																																	
okt-25	9																																	
nov-25	9																																	
des-25	9																																	
jan-26	9																																	
				March 2029	Executive Summary: There are many factors that impact on the current supply and shape of our workforce. These are both external, due to the economic landscape impacting the labour market and internal, within the organisation, or granular at multi-disciplinary team level. We are currently mitigating the risk in this area through effective strategic and operational workforce planning, with a focus on recruitment, retention and people development. In addition, we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams. Risk score trend: The risk score was reviewed in October 2025 and reduce from 12 to 9. The reduction was agreed following the information submitted under the Supply and Shape assurance paper which demonstrates a number of key metric improvements in all areas mitigating the risk.																													

SECTION 1 – Summary																																
RISK ID	01	REVIEW DATE	February 2026	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.																											
				Risk Lead	Chief Operating Officer																											
CORE ENABLER	Service Capacity				STRATEGIC GOAL	1 - Outstanding for quality, safety and experience.																										
CURRENT SCORE TREND	BAF 01 - Capacity <table><caption>BAF 01 - Capacity Trend Data</caption><thead><tr><th>Month</th><th>Score</th></tr></thead><tbody><tr><td>Feb-25</td><td>12</td></tr><tr><td>Mar-25</td><td>12</td></tr><tr><td>Apr-25</td><td>12</td></tr><tr><td>May-25</td><td>12</td></tr><tr><td>Jun-25</td><td>12</td></tr><tr><td>Jul-25</td><td>12</td></tr><tr><td>Aug-25</td><td>12</td></tr><tr><td>Sep-25</td><td>12</td></tr><tr><td>Oct-25</td><td>12</td></tr><tr><td>Nov-25</td><td>12</td></tr><tr><td>Dec-25</td><td>12</td></tr><tr><td>Jan-26</td><td>12</td></tr></tbody></table>				Month	Score	Feb-25	12	Mar-25	12	Apr-25	12	May-25	12	Jun-25	12	Jul-25	12	Aug-25	12	Sep-25	12	Oct-25	12	Nov-25	12	Dec-25	12	Jan-26	12	CURRENT RISK SUMMARY	WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus to deliver the consistency required and to continue to build capacity. This work is being supported by the embedding of the Cancer PTL which is increasing ability to track pathways and understand bottlenecks in pathways, for focused work. Risk score trend: The risk score has remained static since the last period.
Month	Score																															
Feb-25	12																															
Mar-25	12																															
Apr-25	12																															
May-25	12																															
Jun-25	12																															
Jul-25	12																															
Aug-25	12																															
Sep-25	12																															
Oct-25	12																															
Nov-25	12																															
Dec-25	12																															
Jan-26	12																															

SECTION 2 – Risk Scores									
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT
	4	4	16		4	3	12		4
	LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD
Inherent risk score start date		March 2025						Expected date to reach Target Risk Score	
								This will be reviewed at the end of Q2.	

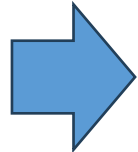
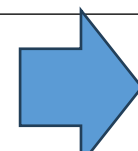
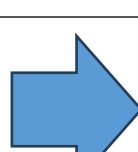
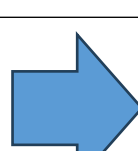
SECTION 3 – Effectiveness, Controls and Assurance			
		Overall Assurance Rating	Current Review Period
			2
			Previous Review Period
			3
		Rationale for Assurance Rating	The risk which will be discussed at Private Board
KEY CONTROLS		SOURCES OF ASSURANCE	

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
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 agreements. 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 of WBS	X			Annual Service Level Agreement (SLA) engagement with each health board, including structured reviews of supply, demand, performance and blood utilisation trends. Active delivery of the Blood Health Plan for NHS Wales through the Blood Health National Oversight Group (BHNOC), including implementation of Patient Blood Management (PBM) activities, KPI monitoring, and alignment with UK and international benchmarking.	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Welsh Government Quality, Planning and Delivery Review.
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 of WBS	X			System pressures are identified early enabling timely corrective action through Department Head review and prompt escalation to Senior Leadership Team and Director. Operational oversight and reporting of BHNOC stock related KPIs.	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. Raise shortage plan at Trust Board level when relevant.	Welsh Government intervention would be invoked when necessary. National Red Cell and Platelet shortage plans.
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director of WBS	X			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. Blood shortage plans developed in agreement with the Health Boards.	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.	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.

C4	Delivery of business-as-usual core services and capacity to support strategic programmes of work.	Directors of WBS and VCS	X			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 — namely Futures Programmes. The WBS Futures programme structure, supported by the Capacity Planning Group (CPG), oversees interdependencies and resource pressures across transformational programmes and business-as-usual activity, with regular governance touchpoints through the WBS Futures governance framework and Senior Leadership Team to ensure sustained delivery of core services alongside strategic programmes.	Highlight and performance reports to WBS Senior Leadership Team and VCS Divisional Team then EMB to review.	QSP committee and Board and external stakeholders if required. Regulatory Inspections such as Medicines and Healthcare products Regulatory Agency and Human Tissue Authority Internal Audit, Wales Audit Office, regulator audits.
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements, to ensure the safety of services. (Advancements in medicines to improve patient safety).	Directors of WBS and VCS	X			WBS - Horizon scanning and representation at key groups 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. Blood Health National Oversight Group. VCS - NICE Guidelines re Cancer drugs and treatments	Trust wide clinical and scientific board. WBS Senior Leadership Team and VCS Divisional Team then EMB Review. QSP SDC	JCC and Welsh Government
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director of VCS	X	X		SE Wales Group	Performance Report – Divisional Team, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review
C7	Demand and Capacity Planning to identify gaps within service delivery models	Director of VCS	X	X		Service area operational planning meeting	Performance Report – Divisional Team, EMB, QSP and Board	Welsh Government Quality, Planning and Delivery Review
GAPS IN CONTROLS						GAPS IN ASSURANCE		ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand and patient outcomes. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally as part of Infected Blood Inquiry recommendations.	There is insufficient assurance on the effectiveness of demand-related decision-making because WBS cannot currently validate whether blood issuing patterns, Health Board activity changes and patient outcomes are aligned due to the absence of real-time vein-to-vein data.	Action 01.06
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.	There is limited independent assurance that variation in clinical utilisation across Health Boards and clinical teams is being effectively addressed to improve standardisation	Action 01.07

SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)

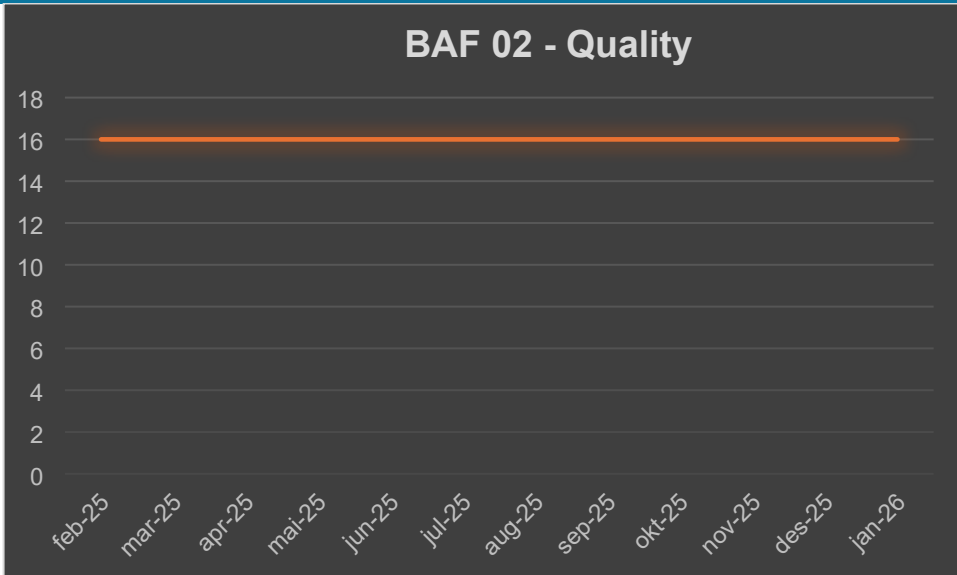
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3418 WBS	There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care.	12	
3643 WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16	
3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	
3634 WBS	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16	
3747 VCS	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment	12	
3714 VCS	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches	12	

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and BAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
01.02	Following publication of the Infected Blood Inquiry Report in May 2024 the Blood Health National Oversight Group has produced a paper for consideration by the Welsh government IBI next steps working group to help align the inquiry recommendations against the National Blood Health plan which should in turn improve prudent use of blood across Wales which in turn supports demand and supply for the Welsh Blood Service.	WBS Director	TBC by Welsh Govt as yet to be scoped		Paper has been endorsed by National Blood Oversight Group on October 8th and was presented to Welsh Government IBI next steps working Group in November. UK Interim report was published in December, and work progresses at a UK wide and Welsh level to support delivery of the recommendations. The service has flagged that delivery of these recommendations will require resourcing across NHS Wales, Revised focus with new Deputy Chief Medical Officer on delivery and commitment, including revised Terms of Reference, membership and task and finish groups. Good progress being made against Leadership and governance arrangements and Education and training workstreams. WBS and Blood Health National Oversight Group have highlighted that Digital Connectivity and a review of workforce supporting transfusion laboratory services across Wales are particular areas that need focus across NHS Wales.	February 26	Trust risk being drafted and will be considered in January QSP and Private Board.	This action is under review and will transfer to BAF 02 regarding Trust wide Quality and Safety

01.03	Capacity and demand business cases across a number of operational areas within WBS have been produced and submitted to JCC for consideration. These include: - Red Cell Immuno-haematology workforce due to increases in demand - Collection team resilience to support demand fluctuations and prevent service going into supply shortages - Introduction of West Nile Virus testing - Increasing recruitment of Welsh Bone Marrow Donor Register Volunteers - Recurrent funding to support our Component Development Laboratory - Staffing infrastructure to support mandated changes upstream. The Blood Supply Chain Planning Group has been established to strengthen oversight and coordination across the end-to-end supply chain. The group is leading the development of an Operational Assurance Framework designed to provide assurance that demand forecasting, collection activity, and component production are aligned with service delivery requirements. This framework will support capacity planning, risk mitigation, and performance monitoring, ensuring resilience and sustainability within the blood supply chain.	WBS Director	Jan 26	Business case discussions between the Trust and commissioners took place in February 2025. None of the cases were supported. October 2025 Resubmitted business cases to JCC for consideration in the IMTP planning cycle. Blood Supply Chain Planning Group: Meets monthly to oversee supply chain resilience. Focus areas include demand forecasting, capacity planning, risk mitigation, and research linked to donor recruitment and retention. Operational Assurance Framework: in development to provide assurance on supply chain alignment. First draft due Q4; development of supporting dashboard starts Jan 2026.	February 26	WBS has gone at financial risk to support some of these cases as part of its IMTP. July 2025 Plan to re-engage with JCC commissioner business cycle on same cases given financial risk being taken. October 2025 Asked for cases to be considered and are expecting them to feature in the planning round. Strengthens governance and planning, reducing the likelihood of supply chain disruptions and improving confidence in meeting service delivery requirements.	
01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing capacity within the outpatient facility and providing care closer to home for the patient	VCS Director	Jan 25	Outreach baseline measured, pathway mapping undertaken by LEAD Practitioner now complete, activity reforecast based on 2025 activity levels. Initial discussion with HBs via COOs meeting	February 26	Understand the operational requirement and the scope/ appetite within HBs. Linked to the Cancer PTL, HIR and Digital Front Door.	Understanding of the operational model within nVCC and outreach locations, as well as the staffing models to support

01.05	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 appropriate	VCS Director	Ongoing		Demand & Capacity undertaken at Service level currently i.e. SACT and Radiotherapy. To date this work has been limited due to the level of data available, meaning discrete work required. However, with the advent of the Cancer PTL & the 'go paperless' initiative more reliable information is becoming available to help drive this agenda and maximise productivity.	February 26	Strengthen the Business Intelligence information linked to performance, capacity & demand and understanding patient flow. This will enable more effective management of resources and service provision.	Will ensure that teams have the information to enable understanding of their services and can manage capacity & demand more effectively.
01.06	Continue to work with NHS Wales Digital, Blood Health National Oversight Group (BHNOG) and the national programmes established through the Infected Blood Inquiry to shape and influence the development of real-time vein-to-vein digital solutions. Establish a defined reporting route through the WBS Futures governance structure to monitor progress and provide updates to SLT and Board on the expected timeline for improved assurance.	WBS Director	Ongoing		New action	February 2026		
01.07	The Blood Health National Oversight Group (BHNOG) to continue leading the national programme of work to reduce avoidable use of blood, including strengthening Patient Blood Management (PBM) adoption and providing clearer, standardised reporting from Health Boards, to support Wales-wide reduction in unwarranted variation in demand management.	WBS Director	Ongoing		New action.	February 2026		

SECTION 1 – Summary											
RISK ID	02	REVIEW DATE	Februaryy 2026	Risk Title	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities, the need for significant service transformation and external factors.					Risk Lead	Director of Nursing, AHPs & Healthcare Science, Executive Medical Director & Chief Operating Officer
CORE ENABLER	Patient and Donor Outcomes and Experience							STRATEGIC GOAL	1 - Outstanding for quality, safety and experience		
CURRENT SCORE TREND	BAF 02 - Quality 							CURRENT RISK SUMMARY	Considerable enhancements made to health and safety processes. However, there is an increase of Duty of Candor incidents within VCS and repeated themes and trends within both divisions identifying the need for robust learning and improvement mechanisms.		
SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	5	4	20		4	4	16		3	3	9
Inherent risk score start date		September 2025						Expected date to reach Target Risk Score		April 2028	
SECTION 3 – Effectiveness, Controls and Assurance											
					Overall Assurance Rating	Current Review Period	3				
						Previous Review Period	3				
					Rationale for Assurance Rating	Trust wide the assurance level is 3, which takes into account the variation across the two clinical divisions.					

								Some measurable impact evident from actions initially taken and an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.			
KEY CONTROLS							SOURCES OF ASSURANCE				
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - 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		
C1	Capacity and demand planning and forecasting	Chief Operating Officer	X	X			Velindre Cancer Services Divisional Team and the introduction of new divisional performance structures to support the operationalisation of the Cancer PTL both internally and across SE regional, moving to a shared PTL.	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking.	Internal Audit, HIW, HEIW and Regional Cancer Meeting		
C2	Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker)	Director of Nursing, AHPs & Healthcare Science COO Director of Planning	X				Pathways Programme VCS/ VCS Quality & Safety Group / VCS Divisional Team	Executive Management Board & Quality, Safety & Performance Committee Benchmarking Peer Review	Regional Cancer Board, JET & IQPD		
C3	Processes in place to capture patient experience, ensuring effective listening and learning	Director of Nursing, AHPs & Healthcare Science Chief Operating Officer			X		Velindre Cancer Service divisional Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & WRP Audits		
C4	Mortality review process and monitoring and Medical Examination Service (MES) in place.	COO Medical Director			X		Velindre Cancer Service divisional Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit		
C5	Velindre Oncology Academy establishment	Director of Nursing, AHPs & Healthcare Science	X	X	X		Velindre Cancer Service divisional Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits		

C6	Clinical audit process and systems in place	Director of Nursing, AHPs & Healthcare Science Medical Director		X	X		Velindre Cancer Service divisional Team/Integrated Quality and Safety Group	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	Internal Audit & Wales Audit Officer Audits
GAPS IN CONTROLS				GAPS IN ASSURANCE				ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	
No PROMS data is currently reported through the organisation.				No current PROMs reporting into PMF				02/01	
The required quality metrics (including mortality) are not currently included in Performance Management Report up Board level. Trust does not currently have a quality dashboard				Quality Dashboard not in place Mortality metrics not all in lace				02/01	
VCS Cancer Data Dashboard not in place.								02/01	
				Patient / Donor voice not currently being systematically formally fed into the meeting structure at all levels of the Trust				02/07	

SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

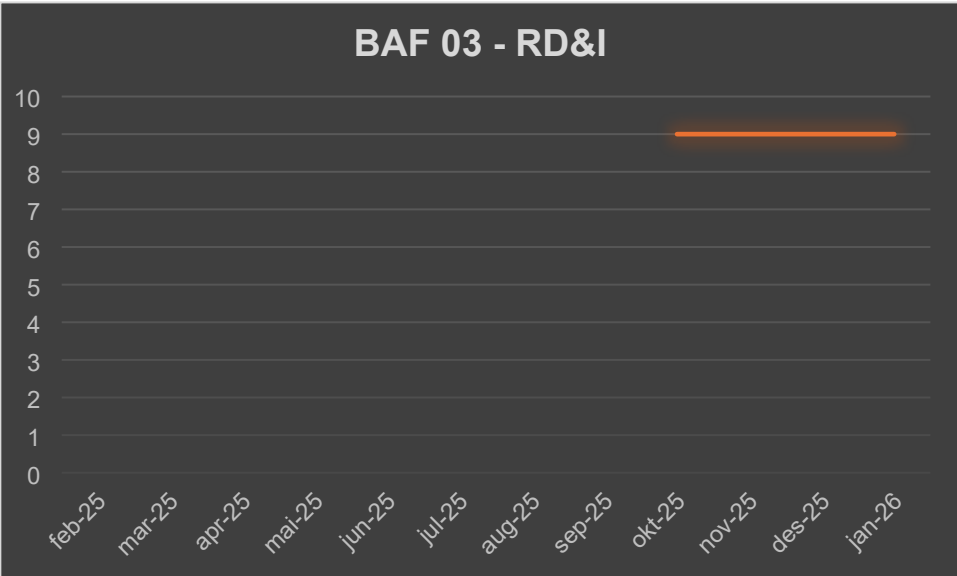
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3418 WBS	There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care.	12	
3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	
3832 VCS	There is a risk to staff safety administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure.	15	
3795 WBS	There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient.	12	
2774 WBS	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	12	
3856 WBS	There is risk to Quality as a result of the installation of data nodes to support the temperature monitoring of 2 new walk-in freezers, leading to disruption of routine services and the implementation of PFM.	12	New risk
3643 WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16	New risk

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	LEVEL/CONTROL WHEN COMPLETE DETAIL IMPACT ON ASSURANCE
02.01	Implement the digitisation of a robust set of service level to Board quality, safety outcome and experience metrics including mortality, aligned with the Performance Management Framework.	Executive Director of Strategic Transformation and Digital	Dec. 2025	2	Some enhancements made to PMF further work required in respect of mortality metrics, PROMs and increasing patient experience feedback at VCS	Jan 2026	A reduction in the likelihood of the risk due to enhanced assurance mechanisms.	
02.02	Deliver a programme of quality and safety investigation training for all potential investigation leads.	Director of Nursing, AHP and Health Science	March 2026	3	Investigation training commenced in November 2025- training dates in place through to March 2026.	Jan 2026	Action should reduce impact and likelihood of the risk through determining the root cause of incidents to prevent future incidents.	
02.03	Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.	Executive Director Finance	March 2027	2	Trust digital PROMS system went live in September within 3 areas. Plan in place to roll out across VCS over the next 2 years. Work is ongoing to import the data to facilitate meaningful analysis.	Feb 2026	Action should reduce impact and likelihood of the risk if there is robust analysis and appropriate action taken following reviewing PROMS outcomes.	
02.04	Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.	Chief Digital Officer	October 2026	1	Implementation plans well under way – on track to have in place by Oct 2026	Jan 2026	Should reduce risk (likelihood and impact) as there is clear evidence that electronic prescribing systems reduce medication, prescription and administration errors.	
02.05	Fully implement all Trust required IBI recommendations.	Chief Operating Officer	tbc	4	Trust is aware of the need to progress infrastructure work and develop business cases for consideration by Joint Commissioning Committee. Escalation to Welsh Government undertaken	October 2025	Should reduce risk (likelihood and impact) by virtue of evidence of learning lessons as outlined by the IBI.	

02.06	Fully implement the revised Putting things Right regulations.	Director of Nursing, AHP and Health Science	April 2026	3	Implementation requirements identified in IMTP – gap analysis undertaken	Jan 2026	Action should reduce the likelihood of the risk by enhanced listening mechanisms	
02.07	Strengthen patient and donor experience feedback mechanisms, specifically to increase the volume of experience feedback provided to the Trust across its services and ensure that patient / donor voice features through floor to Board reporting	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	April 2026	3	Average of 16% feedback for WBS. An increase to 8% VCS patients provided feedback in Quarter 2. New national People Experience framework being implemented on target for completion by April 2026 as noted.	Jan 2026	Action should reduce both likelihood and impact due to enhanced listening mechanisms and opportunities for learning and improvement.	
02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	April 2026	3	Some strengthening undertaken within last 3 months. Further review to be undertaken following publication of the NWSSP hosting review	Jan 2026	Action should reduce both the Trust's overall health and safety risk by being assured that the appropriate quality and safety reporting mechanisms are in place.	
02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	End of March 2026	3	Learning framework in place. However, quality and safety analysis has identified repeated themes which means further strengthening and embedding required with improved ownership and accountability from service level to accountable Director. Benchmarking and Peer Review being incorporated into service redesign and performance, where possible.	Jan 2026	Action should reduce likelihood and impact of risk by ensuring appropriate action will be taken to avoid, in as far as possible, future incidents occurring.	
02.10	To refresh and relaunch Trust patient safety framework.	Director of Nursing, AHP and Health Science	End of Dec. 2025	4	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience.	August 2025	Action should reduce likelihood and impact of risk by having improved awareness, ownership and accountability at all levels.	

02/11	Implement the BCUHB Quality Dashboard and balanced score card	Chief Digital Officer	March 2026	2	Site visit held – project / implementation plan required	Jan 2026		

SECTION 1 – Summary																																			
RISK ID	03	REVIEW DATE	February 2026	RISK TITLE	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10-year Cancer Research Ambition and the Welsh Blood Service Research Strategies. 2. Not fully embedding innovation activities in line with the national Innovation Framework.				RISK LEAD	Executive Medical Director																									
CORE ENABLER	Research, Development, and Innovation				STRATEGIC GOAL	Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority																													
CURRENT SCORE TREND	BAF 03 - RD&I <table><caption>Score Trend Data</caption><tr><th>Month</th><th>Score</th></tr><tr><td>feb-25</td><td></td></tr><tr><td>mar-25</td><td></td></tr><tr><td>apr-25</td><td></td></tr><tr><td>mai-25</td><td></td></tr><tr><td>jun-25</td><td></td></tr><tr><td>jul-25</td><td></td></tr><tr><td>aug-25</td><td></td></tr><tr><td>sep-25</td><td>9</td></tr><tr><td>okt-25</td><td>9</td></tr><tr><td>nov-25</td><td>9</td></tr><tr><td>des-25</td><td>9</td></tr><tr><td>jan-26</td><td>9</td></tr></table>				Month	Score	feb-25		mar-25		apr-25		mai-25		jun-25		jul-25		aug-25		sep-25	9	okt-25	9	nov-25	9	des-25	9	jan-26	9	CURRENT RISK STRATEGY	The risk is currently assessed as moderate but managed, with robust strategies in place to deliver against both the Velindre Cancer Service 10-year Cancer Research Ambitions and the Welsh Blood Service Research Strategy. The risk is being actively managed through robust governance structures reporting to the Trust's RD&I Sub-Committee and onward to the Quality, Safety & Performance and Strategic Development Committees and then to Trust Board, as appropriate. This ensures the Trust maintains alignment with the UK Policy Framework for Health and Social Care Research, The Medicines for Human Use (Clinical Trials) Regulations 2004, as amended; and the ICH Good Clinical Practice Guidelines E6. The oversight of the research risks by the Research Service is supported by delivery plans to manage digital transformation, regulatory preparedness, and strengthen assurance. Key residual risks remain around sustainable funding, workforce capacity, and evidencing OECI / benchmarking outcomes – these are being addressed through targeted actions.			
Month	Score																																		
feb-25																																			
mar-25																																			
apr-25																																			
mai-25																																			
jun-25																																			
jul-25																																			
aug-25																																			
sep-25	9																																		
okt-25	9																																		
nov-25	9																																		
des-25	9																																		
jan-26	9																																		

SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	3	4	12		3	3	9		3	2	6
	Inherent risk score stated date		Oct 2025						Expected date to reach Target Risk Score		Aug 2030

SECTION 3 – Effectiveness, Controls and Assurance

Overall Assurance Rating	Current Review Period	5
	Previous Review Period	5
Rational for Assurance Rating	- Strategies aligned to national frameworks are in place. - Governance structures and oversight are operational. - New digital tools roll-out to begin planning for implementation commencing in FY2025/26, Q3. - Evidence against OECl accreditation metrics and confirmed sustainable funding not yet embedded.	

KEY CONTROLS						SOURCES OF ASSURANCE			
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE	
						- Functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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	
	Research strategies defining Trust ambitions for research & innovation in line with national priorities (Trust Cancer Research Ambition, WBS Strategy, WG Innovation Framework)	Executive Medical Director				- Strategies set direction and ensure alignment to national priorities. - Progress and Performance reported through RD&I Integrated Performance Report - Internal self-assurance. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Quality, Safety & Performance Committee.	Oversight from: - National reporting of key indicators to Health and Care Research Wales. - Monthly meetings with HCRW Research Delivery Management - Joint Executive Team Management meetings with Welsh Government. Additionally external peer feedback.	
	Deliver plans for research governance/delivery are monitored to assure progress on delivery	Head of R&D				- Delivery plans allow oversight and tracking and include IMTP, VPAG delivery reporting, and Charitable Fund Investment plans - Defines Key Indicators and timelines - Reporting through RD&I Integrated Performance Report. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Quality, Safety & Performance Committee Charitable Funds Committee	Reporting through: - Monthly meetings with HCRW Research Delivery Management - HCRW monthly returns - VPAG monthly returns to HCRW	

KEY CONTROLS						SOURCES OF ASSURANCE				
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE		
						- Functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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		
	Benchmarking research activity (through OECI accreditation membership, UK peer cancer centre comparisons)	Head of R&D / Research Delivery Manager				- Benchmarking allows the Trust to provide external performance standards comparisons and mitigates reputational risk from under-performance. - OECI local assessment and data returns and benchmarking output reports - Reporting through RD&I Integrated Performance Report. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee	OECI peer review and international accreditation.		
	Engagement with UK / National bodies	Executive Medical Director / Associate Medical Director for RD&I				- Ensures compliance with national standards and mitigates isolation from national networks. - Progress and Performance reported through RD&I Integrated Performance Report - Internal self-assurance. - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - Monthly meetings with HCRW Research Delivery Management	- MHRA Inspection Findings Reporting - HCRW / Welsh Government Annual Research Performance Review		
	Cardiff Cancer Research Partnership (CCRP)	Cancer Research & Development Strategy Lead				- Enables joint planning and capacity building, mitigates duplication of effort. - Progress and Performance reported through RD&I Integrated Performance Report. - Internal self-assurance. - CCRP Clinical Operational Group - RD&I Senior Core Team oversight. - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee - CCRP Project Board	- Tri-Partite partnership board - Joint Executive Team Management meetings with Welsh Government. - Welsh Government		

KEY CONTROLS						SOURCES OF ASSURANCE			
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE - Functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - 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	
	Welsh Blood Service research governance	WBS Head of RD&I Services				- Strategy aligns WBS research with Trust strategy - Mitigates siloed WBS research activity - WBS Progress and Performance reported through RD&I Integrated Performance Report and monthly research reports. - Internal self-assurance. - WBS RD&I Group - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee	- Welsh Government oversight - Blood Service audits by MHRA, Human Tissue Authority	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
a. Benchmarking with UK peer cancer centres to review optimal model for Research Service infrastructure and delivery within UK organisational structures. b. Limited internal and independent audit of Research Service processes to date. c. Financial sustainability due to dependence on multiple internal and external funding streams.		a. Benchmarking with UK peer cancer centres to review optimal model for Research Service infrastructure and delivery within UK organisational structures. ACTION REF.: 03.01. b. Limited internal and independent audit of Research Service processes to date. ACTION REF.: 03.02. c. Financial sustainability due to dependence on multiple internal and external funding streams. ACTION REF:03.03.

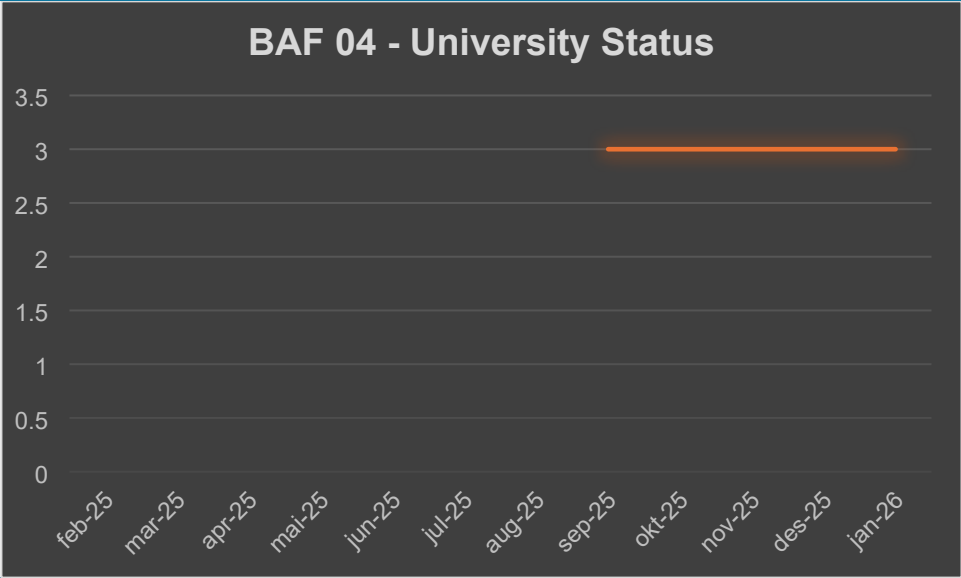
SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)				
DATIX RISK REF		CURRENT RISK RATING	RISK TREND	
	There are currently no risks on the Trust Risk Register relating to this strategic risk			

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL / CONTROL WHEN COMPLETE
03.01	Develop and implement a structured benchmarking programme with UK peer cancer centres to review optimal Research Service infrastructure, workforce, and delivery models. Align benchmarking outputs with OECl Designation criteria and partnership theme.	Associate Medical Director for RD&I / Head of R&D / Research Delivery Manager	December 2026		A benchmarking visit to The Clatterbridge Cancer Centre NHS Foundation Trust was completed on 26 November 2025. This provided valuable, first-hand insight into a mature, disease-site-based approach to research study set-up, delivery, ongoing management, and governance oversight, including the alignment of workforce models, training, and operational accountability. Following the visit, a structured set of clarification and follow-up questions has been submitted to Clatterbridge colleagues to enable deeper understanding of specific operational, workforce, and financial arrangements and to support meaningful comparison with Velindre’s current and future-state models. Key learning themes from the benchmarking activity are now being synthesised into a structured paper, with accompanying recommendations to inform a phased programme of improvement and enhancement for the Velindre Research Service. This includes explicit consideration of how benchmarking outputs align with OECl Designation requirements, particularly in relation to integrated research delivery, workforce capability, governance maturity, and partnership working. Ongoing peer-to-peer dialogue between the two organisations will continue to support this work.	February 2026	Provides external reference points to shape Research Service structure; reduces risk of sub-optimal infrastructure	Assurance strengthened through comparative data, peer review evidence, and alignment to OECl standards.

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL / CONTROL WHEN COMPLETE
03.02	Commission a programme of internal and independent audits of Research Service processes, including study set-up, delivery, and governance. Scope to cover compliance with UK Clinical Trials Regulation and ICH GCP E6(R3), coming into force in April 2026, linked to workforce development/training theme.	Head of R&D / Research Delivery Manager	March 2027		Work is underway to establish a structured programme of internal and independent assurance across Research Service processes, including study set-up, delivery, and governance, aligned to the forthcoming implementation of the UK Medicines for Human Use (Clinical Trials) Regulations 2024 and ICH GCP E6(R3) in April 2026. As a foundational step, a comprehensive refresh of the Research Service Standard Operating Procedure (SOP) suite is in progress. This is being delivered through a phased and risk-based approach, including finalisation of the overarching SOP framework, prioritisation of procedures linked to high-risk and high-impact activities, and allocation of authorship across the Research Service and relevant supporting functions. This work is deliberately sequenced to provide a clear, controlled baseline against which internal audits can be commissioned, ensuring that audit scope, criteria, and findings are directly aligned to current regulatory requirements and inspection expectations. The SOP refresh is being coordinated with wider implementation activity, including inspection readiness planning, workforce training, and the introduction of new digital systems, to ensure consistency between documented processes, operational practice, and assurance mechanisms. This alignment will enable future internal audits to test not only procedural compliance, but also real-world application and governance effectiveness across the study lifecycle. In parallel, benchmarking intelligence is actively informing the development of a comprehensive RD&I / clinical trials workforce training programme aligned to the April 2026 regulatory changes. Foundational work is underway to map training requirements against the UK Clinical Trials Regulations 2024 and ICH GCP E6(R3), alongside consolidation of existing internal provision and identification of priority external training routes, including Health and Care Research Wales and specialist non-commercial and commercial providers.	February 2026	Identifies weaknesses early, reduces exposure at MHRA/OECI inspection	Assurance strengthened through regular audit cycles, embedding independent oversight.

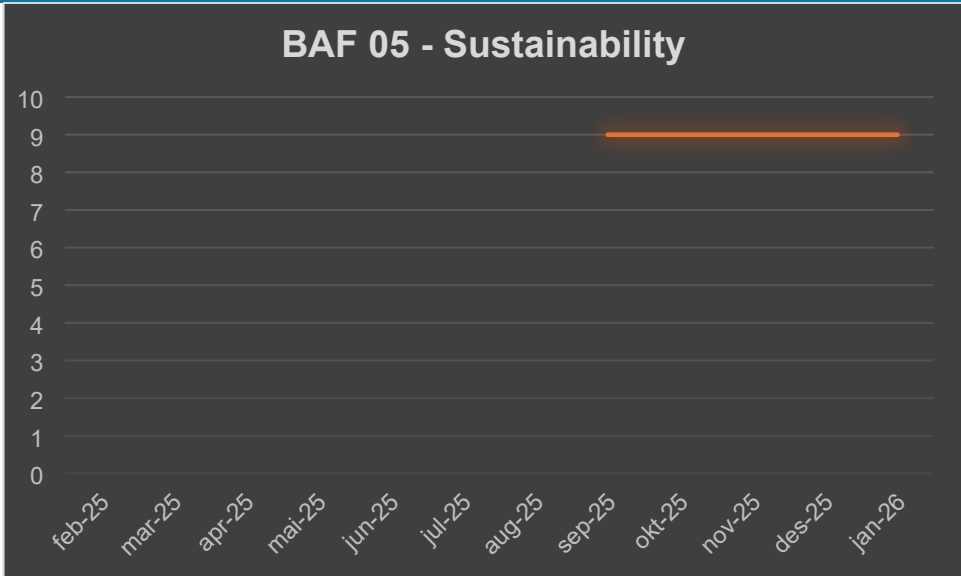
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL / CONTROL WHEN COMPLETE
03.03	Develop and implement a sustainable funding model for RD&I, reducing dependency on charitable and short-term funding streams. Link to financial sustainability theme and VPAG/charitable investment planning.	To be advised	April 2027		VPAG funding arrangements remain in place, with active engagement ongoing with Health and Care Research Wales (HCRW). Work is progressing to reprofile the Year 1 VPAG spending plan and review associated SMART objectives to ensure continued alignment with delivery timelines, workforce deployment, and programme outputs. In parallel, the Charitable Funds Integrated Bid 2026–29 has been considered through Trust governance processes. The development of a longer-term- RD&I funding approach focused on evidencing value and return on investment, including clearer mapping of workforce inputs to research outputs, maximising cost attribution, and supporting additional transition to delivery that facilitates commercial income growth. Executive oversight remains focused on achieving greater financial sustainability over the medium term, with commercial research growth identified as the critical enabler to reducing reliance on short-term and charitable funding streams.	February 2026	Reduces risk of financial instability and service interruption.	Assurance strengthened by predictable, recurrent funding sources and clearer accountability across multiple income streams

SECTION 1 – Summary									
RISK ID	04	REVIEW DATE	February 2026	Risk Title				Risk Lead	Non Gwilym
CORE ENABLER	University Status					STRATEGIC GOAL	An established University Trust which provides highly valued knowledge and learning for all		
CURRENT SCORE TREND	BAF 04 - University Status 					CURRENT RISK SUMMARY	Controls have been identified. All controls reporting as preventative and as being managed resulting in an improved rating of 6.		

SECTION 2 – Risk Scores											
Inherent Risk	Impact	Likelihood	Total	Current Risk	Impact	Likelihood	Total	Target Risk	Impact	Likelihood	Total
	3	1	3		3	1	3		3	1	3
Inherent risk score start date		July 2025							Expected date to reach Target Risk Score		July 2025
SECTION 3 – Effectiveness, Controls and Assurance											
						Overall Assurance Rating	Current Review Period	6			
							Previous Review Period	6			
						Rationale for Assurance Rating	The Assurance Rating is considered on the basis of the risk score, actions and controls in place to mitigate against the risk,				
Key Controls				Sources of Assurance							

ID	KEY CONTROLS	OWNER					FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - 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	
C1	University Independent Board Member	Director of Corporate Governance	X				University Independent Board Member is confirmed and term of office known and understood.	Six monthly review of Board Membership undertaken by Director of Corporate Governance and Trust Board.	Audit Wales Structured Assessment.	
C2	Robust collaboration with university partners, for example deed of association with the University of Wales, Trinity St Davids, Cardiff University: multi-professional research SLA; Cardiff Cancer Research Hub.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	04.02	
C3	Academic partnership arrangements across a range of universities in Wales.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	04.02	
GAPS IN CONTROLS							GAPS IN ASSURANCE		ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.	
No Gaps in controls.							No gaps in assurance		-	
SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)										
DATIX RISK REF									CURRENT RISK RATING	RISK TREND
	There are currently no risks relating to this strategic risk									
SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and BAF Actions)										

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
04.01	Review Board membership	Director of Corporate Governance Director of Corporate Governance	1 October 2025	6	Review will take place during September alongside new Chair and Independent Members Group.	February 2026	Further review will provide assurance that the requirements regarding University Status are being met through Board membership.	Increase in score of assurance level.
04.02	Review of Academic Partnership Board	Director of Corporate Governance Director of Corporate Governance	1 October 2025	4	Review will take place during September alongside new Chair and Independent Members Group.	February 2026	Further review will provide clarity on purpose and structure of Academic Partnership Board.	Increase in score of assurance level.

SECTION 1 – Summary											
RISK ID	05	REVIEW DATE	February 2026	Risk Title	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.					Risk Lead	Director of Place, Portfolio and Partnerships
CORE ENABLER	Sustainability					STRATEGIC GOAL	A sustainable organisation that plays its part in creating a better future for people across the globe				
CURRENT SCORE TREND	BAF 05 - Sustainability 					CURRENT RISK SUMMARY	The Trust has strong operational environmental controls and assurance through governance groups, ISO 14001, and audits. Key gaps in capital decision-making, clinical pathways, and job descriptions are being addressed through targeted actions to achieve full integration and reduce strategic risk.				
SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	4	4	16		3	3	9		2	2	4
Inherent risk score start date		September 2025		Expected date to reach Target Risk Score							
SECTION 3 – Effectiveness, Controls and Assurance											
					Overall Assurance Rating	Current Review Period		4			
						Previous Review Period		4			
					Rationale for Assurance Rating	An assurance level of 4 for sustainability reflects that robust governance, policies are in place. The Climate Action Board provides regular oversight, supported by ISO 14001 certification (surveillance audit passed in October 2025), sustainability internal audits, and active working groups driving progress across all key themes. Clear reporting, engagement, and delivery against sustainability objectives demonstrate strong assurance and continuous improvement.					
KEY CONTROLS					SOURCES OF ASSURANCE						

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
C1	Creating Wider Value: Our Organisational Approach	Trust Sustainability Manager		X		Performance reporting / highlight reports	Well-being Objectives alignment embedded in Trust governance – board papers Climate Action Board	ISO 14001:2015 External Audit NWSSP Internal Audit Audit Wales
C2	Sustainable Care Models	Trust Sustainability Manager		X		Review through Clinical Sustainability MDT Climate Action Board ISO14001:2015 Internal Audits Environment Policy / divisional Environmental Statements Enviromental Manual	Clinical Sustainability MDT EMB SLT Strategic Development Committee	NWSSP Internal audit Audit Wales
C3	Carbon Zero	Trust Sustainability Manager		X		Site based Sustainability Implementation Plans (SIPs) Site-level energy monitoring Enviromental Manual	Cynefin Fire, Risk, Estates, Sustainability and Health &0 Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C4	Sustainable Infrastructure	Trust Sustainability Manager	X			Capital projects – nVCC / TGI Project risk registers Site based Sustainability Implementation Plans	Capital Project Board/ nVCC Project Board Specialist engineering / sustainability consultants on nVCC project Reviewable Design Data Process	BREAM Excellent aiming for Outstanding standards in nVCC / TGI. ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
C5	Sustainable Infrastructure	Trust Sustainability Manager	X			Waste Management Policy Waste segregation and recycling at source Single-use plastic phase-out Site based Sustainability Implementation Plans Site level waste monitoring	ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health &0 Safety Group (FRESH) ISO14001:2015 Management Group	ISO 14001:2015 External Audit NWSSP Internal Audit Waste contractor compliance audits

C6 C7 C8 C9 C10	Transition to a Renewable Future	Trust Sustainability Manager		X		Capital projects – nVCC / TGI Site based Sustainability Implementation Plans Building Management System (BMS) optimisation	Quality, Safety & Performance Committee Capital Project Board/ nVCC Project Board Specialist engineering / sustainability consultants on nVCC project Reviewable Design Data Process	BREAM Excellent aiming for Outstanding standards in nVCC / TGI. ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
	Connecting with Nature	Trust Sustainability Manager	X			Green Social Prescribing Partners Biodiversity Enhancement Plan (incl. in SIPs)	Climate Action Board Engagement Committees Activities	External biodiversity audits Internal Audit ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
	Greening Our Travel and Transport	Trust Sustainability Manager	X			Trust Travel Plan 2022 – 2027 Site based Sustainability Implementation Plans Cycle to Work Scheme	Annual Travel Survey ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health & Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
	Adaption to Climate Change	Trust Sustainability Manager	X			Climate risk assessments Site emergency preparedness plans Incorporation of adaptation measures in nVCC / TG projects Site based Sustainability Implementation Plans	Climate Action Board Health & Safety Meeting ISO14001:2015 Management Group Cynefin Fire, Risk, Estates, Sustainability and Health & Safety Group (FRESH) ISO14001:2015 Management Group Quality, Safety & Performance Committee	ISO 14001:2015 External Audit NWSSP Internal audit Audit Wales
	Our People as Agents for Change	Trust Sustainability Manager		X		Sustainability Induction and Training Staff engagement programmes Sustainability Staff awards	Healthy and Engaged Steering Group Fire, Risk, Estates, Sustainability and Health & Safety Group (FRESH)	ISO 14001:2015 External Audit

GAPS IN CONTROLS		GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Integration of sustainability into all governance and capital decision-making		Capital projects may be approved without consistent consideration of environmental impacts	5.1
Embedding sustainability in clinical pathways (new Clinical MDT not yet fully operational)		Under development and not yet integrated into standard practice	5.2
Inclusion of sustainability in all job descriptions		Not currently part of standard recruitment materials or role profiles; opportunity to align with Well-being of Future Generations requirements	5.3

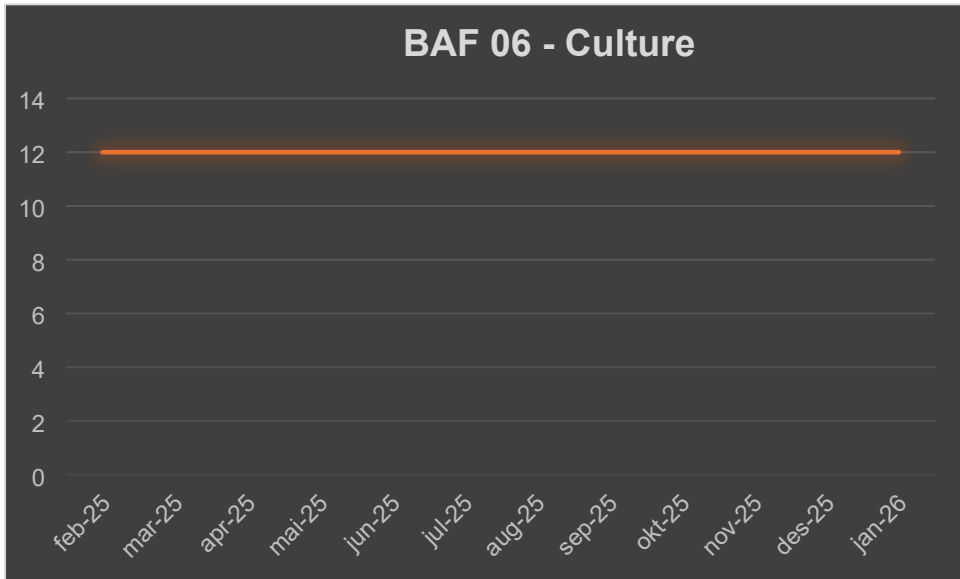
SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
	There are currently no risks relating to this strategic risk		

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
5.1	Embed sustainability considerations into capital project decision-making processes, including mandatory environmental impact assessments in business cases	Trust Sustainability Manager / Capital Projects Lead	31/03/2026	3	Draft environmental impact assessment template developed. Discussions underway with Capital Project Manager.	February 2026	Reduces risk that capital projects progress without due consideration of environmental and sustainability factors.	Provides the Board with assurance that sustainability is systematically addressed in all investment and governance processes. Strengthens First and Second Line Defence.
.3	Include sustainability and Well-being of Future Generations duties in all job descriptions and recruitment materials	Trust Sustainability Manager /Workforce Lead	31/03/2026	2	Review of current job descriptions underway prior to developing draft wording prepared for future recruitment packs.	February 2026	Addresses risk that sustainability is not embedded into organisational culture and staff responsibilities.	Ensures sustainability is reinforced as a core organisational value. Expands cultural and operational controls across the First Line of Defence.

of

SECTION 1 – Summary										
RISK ID	06	REVIEW DATE	February 2026	Risk Title	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes				Risk Lead	Director of OD and Workforce
CORE ENABLER	Organisational Culture				STRATEGIC GOAL	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations				
CURRENT SCORE TREND	BAF 06 - Culture 				CURRENT RISK SUMMARY	This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 2026 on the organisational development plan to support the transition to nVCC. Risk score trend: The risk score has remained static since the last period.				

SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	4	4	16		3	4	12		3	2	6
Inherent risk score start date		March 2025						Expected date to reach Target Risk Score		31.03.2027	
SECTION 3 – Effectiveness, Controls and Assurance											
						Overall Assurance Rating	Current Review Period	3			
							Previous Review Period	3			
						Rationale for Assurance Rating	Detail of assurance levels reported though the assurance paper on Workforce Supply and Shape to the Quality, Safety and Performance Committee.				
KEY CONTROLS				SOURCES OF ASSURANCE							

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
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	Director of Planning	X			Reports to EMB	Trust Board reporting on strategy and controls via cycles of business	Welsh Government reporting via JET and IMTP
C2	Approved Education Implementation plan aligned to People Strategy to support the educational development of the Organisation to support the Trust direction	Deputy Direct of OD and People	X			People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Deputy Direct of OD and People	X			People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C4	Trust Values and Behaviour Framework	Deputy Direct of OD and People	X			Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C6	Health and Wellbeing infrastructure for the Trust to support physical and psychological wellbeing of staff	Deputy Direct of OD and People	X			Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Assistant Director of Communications	X			Reports to EMB	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Director of Planning	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C9	Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles	Chief Operating Officer	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C10	Operational workforce plans developed to support agreed service models	Chief Operating Officer	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports

C11	Avoidable employee harm principles are embedded into the management of behaviours within the Trust	Director of OD and People	X				Healthy and Engaged steering group and Local Partnership Forum	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C12	Monitor Welsh Language Standards, working with Divisions on improvement plans	Director of OD and People	X				Welsh Language Development Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Further work is required to fully develop control C5.		
Communication infrastructure needs to be in place to support the communication of leadership messages and of staff including employee voice		06.12

SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
	There are currently no associated risks on the Trust Risk Register		

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF Actions)

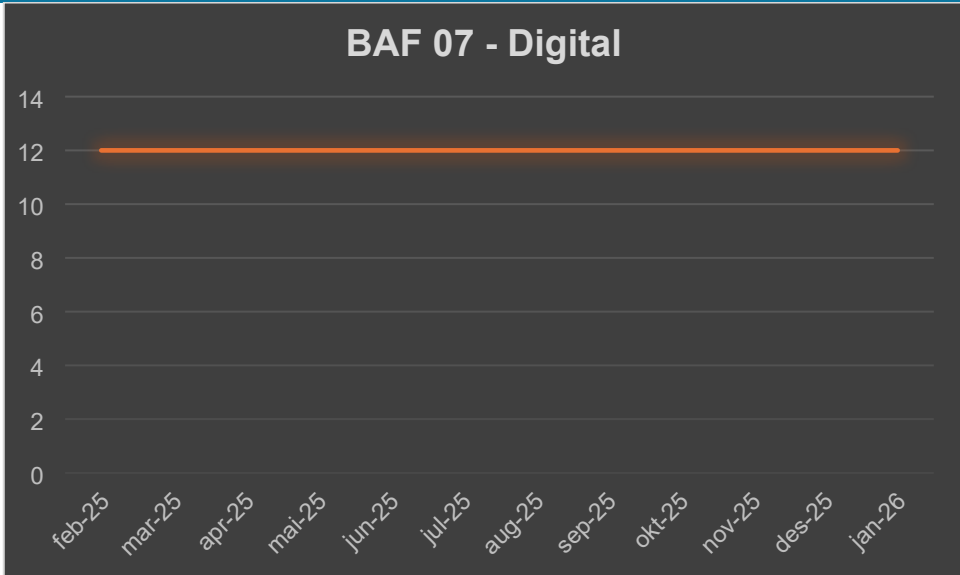
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
06.05	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	OD Specialist	31.03.2026		Quarter 3 report went to the Healthy and Engaged Steering Group on 11.02.2026. As at January 2026, compliance with the Anti-racist Wales e-learning package was 88%	February 2026		

06.06	Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	OD Specialist	31.03.2026		Quarter 3 report went to the Healthy and Engaged Steering Group on 11.02.2026. Actions have been completed regarding launching Work in Confidence and the framework for Speaking Up Safely. Areas still to be worked on relate to the culture development which are under consideration at Board level.	February 2026		
06.11 (now includes previous action 06.07)	Embed positive values and behaviours across the Trust to create positive culture. Cultural Baseline Review	Interim Director of People and OD	March 26		Capability and capacity required to complete the work. Following Board discussion programmes are being commissioned to support the development of culture, leadership and governance.	February 2026		
06.12	C5 Introduce an infrastructure to support Communication infrastructure in place to support the communication of leadership messages and engagement of staff including employee voice	Assistant Director of Communications	March 26		Draft infrastructure plan developed and under review.			

CLOSED ACTIONS

06.01	Undertake analysis of current employee voice mechanisms and develop an engagement action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	OD Specialist	Mar 25		Feedback from staff showed a desire to have clearer information about how to Speak Up. A video has been created and added to the intranet which is now used for general staff information and in induction situations. Work in Confidence is being commissioned to offer an additional, anonymous, route for reporting concerns. This action has been subsumed into action 6.15 and can be closed.	25.06.2025		

06.02	Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Head of Workforce	Apr 25		06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session, a meeting will be planned with the Chair of Strategic Development Committee to plan governance routes. 27.01.2025 Session delivered to Board on the Duty. Meeting with SDC Chair set up. 11/09/2025 - closed.	September 2025		
06.08	Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working				KPIs and metrics are a standard agenda item on Healthy and Engaged Steering Group. Action Closed			
06.09	Deliver an action plan for 2024/25 to support our commitment to the Trust Anti- Racist Action plan				Contained in action 6.05. This can be closed			

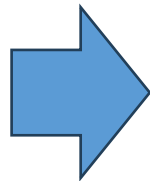
SECTION 1 – Summary												
RISK ID	07	REVIEW DATE	February 2026	Risk Title	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security					Risk Lead	Chief Digital Officer	
CORE ENABLER	Digital Transformation					STRATEGIC GOAL	All					
CURRENT SCORE TREND	BAF 07 - Digital 					CURRENT RISK SUMMARY	Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position. Risks have been added to reflect the operational Digital risk - including challenges with delivering the National Programmes for RISP and LIMS. Go-live date for RISP agreed (April '26 from January 26) due to National/Regional image viewer capabilities. No go-live date agreed for LIMS nationally., some elements are live, however blood transfusion module does not have a go live date. The delivery of National Programmes through DHCW re still in escalation level 3. Key controls have been reviewed, gaps identified and action plan updated. Risk score trend: The risk score has remained static since the last period.					
SECTION 2 – Risk Scores												
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL	
	4	4	16		4	3	12		4	2	8	
Inherent risk score start date			March 2025						Expected date to reach Target Risk Score			June 2026
SECTION 3 – Effectiveness, Controls and Assurance												
						Overall Assurance Rating	Current Review Period	3				
							Previous Review Period	3				
						Rationale for Assurance Rating	Assurance Rating 3 was agreed through the Digital Annual Report process at QSP and continues to represent the overall digital position.					
KEY CONTROLS					SOURCES OF ASSURANCE							

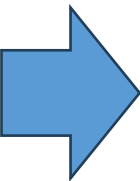
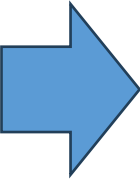
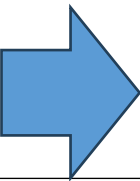
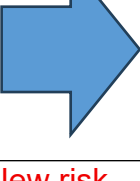
ID	KEY CONTROLS KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
							- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
C1	Trust Digital Strategy - Published Oct '23	Carl James	X				Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	EMB/ SIRO Reports/ Strategic Development Committee/ QSP Committee/	Internal Audit
C2	Trust Digital Strategy - Published Oct '23	Carl James		X			Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	EMB / National Programme Boards / SIRO Reports/ Strategic Development Committee/ QSP Committee/	Internal Audit/ National Programme Governance
C3	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Carl Taylor	X				Staff feedback - KLAS Survey - Mandatory Training stats	EMB /SIRO Reports/ Strategic Development Committee/ QSP Committee/	Internal Audit
C4	Training & Education packages to develop internal capabilities – including for exec and Board	Carl Taylor	X				Patient and Donor feedback Trust Digital Inclusion Plan	EMB / Strategic Development Committee/ QSP Committee	Internal Audit / Digital Communities Wales Accreditation
C5	Training & Education packages for donors, patients	Carl Taylor	X				Review of proposals via EMB/Board Digital IMTP Trust Capital Programme Digital Spend included in PMF (Current 2.6%)	EMB / Strategic Development Committee/ QSP Committee/	Internal Audit
C6	Ring-fencing digital advancement in Trust budget – benchmark 4%	Carl Taylor	X				Review of proposals via EMB/Board Digital Programme Board	EMB / Strategic Development Committee/ QSP Committee / Audit Committee	/ Internal Audit/ External Audit of Accounts
C7	Specifically development of digital resources capacity and capability	Carl Taylor	X				Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales Digital Inclusion Plan accreditation achieved April '25	EMB / Strategic Development Committee/ QSP Committee/	Digital Communities Wales Accreditation
C8	Digital inclusion in wider community	Carl Taylor	X				Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	EMB QSP Committee/	Internal Audit/ Digital Communities Wales
C9	Prioritisation and change framework to manage service requests	Carl Taylor			X		Trust Digital governance reporting Digital Programme Board	EMB / Cyber Action Plan / QSP Committee	Internal Audit / Cyber Resilience Unit

C10	Levels of unsupported applications/ legacy systems	Carl Taylor		X		Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	EMB / SIRO Reports/ Strategic Development Committee/ QSP Committee/	Internal Audit / Cyber Resilience Unit
C11	Trust digital Governance	Carl Taylor		X		Review via Divisional SMT/SLT	EMB / SIRO Reports/ QSP Committee/	Internal Audit / WG IQPD
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Carl James		X		Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	EMB / Strategic Development Committee/ QSP Committee	Internal Audit/WG/CRU as competent authority for NIS
C13	Cyber Assurance Controls in place	Carl Taylor	X	X		Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	EMB / SIRO Reports/ Strategic Development Committee/ QSP Committee	Internal Audit/CRU as competent authority for NIS
C14	Digital transformation is guided by an agreed digital architecture.	Carl Taylor		X		Digital Programme Board Digital Design Authority being established	EMB / Strategic Development Committee	Internal Audit
C15	Establish strategy, policies and guidance for the implementation and maintenance of AI technology	Carl Taylor/ Clinical and Scientific Strategy Board	X	X		Clinical and Scientific Strategy Board/ Digital Programme Board/ Caldicott Guardian, SIRO, DPO	EMB / Strategic Development Committee/ Quality, Safety and Performance Committee	Internal Audit/ CRU?/ DDaT Leadership Board
C16	Trust Information Governance	Matthew Bunce (SIRO)	X	X	X	IQSG, Divisional Quality and Safety Hubs, Divisional Directors	EMB / Performance Committee, Independent Member for IG/Digital	Internal Audit/ CRU?/ DDaT Leadership Board, ICO, Welsh Government

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
C3 LIMS and RISP minimising the impact of national programme delays		07.04
C6 Not yet at 4% benchmark level, no current plan of how to reach the required level.		07.05
C14 The impact assessment of the national target architecture and alignment of local Velindre architecture		07.04

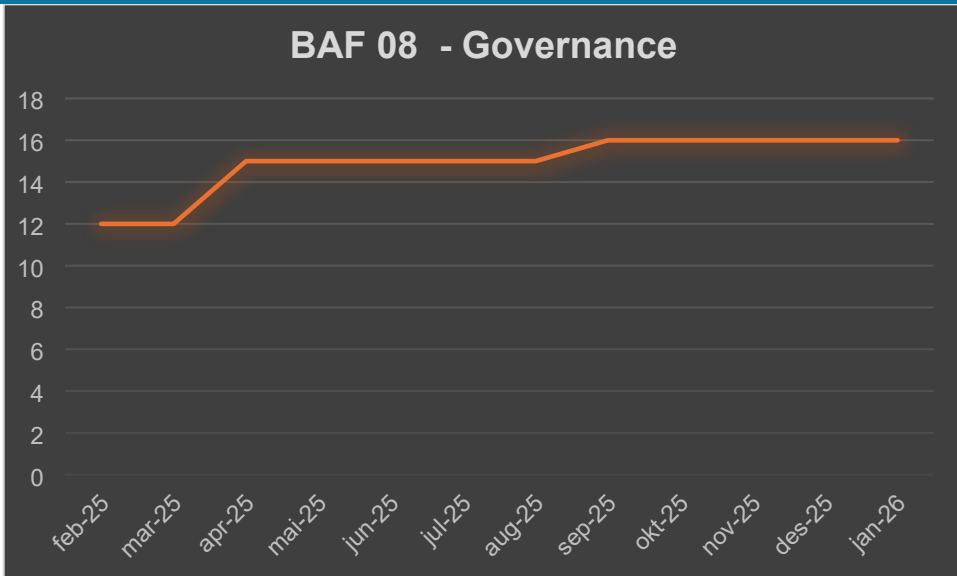
SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3634 Corporate	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16	

3643 WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	15	
3633	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	12	
3632	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16	
3646 Corporate	There is a risk to PERFORMANCE AND SERVICE SUSTAINABILITY that the WLIMS2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes and additional demand for further development of existing legacy systems. Project ID WO2-02 Risk ID R131	20	
3388 WBS	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16	
3716 WBS	There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.	12	New risk
3801 WBS	There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise	16	New risk

SECTION 5 – ACTION PLAN (IMTP Priority Improvement Actions and BAF Actions)								
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE

07.01	Create the Trust Digital Reference Architecture to support C14 and others	Carl Taylor	Mar 26	2	National Target Architecture has been completed and is being formed into a set of business cases. Digital Design Authority has now meets regularly. National Target Architecture programme has now been initiated and the Trust continue to actively engage in the business case development.	Feb 26	Digital Design Authority will guide digital transformation	The level of assurance should increase from 3-4 for C13, C15 and C16
07.02	C9 - Prioritisation framework needs to be established for the Data and Insight Service. Prioritisation framework to be introduced by Portfolio Team.	Lauren Fear	Mar 26	3		Feb 26	Will contribute to reduction in likelihood of risk	C9 would move to Effective
07.03	Reviewing control framework with Head of Information Governance for cross-check and alignment	Carl Taylor	Complete		Review, cross check and alignment complete.	Feb 26	Will contribute to reduction likelihood of risk Controls C15 and C16 are included in the BAF	Additional assurance for C11, C13
07.04	Active participation in new Digital Data and Technology Leadership Group and Delivery Board. Agreed Trust's participation in the two groups and influence the scope.	Carl Taylor/ Carl James	April 26		DDAT Group have met three times and delivery board have met twice. The Trust has been represented in those meetings.	Feb 26		
07.05	Complete digital diagnostic and the investment case for future investment in the digital service	Carl Taylor/ Matt Bunce	March 26 for diagnostic		Diagnostic is well advanced. Initial feedback was presented to the Digital Programme Board in January 2026	Feb 26		

SECTION 1 – Summary											
RISK ID	08	REVIEW DATE	January 2026	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.					Risk Lead	Director of Corporate Governance
CORE ENABLER	Organisational and Clinical Governance					STRATEGIC GOAL	1 - Outstanding for quality, safety and experience				
CURRENT SCORE TREND	BAF 08 - Governance 					CURRENT RISK SUMMARY	Refreshed Risk Policy on track to deliver for 3 March 2025 Audit committee. The Trust is working with Welsh Government and NWSSP regarding the next steps for the review of NWSSP Accountabilities and Governance. A specification for expert advice on a review of the Board's structure and development programme has been completed due to commence in the new year and to be concluded before the end of the FY. Structured Assessment interviews underway to be completed before the end of the calendar year. Target date has been reduced due to publication of the WG report and progress made on Risk Policy and Board Development programme.				
SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	4	4	16		4	6	16		3	2	6
	Inherent risk score start date		March 2025		Expected date to reach Target Risk Score: May 2026						
SECTION 3 – Effectiveness, Controls and Assurance											
					Overall Assurance Rating	Current Review Period	3				
						Previous Review Period	3				
					Rationale for Assurance Rating	Increased assurance rating due to receipt of WG report on NWSSP hosting arrangements and confirmed plan for review of Risk Policy.					
KEY CONTROLS					SOURCES OF ASSURCE						

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
							- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
C1	Trust Risk Register framework, policy, procedures and Risk Appetite Statement.	Director of Corporate Governance		X			Divisional Management Boards Executive Management Board	QSP/Audit/Strategic Development Committees (BAF), Trust Board	Internal Audit Reports
C2	Annual Assessment of Board Effectiveness	Corporate Governance Manager			X		Annual Board Effectiveness review	Audit Committee	Internal Audit Reports
							Annual Self-Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	Trust Board	
C3	Board Committee Effectiveness Arrangements	Director of Corporate Governance	X				Internal Audit Review	Audit Committee	Audit Wales Structured Assessment Programme / Reports
								Trust Board	Joint Escalation & Intervention Arrangements
C4	Board Development Programme	Director of Corporate Governance	X				Programme established	Trust Board in Board Development	Internal Audit of Board Committee Effectiveness
									Audit Wales Structured Assessment
									Audit Wales Review of Quality Governance Arrangements
C5	Quality of assurance provided to the Board	Director of Corporate Governance	X				Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	Trust Board assessment via formal annual and additional effectiveness review exercises	Specialist external input as required, for instance on Socio-economic Duty
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Director of Corporate Governance	X				Full cross-reference of Governance, Assurance and Risk work into BAF 06 in this respect	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Director of Corporate Governance	X				Executive Management Board	Strategic Development Committee Audit Committee Quality, Safety and Performance Committee	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports
GAPS IN CONTROLS							GAPS IN ASSURANCE		ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Risk Policy under review Board development programme under review							Third line of defence in respect of C4 - Board Development Programme		Refreshed programme to be discussed by Board on 23 October 2025.

SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3656	There is a risk to the quality of clinical and corporate governance caused by a lack of assurance and effective reporting of hosted units' custom and practice with regard to: - Employment issues - Health and Safety issues - Medical licences - Scope of Corporate Activity	16	

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work.	Director of Corporate Governance	Nov-24	5	External benchmarking now embedded into practice.	Oct 2025	Benchmarking will provide further assurance to the Board. GAR Group to receive update at next meeting in May 2025.	Delivery of the action will provide assurance to the Board on the quality of GAR programme output. Output to be considered as accessible to all staff and as an enabler to service improvement.
08.02	Develop new plan for phase 2 GAR programme.	Director of Corporate Governance	Dec-24	2	GAR focused on improvements on decision/action reporting for minutes, refreshed risk policy and finalising BAF.	Oct 2025	Activity during January / February 2025 significantly reduces the risk of the lack of clarity of business priorities and focus. A consolidated plan has been developed and progress to implement where there is agreement on actions isn't impeded by the approval of the overarching programme.	The delivery of the GAR programme will provide the Trust with assurance on its governance arrangements. This will impact the risk score significantly.
08.03	Review Trust Risk Policy	Director of Corporate Governance	March-2026	2	EMB to consider new policy at January / February meetings in advance of March 2026 Audit Committee.	January 2026	Updated policy with updated flowcharts and educational assets available for all Trust staff.	Refreshed process for Risk management, reporting and training. Positive impact on strategic risk related to governance of Trust risks.

08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high-quality services today and shaping our services for the future	Director of Corporate Governance	March 2026	2	GAR Group met in October 2025 to consider next steps for GAR. EMB considered: 1. Minutes principles 2. Template for Committee and Board Papers 3. Ways of Working – a guide to engaging and managing VUNHST Board and Committee business	January 2026	• When delivered, the Corporate Governance Manual will provide a means for ongoing reference and information on how Trust governance works and the standards set. • The review of the Trust's current governance structures will take into account changes to the Trust's work programme since the last review in 2020, to ensure we are fit for the future. • Work to review the current hosting arrangements underway and will consider Welsh Government review (July 2025).	A structure fit for the future, clearly articulated in a Corporate Governance Manual that is visible to the organisation and adhered to, as evidenced by KPIs.
08.05	Review Terms of Reference for all Board Committees capturing all requirements in relation to Duty of Quality.	Director of Corporate Governance	MArhc 2026	3	To be completed by end of December 2025.	January 2026	Board assured that scope of Committees' work referencing requirements of Duty of Quality effectively.	All ToR up to date and consistent in their interpretation of the Duty of Quality and its impact on Board Committee work.
08.06	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	Nov-25	5	Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Assurance level awareness training complete. Board training 23 October 2025.	January 2026	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.
08.07	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies.	Director of Corporate Governance	Nov-25	4	First phase complete. Awareness raising exercise underway.	Oct 2025	Risk of non-compliance with national policies reduced. Policy updates timely.	All staff to be aware of latest policy updates and assured that information presented is up to date.

08.08	Prepare paperwork outlining concerns and solutions to improve hosted services governance in advance of distribution of WG review	Director of Corporate Governance	Nov.25	2	Executive Board discussions to commence January 2026 following publication of WG commissioned report	January 2026	None – but it will allow us to respond quickly to the WG report. Urgent issues will require escalating.	Clarity on priorities to refresh governance of hosted services.
08.09	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	March 2026	4	Duty of Quality session scheduled for Board Development February 2026	January 2026	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.
08.10	New Board Development Programme delivered	Director of Corporate Governance	March 2026	3	Specification for external expert advice completed December 2025. New provider to commence work in January 2026.	January 2026	a	
CLOSED ACTIONS								
08.06	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	Nov-25	4	Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Assurance level awareness training complete. Board training 23 October 2025.	Oct 2025	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.

SECTION 1 – Summary																																
RISK ID	09	REVIEW DATE	February .2026	Risk Title	A strategic risk emerges if the Trust does not secure sufficient funding for the provision of it services or does not maximises its use of finite resources, which could negatively impact on the care that our patients and donors receive																											
				Risk Lead	Director of Finance																											
CORE ENABLER	Financial Sustainability and Long-Term Value				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																										
CURRENT SCORE TREND	BAF 09 - Finance <table><caption>Risk Score Trend Data</caption><thead><tr><th>Period</th><th>Risk Score</th></tr></thead><tbody><tr><td>feb-25</td><td>12</td></tr><tr><td>mar-25</td><td>12</td></tr><tr><td>apr-25</td><td>12</td></tr><tr><td>mai-25</td><td>12</td></tr><tr><td>jun-25</td><td>12</td></tr><tr><td>jul-25</td><td>12</td></tr><tr><td>aug-25</td><td>12</td></tr><tr><td>sep-25</td><td>12</td></tr><tr><td>okt-25</td><td>12</td></tr><tr><td>nov-25</td><td>12</td></tr><tr><td>des-25</td><td>12</td></tr><tr><td>jan-26</td><td>12</td></tr></tbody></table>				Period	Risk Score	feb-25	12	mar-25	12	apr-25	12	mai-25	12	jun-25	12	jul-25	12	aug-25	12	sep-25	12	okt-25	12	nov-25	12	des-25	12	jan-26	12	CURRENT RISK SUMMARY	Executive Summary There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Operational Summary Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.
Period	Risk Score																															
feb-25	12																															
mar-25	12																															
apr-25	12																															
mai-25	12																															
jun-25	12																															
jul-25	12																															
aug-25	12																															
sep-25	12																															
okt-25	12																															
nov-25	12																															
des-25	12																															
jan-26	12																															

SECTION 2 – Risk Scores									
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	
	4	4	16		4	3	12		
	Inherent risk score start date		March 2025						
									Expected date to reach Target Risk Score
									April 2029 in line with the three-year IMTP. Given the challenging financial position including the move to the nVCC we are unlikely to achieve the target risk score in the short term, however there is confidence in achieving a breakeven position in each year of the IMTP.

SECTION 3 – Effectiveness, Controls and Assurance		
Overall Assurance Rating		Current Review Period 4
Rationale for Assurance Rating		Previous Review Period 4
		Assurances and controls largely in place with policies and procedures supporting financial governance, however the emerging costs

pressures and investment decisions are impacting on the Trusts financial sustainability. A proposed financial recovery plan with cut costing options and improved operations is being considered aligned with the 2026/27 IMTP financial plan which should support an increase in the assurance rating and reduce the risk score.

KEY CONTROLS			SOURCES OF ASSURANCE					
ID	KEY CONTROLS	OWNER				THIRD LINE OF DEFENCE		
			PREVENTATIVE	MITIGATING	DETECTIVE			
			FIRST LINE OF DEFENCE			SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE	
			- functions that own and manage risk - Self-assurance					
			SECOND LINE OF DEFENCE			THIRD LINE OF DEFENCE	THIRD LINE OF DEFENCE	
			- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams					
						THIRD LINE OF DEFENCE	THIRD LINE OF DEFENCE	
			- Functions that provide independent assurance - 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					
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting Head of Finance Business Partner Budget Holders			X	Budget holders, reports and training, Touch Point meetings	Divisional Finance Reports and Performance; Finance Business Partners	Internal Audit / External Audit
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance Head of Finance Business Partnering			X	Directorate Level Budget holders, reports and training, Touch point meetings	Divisional Finance Reports, and Performance; Finance Business Partners	Internal Audit / External Audit
FSLTV3	Divisional Performance Review	Deputy Director of Finance Head of Finance Business Partnering			X	Divisional Senior Leadership Teams, reports, Touch Point meetings	Executive Finance Reports; Senior Finance Team	Internal Audit / External Audit
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	Executive Budget Holders / Programme SROs	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	Internal Audit / External Audit
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	Executive Budget Holders / Programme SROs	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	Welsh Government / NHS Executive (FP&D) / External Audit
FSLTV6	Monthly Finance and Performance Meetings	Executive Director of Finance		X		Executive Budget Holders / Divisional Directors	Divisional Finance Reports, and Performance; Finance Business Partners	Internal Audit / External Audit

FSLTV7	Collective Commissioners Review	Executive Director of Finance	X	Directorate Level Budget holders, reports and training	Collective Commissioning Group LTA reporting Weakness in controls identified in relation to LTA activity data capture and mapping to appropriate currencies to ensure Trust recovers all income due for work undertaken	LHB Commissioners
FSLTV8	Investment Appraisal	Executive Director of Finance Executive Director of Strategic Transformation, Planning & Digital	X	Executive Budget Holders / Programme SROs	Capital Planning and Delivery Group; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X	Executive Budget Holders / Programme SROs	Trust Board and Committees	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	Trust Board and Committees; Delegated Financial Limits	Internal Audit / External Audit
FSLTV11	Value Based Healthcare programme	Executive Director of Finance Executive Medical Director	X	Value Based Healthcare project leads; VBH programme SROs	Value Based Healthcare steering committee / Executive Management Board, Strategic Development Committee	LHB Commissioners / Welsh Government / Internal Audit / External Audit
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance Head of Financial Services & Accounting	X	Requisitioners / Budget Holders	PSPP Group; Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	Internal Audit / External Audit
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance Head of Financial Services & Accounting	X	Budget Holders: Private Patients lead; reports	Debtors Reporting; Senior Finance Team;	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit

FSLTV1 4	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting	X	Budget Holders; Heads of Division; Divisional Directors	Capital Planning and Delivery Group; Executive Management Board; Fixed Assets Register Reporting	Internal Audit / External Audit
FSLTV1 5	Major Capital Programmes monitoring	Chief Executive	X	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	Capital Planning and Delivery Group; Executive Management Board	Internal Audit / External Audit
FSLTV1 6	Counter Fraud	Deputy Director of Finance / Head of Financial Services & Accounting	X	Budget Holders, reports and training	Counter Fraud Reports; Audit Committee	Internal Audit / External Audit
FSLTV1 7	Tax management	Deputy Director of Finance / Head of Financial Services & Accounting	X	Budget holders, requisitioners, reports and training	Financial Operations Team; VAT working group	External Advisory (EY) / Internal Audit / External Audit / HMRC
FSLTV1 8	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X	Exec Directors, Divisional Directors, Budget Holders, reporting and training	Procurement Compliance reporting; Audit Committee	Internal Audit / External Audit

GAPS IN CONTROLS

GAPS IN ASSURANCE

ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

Scheme of Delegation and Governance Framework for All Major Programmes	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)
There is a need to be able to evidence use of medicines are providing the best value for patients	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
There are issues with the processes around LTA activity capture and mapping to currencies with some activity currently not being identified and charged to commissioners. Additional system and process controls have been established which has in part mitigated data issues, however, weakness remains, specifically in relation to the Radiotherapy IRS implementation which is being addressed with Service and Business Intelligence.	LTA Activity performance monitoring review has concluded providing assurance and ensuring that controls are in place, however the review process will continue as part of routine practice. An exercise is currently underway to review the contract model to ensure we are recovering the income for cost of service.	F7

SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
	There are no risks related to this BAF		

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE

09.01	Development of VBHC programme of work to identify areas of unwarranted variation and actions to improve	EDoF / DDoF/COO	Delivery over 24/25-26/27	4	VBHC Programme of work for 2024-25 to 2025-26 agreed by Trust Board overseen by the VBHC Steering Group. Assurance provided through review at SDC and QS&P Committees. 2025-26 Progress: • Digital PROMS platform now operational for Prostate, Lung and Neuro-oncology. Communication Plan in place to support with adoption. Work underway to deploy within wider Urology, CUP, Colorectal, VAP and Palliative care as part of phase 2 • PROMS Questionnaires - continue to be developed and agree national sets - focus on Breast and Colorectal • SST Data Insights Dashboard ongoing insight and awareness raising to support clinicians in reducing unwarranted variation e.g. referral patterns, admission rates, medicines prescribing, use of VAP service. Also used to calculate opportunities for a virtual thyroid follow up service (to replace telephone) • Self administration pathway for denosumab subcutaneous injections is being refined prior to opening for all eligible patients, improving outcomes while releasing resource for more complex treatments. • Data quality improved for historical open pathways, addressing clinical risk • Financial evaluation of projects supported via TDABC. • Training, communication & engagement - communication strategy in place, training & engagement sessions undertaken; further staff members undertaking Swansea University Value in Health course • Non-recurrent funding secured to develop a national pathway for people with Genetic Haemochromatosis to become blood donors. This reduces	13/02/26	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	Control 11 - VBHC effectiveness will improve from PE to E and assurance will be enhanced further

						demand within the health boards and improves the supply of blood donations whilst being more convenient for the individuals involved. November saw the highest ever number of units donated by people with GH at 90. Agreement to support Frailty work within VCS with non-recurrent funding. This will identify the scale of opportunity to improve outcomes and resource use for frail patients in the long term			

09.02	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	Delivery over 2024/25 to 2026/27	4	Savings / Efficiencies opportunity Pipeline identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit supply (underway) & further areas to be identified through Medicines Strategy Group, Workforce re-design - service divisions to identify all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and productivity improvement, Procurement reviews of non-pay spend to identify opportunities for cost improvement in income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery. Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance. IMTP savings created using SMART actions to strengthen identification, monitor progress and delivery. Finance workshop with Executive team took place in 2025/26 to present the current financial position and discuss disinvestment options and financial recovery. A monthly finance and performance review meeting will soon be established for Execs for early awareness of any risks or underperformance.	08.10.2025	Identification of opportunities for new savings initiatives and disinvestments / choices along with enhanced scrutiny via the establishment of the Finance and performance monthly review will support financial sustainability and reduce risk	Control 6 - Finance & Investment enhanced monitoring will improve from PE to E and assurance will be enhanced further

						A Finance and planning Committee to be established during 2026/27 which will focus on the financial position and performance.			
	09.03	Development and review of Financial Control Procedures		2026/27	6	All FCPs have been reviewed and updated. FCPs have now been included on the Finance Intranet page for access by the service. Further analysis being undertaken to review any processes that may benefit from establishing FCPs.	13.02.2026	Strengthened control procedures will support risk mitigation	Control 10 - Scheme of Delegation and Delegated Financial Authority will improve from PE to E and assurance will be enhanced further
	09.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	Investment appraisal process &	4	Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria aligned to the 3 areas identified.	17.08.2025	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance

09.05	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	Dec 2025	4	Cardiff Cancer Research Hub financial plan review has identified that in 2025-26 costs are covered by funding but there is a risk of shortfall in 2026-27 between anticipated trial & other income and forecast costs. Further work taking place with Cardiff & Vale to model additional trial activity and impact on cost and income. A tri-party risk share proposal for the Programme Hub element of the service has been agreed in principle with C&V and Cardiff University to contribute to a financially sustainable and risk sharing model. Private Patients Income: Liaison Financial external consultants re-engaged for the first half of the financial year to support the Trust in completion of remaining financial / commercial actions in improvement plan 1) negotiate new contracts with insurance companies & revisions to tariffs 2) additional activity charging separately for pathology 3) negotiation around payment of old debts. Work to also include negotiation with the Trust CAG sharing of the financial risk around PP credit loss (bad debts) and agreeing consistent charges for PP support to consultant private practice. Draft agreement discussed at CAG and awaits final approval. Work continues with Liaison Financial external consultants whereby an extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers is actively underway and involves pathology charging as well as payment of old debts.	08.10.2025	Attracting external / alternative sources of income will decrease pressure on reliance on exchequer income thereby supporting financial sustainability and reducing overall financial risk	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance

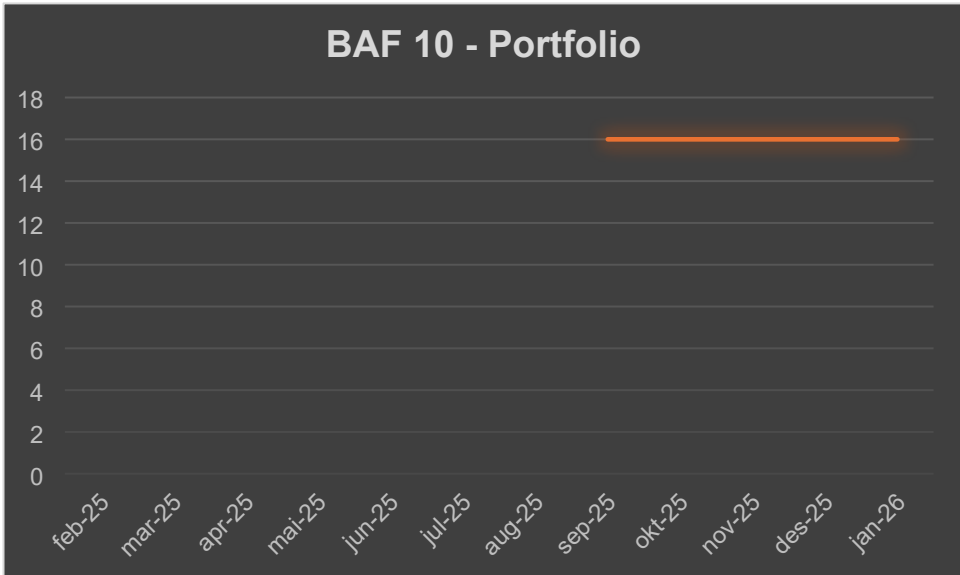
					A revised charging tariff had been agreed with an implementation date of 1 st July 2025 with further rates from 1 st November 2025. Contract negotiations are actively underway with those insurers that have specific queries and those involving payment of old debts.			
09.06	Develop Scheme of Delegation and Governance Framework for All Major programmes	EDoF / DDoF	Ongoing (required on approval of each major programme)	4	A Scheme of Delegation and Governance Framework has been developed for nVCC and Integrated Radiotherapy Solution (IRS) Subject to WG approval a Scheme of Delegation and Governance Framework will be developed for the WBS infrastructure programme and any other major programmes as required.	13.02.2026	Mitigate the risks of non-compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA

09.07	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for. Risk to be added to Datix to reflect the control weakness in activity data capture and mapping to contract activity to ensure Trust recovers all income for work undertaken.	EDoF / EDoSTP&D / COO	Dec '24 to Mar '25	3	LTA Activity performance monitoring review has concluded providing assurance and ensuring that controls are in place, however the review process will continue as part of routine practice. An exercise is currently underway to review the contract model to ensure we are recovering the income for cost of service. VCS is currently reporting a year to date LTA over performance for 2026-27 which will be used to mitigate the risk on the RSU activity underperformance.	13.02.2026	Initial actions have led to additional activity being captured in the data warehouse and charged to LTAs. A change in contract currency may result in additional income recovery subject to commissioner support and approval.	Control 7 Collective Commissioners Review - Weakness in control systems around data capture and mapping to LTA currencies will be mitigated leading to this control effectiveness being changed from Partially Effective to Effective and Control assurance through second line of defence LTA Performance Monitoring improving from Inconclusive Assurance to Positive Assurance

14.11.2025	LTA contract with Commissioners and re-basing exercise	EDof / EDirector of Planning / COO / VCS Director	2026/27	To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-05 to a 'current activity' baseline and NICE consumption Hywel Dda UHB unilaterally forced the Trust to move to an LTA based on actual activity in 2025/26, and the Trust has begun conversations with its three main commissioners, however, it is unlikely to reach agreement in time to recharge on an actual activity basis for 2026/27. This resulted in a £0.825m loss in income recurrently from Hywel Dda UHB. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£124k which will be removed recurrently in 2026-27. The Trust is facing further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding and the National Discretionary uplift which total £0.474m (as at 2024/25) and are provided to the Trust via the LTAs as per the Trust funding model. Unless an agreement can be reached by the 28th February, which is the deadline for agreeing to funding principles, the Trust will have to raise an arbitration case with WG. A deputy Director of finance task and finish group for commissioning has been established with the first meeting	13/02/2026	Ability to have consistent approach to LTA recharge mechanism with Commissioners resulting in a cost neutral adjustment protecting the Trust income and source of funding.	Control 7 Collective Commissioners Review / Control 6– Contract rebase agreement will allow Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance

					taking place on the 27.02.2026 to review contract re-basing exercises and agree a standardised approach. Given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2026-27.			
	The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include:							
09.11	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	Ddof, Divisional Directors		April 2026	Finance workshop with Executive team took place on the 18.08.2025 where the current financial position was presented and to discuss disinvestment options and financial recovery. Ongoing work with initial review captured as part of the 2026 IMTP process.	08.10.2025	Mitigate financial cost pressure and risks to ensure financial sustainability	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial assurance
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre							

9.12	Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).			Having met most of its objectives, the scope of the programme has widened to Anaemia Management. A national pathway is in place with compliance monitored for pre-operative anaemia. A pathway for post-operative anaemia management was launched in Q3 25/26. Preparations in place for a dashboard to monitor uptake and impact. Work ongoing with the 3Ps programme to incorporate an anaemia screen at the Waiting Well stage and to trial the inclusion of an anaemia screen within Menopause assessment clinics. Publication of first manuscript linked to this work expected in Q2 26/27.	12/2/26	The impact of the programme is mostly felt within the Health Boards as patient outcomes are improved including a reduced post operative LOS, reduction in readmissions and mortality 1 year post treatment.	Control 11 - VBHC effectiveness

SECTION 1 – Summary										
RISK ID	10	REVIEW DATE	February 2026	Risk Title	There is a risk that the scale and complexity of the change across the organisation may exceed the organisation’s capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence				Risk Lead	Director of Place, Portfolio & Partnerships
CORE ENABLER	Portfolio Delivery					STRATEGIC GOAL	Would impact on all of the Trust Strategic Goals			
CURRENT SCORE TREND	BAF 10 - Portfolio 					CURRENT RISK SUMMARY	VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented, and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level. BAF 10 was discussed at Strategic Development Committee, the controls will be tightened and updates reflected in the next reporting cycle.			

SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	4	4	16		4	4	16		3	2	6
Inherent risk score start date		September 2025						Expected date to reach Target Risk Score		September 2026	

SECTION 3 – Effectiveness, Controls and Assurance			
	Overall Assurance Rating	Current Review Period	3
		Previous Review Period	3
	Rationale for Assurance Rating		
KEY CONTROLS		SOURCES OF ASSURANCE	

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - 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
C1	Executive Leadership	Lauren Fear		X	X	- Meeting with all Executives to describe the benefits and business need for implementing portfolio management across the Trust. Complete - Discussion at Board Development Sessions 23/10/2025 - Complete - Discussions with LF and Exec colleagues Complete	- The executive is engaged and are leading the portfolio and understanding is increasing. Partially Complete - Reports are received at EMB. November EMB Complete	- The executive are able to receive portfolio escalations and take positive action. Portfolio Board now set up as part of EMB. Complete - Effectiveness report after 12 months to EMB.
C2	Develop a Portfolio Governance Framework / Handbook	Gavin Bryce	X	X		Community of Practice for project, programme and portfolio staff commenced in June2025 with a view to improving standards and reducing inconsistencies in practice. Ongoing Activity	A Portfolio Governance / Handbook will set out the necessary Governance arrangements to ensure effective delivery of the Portfolio, or highlight areas for escalation to the Executive Management Board Partially complete	The Strategic Development Committee will provide assurance to the Trust Board on the Portfolio Governance arrangements
C3	Portfolio Prioritisation and Phasing	Gavin Bryce	X	X	X	Develop the prioritisation tool for the portfolio. Initial Prioritisation Tool Complete	A prioritisation exercise will determine which portfolio activities have the greater priority and should be resourced accordingly. This will be overseen by the Executive Management Board Initial discussions with Executive have informed the design of a draft prioritisation tool Partially Complete	The Executive Management Board, Strategic Development Committee will provide assurance to the Trust Board on the prioritisation and phasing arrangements
C4	Capacity & Resource Planning	Gavin Bryce			X	Following on from the prioritisation exercise a resource planning piece is necessary to identify the required verses actual resource availability. This will be overseen by the Executive Management Board	The Strategic Development Committee will provide assurance on Portfolio capacity and resourcing	Trust Board approval on Portfolio capacity and resourcing

C5	Benefits Management and Realisation plan	Gavin Bryce	X	X	X	Carry out a benefit baselining process to identify all benefits across the portfolio.	A portfolio benefits plan will be delivered so the portfolio benefit delivery can be managed and optimised and any threats to benefit delivery identified. This will be overseen by the Executive Management Board	The Strategic Development Committee will provide assurance to the Trust Board on the effectiveness of the Portfolios Benefits Management				
	C6	Effective Portfolio Reporting	Gavin Bryce	X	X				X	Design and develop a reporting dashboard for the portfolio	There are effective reporting arrangements in place for the Portfolio and regular reporting is being achieved. Reporting to EMB	The Strategic Development Committee will provide assurance to the Trust Board on the effectiveness of the Portfolios reporting.
	C7											
GAPS IN CONTROLS						GAPS IN ASSURANCE		ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.				
None						None		None				

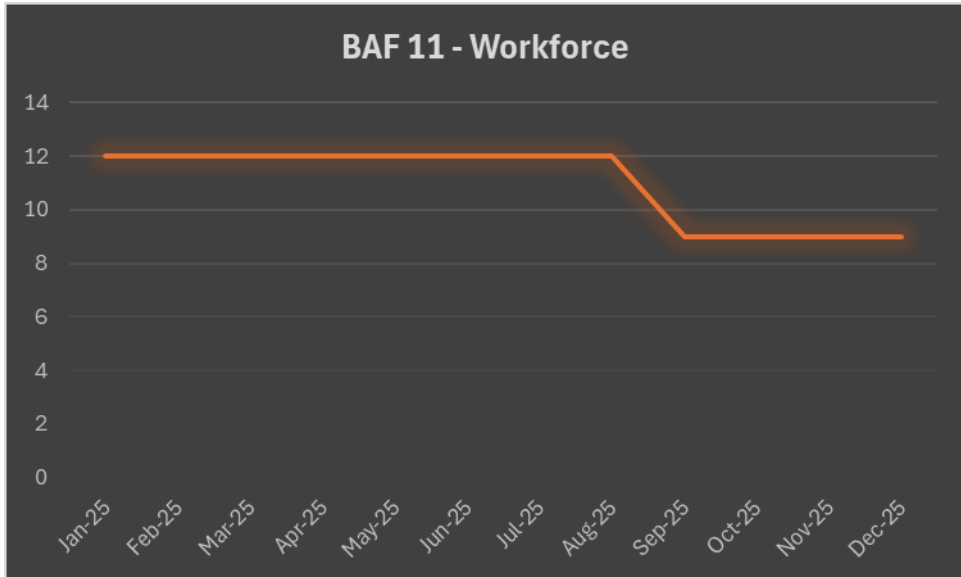
SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
N/A	There are currently no relevant risks on the Trust Risk Register	N/A	N/A

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and BAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
10.1	Develop a Portfolio Governance Framework / Handbook	Gavin Bryce	December 2025	3	Portfolio Handbook 90% complete	January 2026		
10.2	Carry out Portfolio Prioritisation and Phasing	Gavin Bryce	December 2025	2	Draft Prioritisation Framework complete requires approval before prioritisation exercise can be completed	January 2026		

10.3	Carry out Capacity & Resource Planning	Gavin Bryce	January 2026	2				
10.4	Carry out Benefits Management and Realisation plan	Gavin Bryce	January 2025	2	Not started			
10.5	Establish Effective Portfolio Reporting	Gavin Bryce	January 2026	4	Effective Power BI dashboard in place 90% of data correct work ongoing to improve compliance with incremental design improvements to dashboard.			

SECTION 1 – Summary																																
RISK ID	11	REVIEW DATE	February 2026	Risk Title	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain an optimised workforce supply and shape.																											
				Risk Lead	Director of OD and Workforce																											
CORE ENABLER					STRATEGIC GOAL	1 - Outstanding for quality, safety and experience																										
CURRENT SCORE TREND	BAF 11 - Workforce <table><caption>BAF 11 - Workforce Score Trend</caption><tr><th>Month</th><th>Score</th></tr><tr><td>Jan-25</td><td>12</td></tr><tr><td>Feb-25</td><td>12</td></tr><tr><td>Mar-25</td><td>12</td></tr><tr><td>Apr-25</td><td>12</td></tr><tr><td>May-25</td><td>12</td></tr><tr><td>Jun-25</td><td>12</td></tr><tr><td>Jul-25</td><td>12</td></tr><tr><td>Aug-25</td><td>12</td></tr><tr><td>Sep-25</td><td>9</td></tr><tr><td>Oct-25</td><td>9</td></tr><tr><td>Nov-25</td><td>9</td></tr><tr><td>Dec-25</td><td>9</td></tr></table>				Month	Score	Jan-25	12	Feb-25	12	Mar-25	12	Apr-25	12	May-25	12	Jun-25	12	Jul-25	12	Aug-25	12	Sep-25	9	Oct-25	9	Nov-25	9	Dec-25	9	CURRENT RISK SUMMARY	There are many factors that impact on the current supply and shape of our workforce. These are both external, due to the economic landscape impacting the labour market and internal, within the organisation, or granular at multi-disciplinary team level. We are currently mitigating the risk in this area through effective strategic and operational workforce planning, with a focus on recruitment, retention and people development. In addition, we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams. Risk score trend: The risk score was reviewed in October 2025 and reduce from 12 to 9. The reduction was agreed following the information submitted under the Supply and Shape assurance paper which demonstrates a number of key metric improvements in all areas mitigating the risk.
Month	Score																															
Jan-25	12																															
Feb-25	12																															
Mar-25	12																															
Apr-25	12																															
May-25	12																															
Jun-25	12																															
Jul-25	12																															
Aug-25	12																															
Sep-25	9																															
Oct-25	9																															
Nov-25	9																															
Dec-25	9																															

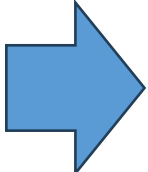
SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	3	9		2	3	6
	Inherent risk score start date		March 2025						Expected date to reach Target Risk Score		Current work programme to March 2029

SECTION 3 – Effectiveness, Controls and Assurance

						Overall Assurance Rating	Current Review Period	4
						Rationale for Assurance Rating	Previous Review Period	4
						The assurance level reflects the decommissioned education strategy and the completed actions resulting in an assurance level of 4 through the next cycle.		
KEY CONTROLS						SOURCES OF ASSURANCE		
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE functions that own and manage risk Self-assurance	SECOND LINE OF DEFENCE Functions that oversee or specialise in risk management Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - 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
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intents of Workforce Planning - 'Planned and Sustained Workforce' and 'Skilled and Developed People'	Sue Thomas	X			People and Development Steering Groups	Performance reporting to Executives and Trust Board	Internal Audit Reports
C2	Approved Workforce Planning Methodology aligned to Trust Values and Behaviours	Sue Thomas	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C3	Educational pathways in place to support the recruitment of new skills and development of new roles	Sue Thomas	X			Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suit of workforce planning tools	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C4	Consistent recruitment and selection process	Sue Thomas	X			The Trust has robust polices and processes in place to support effective recruitment and selection in a fair and consistent way.	Reports to EMB, Committees and Trust Board	Internal Audit Reports
C5	Workforce Planning - training and skills development for managers and service leads.	Sue Thomas	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Regular performance reports and Supply and Shape paper are submitted to EMB and QSP	Internal Audit Reports
C6	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in Workforce Planning skills	Sarah Morley	X			Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit

C9	Dedicated Workforce Planning Team and supporting infrastructure in place for the Trust, that is able to support service leads in the review, design and implementation of comprehensive workforce plans.	Amanda Jenkins	X	X	X	Regular monitoring at divisional groups, as well as integrated POD, Finance and Service Leads oversight, through the Strategic Workforce Planning Group.	Reports to EMB, Committee and Trust Board.	Internal and External Audit
	Workforce planning reporting through is embedded in senior and executive leadership reporting.	Amanda Jenkins			X	Regular monitoring at divisional groups, as well as integrated POD, Finance and Service Leads oversight, through the Strategic Workforce Planning Group.	Reports to EMB, Committee and Trust Board.	Internal and External Audit
	A consistent employer brand developed to support recruitment marketing and advertising in hiring processes.	Amanda Jenkins	X	X		Monthly recruitment metrics and reporting received from NWSSP recruitment team.	Reports to EMB, Committee and Trust Board.	Reports to EMB, Committee and Trust Board.
GAPS IN CONTROLS			GAPS IN ASSURANCE			ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.		

SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3634	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully, stress and burnout for the digital team and regularly changing priorities.	16	

SECTION 5 – ACTION PLAN
(IMTP Priority Improvement Actions and TAF Actions)

ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE

11.1	Development of a Trust Workforce Plan	Deputy Director of OD and Workforce	September 2025	4	30.04.2025 Appointment of AD Workforce Planning 1st May will provide a sharper focus and organisational direction on Workforce Planning to deliver the Supply and Shape workstream of the People Strategy 10.07.2025 Workforce plans are in train throughout the Trust and progress noted via the Supply and Shape paper, most recent update to QSP 8th May and next update in November 2025. A specific paper on Workforce Planning progress will be brought to EMB and committees in September. 11.09.2025 Paper on Workforce Planning progress has been integrated into the new iteration of 'Supply and Shape' assurance paper. This is due to EMB in October and QSP in November. 13.10.2025 Governance mechanisms for strategic workforce planning in the Trust set up in collaboration with Workforce, Finance and Service Leads. 18.12.2025 Propose to close this action. The Trust's Strategic Workforce plan to recruit, develop and retain staff is presented through the Supply and Shape assurance paper.	December 2025	The impact will be reduced once the short and medium term actions are completed.	Assurance level moved from level 3 to level 4, as agreed at QSP in October 2025 aligned with the updates in the supply and shape assurance paper.
11.2	Embed workforce planning into monthly Divisional Senior Leadership Workforce reporting. Moved to C10 – Feb 2026	Assistant Director of Workforce Planning	Complete	3	Additional Resource for Workforce Planning through IMTP not supported. Alternative plan to embed workforce planning though the wider team undertaken instead. Monthly meetings underway with ongoing dedicated support for recruitment, development, retention and people analytics.	December 2025	Having workforce planning embedded into monthly management meetings with Advisors and BP's ensures alignment between operational performance and effective people management and ensures early intervention to support the development of the workforce at micro and meso levels within the Trust.	Assurance Level 6 - this is now part of BAU within the Trust and sustained improvements are being made as detailed in the workforce metrics reported within the Supply and Shape Assurance Paper to Quality, Safety and Performance Committee.

11.3	Implementation of the Attraction and Resourcing Project Moved to C11 – Feb 2026	Assistant Director of Workforce Planning	Complete	4	Initial implementation completed. Financial agreement for ongoing resource agreed as part of the IMTP. Project to become part of BAU for POD.	December 2025	The Trust will be able to reach a wider audience outside of current NHS job boards, improve employer branding and support targeted recruitment campaigns. This in turn will improve the workforce metrics across the Trust, growing our workforce and reducing turnover as we become an employer of choice.	Assurance Level 4 - Robust plan in place with actions and deliverables reported through Supply and Shape Assurance Paper to Quality, Safety and Performance Committee
11.4	Implementation of the Nurse Retention Plan through the Professional Nursing Forum	Executive Director of Nursing and Divisional Nurse Leads	April 2026	4	Nurse Retention Plan currently in draft 27.01.2025 EMB endorsed the NRP, implementation underway. 14.10.2024 A number of successful actions have been completed including implementation of Restorative Clinical Supervision, Bitesize Compassionate Leadership training and embedding the 'Belong Thrive, Stay' Toolkit across both divisions. 26.02.2026 Programme on track to be completed by deadline. Improved retention rates seen.	February 2026	The Retention Programme is part of a broader initiative aimed at addressing the challenges faced in NHS Wales workforce, with an immediate emphasis on Nurse retention. The aim of the of the programme is to improve retention of our workforce as a key plank of our current and future workforce supply.	
11.5	Develop a Velindre University NHS Trust Staff Bank.	Assistant Director of Workforce Planning	April 2026	3	26.02.2026 Successful appointments made across Nursing and HCSW roles and within WBS. Bank capacity is improving in priority areas, helping to support short-notice cover and reduce agency dependency. Action plan for phase 2 of bank development underway.	February 2026	A Staff bank will provide a pool of skilled, trained workers who can be deployed flexibly to provide service resilience and reduce reliance on high-cost agency workforce. It also supports the growing trend seen within the labour market related to working flexibility of the workforce, attracting more candidates to the Trust.	

11.6	Develop and provide Welsh Language education and learning opportunities for staff at all levels within the Trust.	Assistant Director of Workforce Planning	September 2026	3	26.02.2026 Successful appointments made across Nursing and HCSW roles and within WBS. Bank capacity is improving in priority areas, helping to support short-notice cover and reduce agency dependency. Action plan for phase 2 of bank development underway.	February 2026	Providing dedicated skills development in Welsh Language will ensure the Trust is able to provide our services bilingually improving the quality, safety and dignity of care provided.	
	Establish a talent management process that identifies high potential at all levels within the organisation.	Assistant Director of Workforce Planning	April 2027		26.06.2026 Structured interviews with Trust Leaders at various level in progress. Final self-assessment and action plan to be completed by April 2026	February 2026	Having a talent management process will enable the Trust to identify and support high potential people and prepare future leaders early, reducing risks on succession planning.	
	Develop a network of management coaches across the Trust in partnership with local education providers.	Assistant Director of Workforce Planning	November 2026		26.02.2026 Funding secured from Bridgend College to deliver Chartered Institute of Management Certificate in Coaching & Mentoring.18 learners subscribed for cohort one and further cohorts scheduled.	February 2026	Embedding coaching into the organisation promotes a learning culture where reflection, feedback, and growth are valued and encouraged and managers feel supported to foster positive team environments, contributing to overall workforce stability.	

CLOSED ACTIONS

Audit Committee Update – Velindre University NHS Trust

Date issued: March 2026

This document has been prepared for the internal use of Velindre University NHS Trust as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

© Auditor General for Wales 2025. No liability is accepted by the Auditor General or staff of the Wales Audit Office in relation to any member, director, officer, or other employee in their individual capacity, or to any third party, in respect of this report.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee Update

About this document	4
Accounts audit update	4
Performance audit update	5
Other relevant publications	8
Additional information	9

About this document

- 1 This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Velindre University NHS Trust (the Trust). We shared our Audit Plan for our 2025 work programme at the May 2025 Audit Committee. We will share a copy of the 2026 Audit Plan in the May 2026 Audit Committee.
- 2 Also included is information on:
 - other relevant examinations and studies published by the Audit General;
 - relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports); and
 - details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

Accounts audit update

- 4 Following the certification of the Trust's charitable fund accounts on 30 January 2026 all of our 2024-25 financial audit work at the Trust is now complete.
- 5 2025-26 planning work has also commenced as we work toward our 30 June 2026 audit deadline.

Performance audit update

6 **Exhibit 1** summarises the status of our current and planned performance audit work.

Exhibit 1 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
2024 Audit Plan				
Structured Assessment – 2024 deep dive review of investment in digital systems to support service resilience and transformation	Executive Director of Strategic Transformation, Planning and Digital	Examination of digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency - to be undertaken across all health bodies.	In progress	May 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Quality Governance Follow-Up Review	Executive Director of Nursing, Allied Health Professionals and Health Science	My audit team will follow-up the Trust's progress in implementing actions to address the findings of my 2022 report on its quality governance arrangements.	In progress	May 2026
2025 Audit Plan¹				
Structured Assessment 2025	Director of Corporate Governance	A review of the corporate arrangements in place at the Trust in relation to: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and	In progress	May 2026

¹ After discussion with the Trust, we removed our planned audit review on cancer services from the 2025 audit plan.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		Corporate financial planning and management arrangements.		
Structured Assessment – 2024 deep dive review of arrangements to manage estates	Director of Place, Portfolio and Partnerships	Examination of the effectiveness of corporate arrangements to manage the Trust's estate with a particular focus on how the body is prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose	In progress	May 2026
Annual Audit Summary 2025	Director of Corporate Governance /Executive Director of Finance	Summary of audited work completed in 2025	In progress	May 2026

Other relevant publications

7 **Exhibit 2** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 2 – relevant examinations and studies published by the Auditor General

Title	Publication Date
<u>Private finance – public impact Examining decision-making for the new Velindre Cancer Centre</u>	February 2026
<u>Data matching of GP patient lists</u>	January 2026

8 Our data tools are available on our website.

Additional information

9 **Exhibit 3** provides information on corporate documents published by Audit Wales in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Audit Wales corporate documents

Title	Publication Date
<u>Fee Scheme 2026-27 Audit Wales</u>	January 2026
<u>Interim Report 2025-26</u>	November 2025
<u>Estimate of Income and Expenses for the year ended 31 March 2027</u> <u>Supporting information for the Estimate of Income and Expenses</u>	November 2025



Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

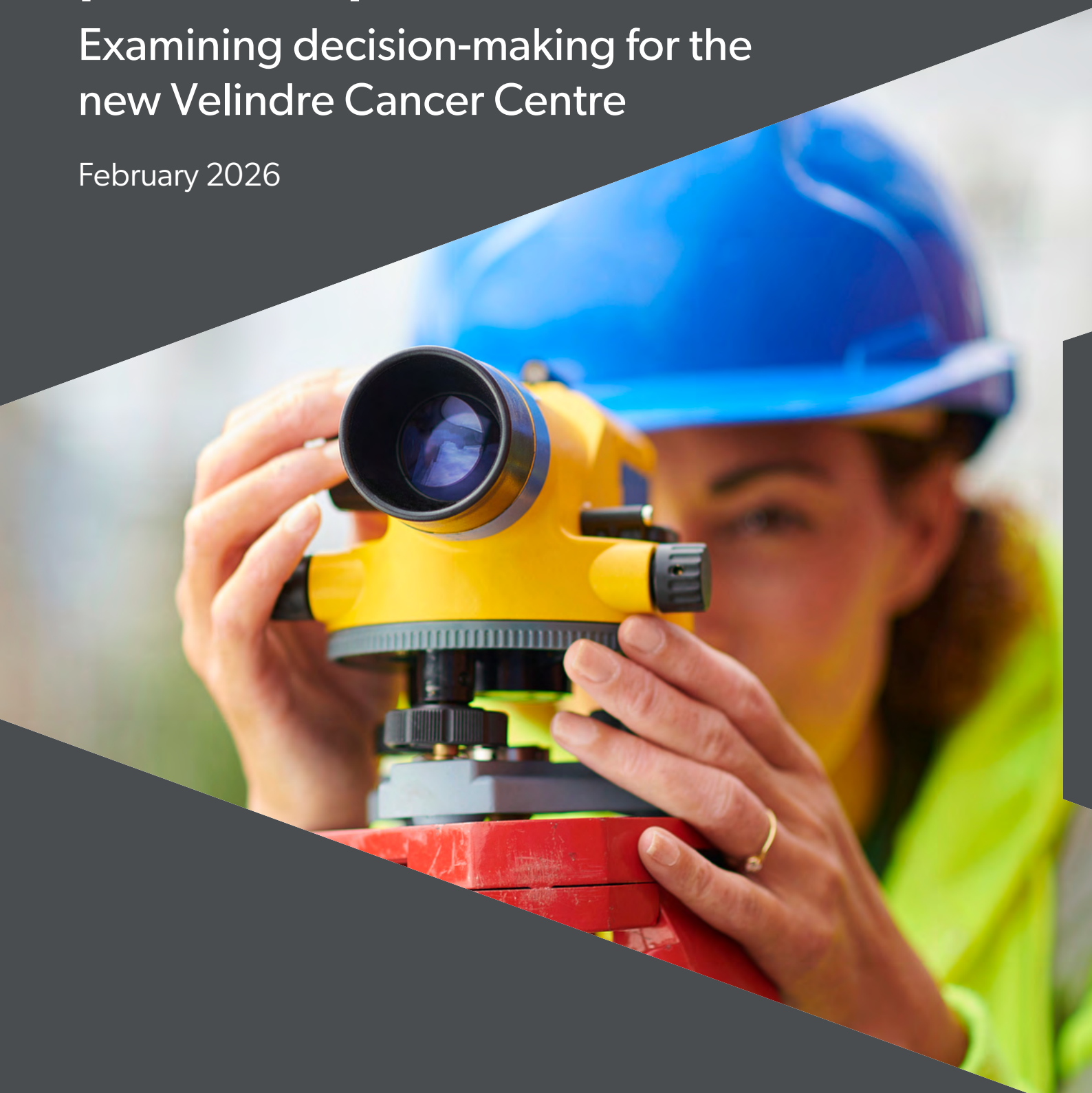
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Private finance – public impact

Examining decision-making for the
new Velindre Cancer Centre

February 2026



We have prepared and published this report for presentation to the Senedd under section 145A of the Government of Wales Act 1998.

© Auditor General for Wales 2026

You may re-use this publication (not including logos) free of charge in any format or medium. If you re-use it, your re-use must be accurate and must not be in a misleading context. The material must be acknowledged as Auditor General for Wales copyright and you must give the title of this publication. Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned before re-use.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

- call us on 029 2032 0500
- email us at info@audit.wales

You can use English or Welsh when you get in touch with us – we will respond to you in the language you use.

Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot	4
Auditor General's view	7
Key facts and figures	8
Our findings	10
Recommendations	39

Appendices

1 About our work	42
2 About the nVCC contract	47
3 Cost estimates for the nVCC at different times	55
4 Public sector parties featured in this report and other key terms	56



Audit snapshot

What we looked at

- 1 In March 2024, after Welsh Government approval, Velindre University NHS Trust (the Trust) agreed a long-term contract with a private consortium, ACORN, to design, build, finance and maintain the new Velindre Cancer Centre (nVCC) in Whitchurch, Cardiff. We examined whether the Trust and the Welsh Government can demonstrate a sound basis for key decisions on the nVCC taken so far.
- 2 We focused on developments around and since Outline Business Case (OBC) approval in March 2021, including the procurement process, approval of the Full Business Case (FBC), and the agreed contract. We have not examined progress with construction, although we touch on related matters, the model of care delivery, or choice of location for the nVCC.

Why this is important

- 3 The Trust's existing cancer centre in Cardiff, serving around 1.7 million people, is no longer deemed fit for purpose. Improving cancer services is a key priority for NHS Wales and the nVCC supports national and regional healthcare objectives. It is a central part of the Trust's wider Transforming Cancer Services programme for south-east Wales.
- 4 The nVCC will be funded, in part, by the Welsh Government's Mutual Investment Model (MIM). Through the MIM, ACORN will build and maintain the nVCC in return for an Annual Service Payment (ASP), payable for 25 years.
- 5 To date, the nVCC is the only NHS project to use the MIM. The project has already attracted a lot of public interest, including around its location, the model of cancer care, the use of the MIM, and the appointment of ACORN. The significant long-term costs make a sound basis for decisions even more important.

What we have found

- 6 Cost estimates have evolved over time but delays in the latter stages of the nVCC project's development increased its exposure to price inflation. The most significant cost is the MIM contract with ACORN (the nVCC contract) which is projected at £885 million over 25 years. Within this, the contracted construction cost of £321 million appears reasonable given the Trust's benchmarking and other advice.
- 7 As well as the nVCC contract, there are other costs to bring the nVCC into operation and manage it. These costs are expected to be at least £765 million over 25 years.
- 8 However, we estimate that continuing to manage and maintain the existing centre would otherwise have cost at least £600 million over 25 years. This would also have been without any additional benefits the nVCC offers.
- 9 Overall, the governance arrangements supporting key decisions provide assurance that they were properly made. The Trust followed well-established business case and project management processes satisfactorily enough, and there has been appropriate scrutiny and expert and stakeholder input. The procurement process followed the regulations in place at the time, informed by extensive legal advice.
- 10 While we have identified areas for improvement in the parts of the process we examined, we do not consider that they undermine the overall integrity of the final decisions to proceed with the nVCC contract. For example:
 - Because the Welsh Government chose the MIM approach early on, other ways to fund the project were not fully explored at later stages. Aspects of the approach used to justify that the MIM offers value for money in this case are also open to challenge.
 - More generally, we think key documents could have provided greater assurance on the application of the sustainable development principle. However, we are satisfied that this has been a relevant consideration throughout the process.
- 11 Whether spending on the nVCC delivers value for money will depend on whether it delivers the expected benefits over time and in a changing environment for cancer services. It will also depend on whether provisions in the nVCC contract to protect the public purse stand strong.

What we recommend

- 12 Our work has looked back over decisions made and the processes followed. However, we have made four forward looking recommendations. These include recommendations for:
- the Welsh Government – around improving business case guidance, and working with other public bodies to learn and share lessons from the nVCC project; and
 - the Trust – around how it assures itself of value for money in the event of changes under the nVCC contract and demonstrating how outcomes from the nVCC project support its wider strategic objectives.



Auditor General's view



Decisions about the nVCC project have been for the bodies involved to make, mindful of the overall costs and the inherent risks of long-term private finance contracts. While I recognise there are those who remain opposed to the project, the processes followed by the Trust and the Welsh Government during the period we examined have, overall, provided a sound enough basis for those decisions.

Our findings do not, however, mean that the construction and operation of the nVCC will be problem-free. And it will be some years before a broader assessment of value for money can be made.

Adrian Crompton

Auditor General for Wales





Key facts and figures

Timings



15 years – time since the Trust first submitted a formal proposal to the Welsh Government to replace the existing Velindre cancer centre.



March 2021 – the Welsh Government approved the Trust’s Outline Business Cases for the nVCC and enabling works.



March 2024 – the Trust reached Financial Close on the nVCC contract with ACORN.



April 2027 – the anticipated first patient treatment date and start of the 25-year operations phase for the nVCC contract.



March 2052 – the end of the nVCC contract with ACORN.

Costs and benefits



£885 million – the projected cost for design, construction, finance, and maintenance under the nVCC contract with ACORN. This is the sum of the expected Annual Service Payments (ASPs) due over 25 years.



At least £765 million – the estimated core costs outside of the nVCC contract to bring the nVCC into operation and manage it over 25 years post-construction.



£321 million – the contracted value, at Financial Close in March 2024, of the nVCC construction and development costs to be repaid as part of ASPs.



3.2 Benefit Cost Ratio – for every £1 spent on the nVCC and interdependent projects beyond the business-as-usual option, the Trust estimates it will generate £3.20 of additional benefits.



11 community benefit key performance indicators – agreed in the nVCC contract with ACORN, including around job creation, apprenticeships, and other outreach.

Our findings

13 We have structured our findings into four sections:

- Costs and timeframes – some of the history of the nVCC project since 2010 and how its costs have developed and now stand.¹
- The use of MIM – the basis for using this form of finance for the nVCC and related issues.
- Procuring the contract – the procurement process for the nVCC and how the Trust responded to concerns relating to ACORN's appointment.
- Business case process and project management – the approach followed to develop and manage the nVCC project.

Costs and timeframes

The nVCC project had been over a decade in the making when the Trust appointed ACORN in 2022, with cost estimates changing as plans evolved

14 The existing Velindre Cancer Centre houses the Trust's clinical services. Built in 1956, it has since been improved and extended. However, it is no longer deemed fit for purpose because:

- it lacks the facilities or space to meet future demand volumes or treatments;
- much of the accommodation is non-compliant with statutory requirements;
- the patient environment is sub-optimal and inefficient;² and
- maintenance costs are increasing and unsustainable.

¹ Throughout this report, we have adjusted historical cost estimates for inflation using HM Treasury's GDP deflator to apply a common price base. **Appendix 1** sets out further details on this approach. **Exhibit 8** in **Appendix 3** sets out how estimates of the cost of the nVCC have varied since October 2010, including in relation to what is included in those estimates. It reflects adjusted and non-adjusted figures and includes some additional detail.

² There are multiple crossover spaces that are used by patients, visitors and staff due to services being inappropriately located. This results in poor service flow and workforce inefficiencies. There are also issues around maintaining appropriate patient safety and confidentiality.

- 15 In October 2010, the Trust submitted the original proposal to the Welsh Government to replace the centre at an estimated capital construction cost of £327.4 million. The Welsh Government did not approve these proposals, we understand because there was not enough capital funding available. We understand this estimate did not include enabling works on the scale later included.
- 16 Following discussions, in December 2014 the Welsh Government approved the Trust's initial proposals for the Transforming Cancer Services programme. This included an estimated capital construction cost for the nVCC and enabling works of £276.0 million. This business case set out a long-list of options for financing the new centre, including private finance, although it did not appraise them in full.
- 17 There followed a series of engagement events through 2015, 2016 and 2017. In February 2017, the Welsh Government announced that the nVCC would be financed using the MIM (see also **paragraphs 52 to 56**). The Trust then approved its current Transforming Cancer Services programme in September 2017.
- 18 In March 2021, the Welsh Government approved separate OBCs for the nVCC and enabling works which, between them:
- confirmed the nVCC would still be funded through the MIM and put the estimated capital construction cost at £204.0 million following changes to the assumed design and footprint since 2014, and contributing to an indicative ASP of £19.2 million;³
 - agreed the capital requirements for the enabling works, to be procured in advance of nVCC FBC approval, and allowing for a cost of £30.4 million which would not be recoverable if the nVCC project did not go ahead;
 - set out the rationale for the nVCC, including the clinical model, in the context of the wider Transforming Cancer Services programme;
 - recognised the financial implications of interdependent but separate projects;
 - allowed procurement processes to proceed; and
 - aimed to ensure that a 'shovel ready' site would be available to the chosen contractor at Financial Close – the point when financial, construction, and service agreements would be in place for the nVCC MIM project.

3 **Appendix 2** sets out further details on the payment mechanism for the ASP in the final nVCC contract which includes repayment of ACORN's financing package for the construction, maintenance over 25 years, and certain other costs.

- 19 At the time of these approvals, completion of enabling works and Financial Close on the nVCC contract was projected to be 31 January 2023. Construction completion was to be March 2025, with the nVCC expected to open for patients in June 2025.
- 20 The Trust went out to tender for the nVCC contract in April 2021 and concluded its pre-qualification process for potential bidders in September 2021.⁴ The Trust's updated estimates as of September 2021 put the construction cost at £226.7 million.
- 21 The Trust appointed ACORN as its 'successful participant' in July 2022. ACORN's final tender price submitted in June 2022 assumed a capital construction cost of £296.5 million.

Work to prepare the site began in 2022 but the nVCC contract could not proceed until planning and environmental consents were granted

- 22 The nVCC site required enabling works, including for habitat management, utility connections, development of dedicated roads and bridges for main access, emergency vehicle access, and construction access.⁵ In December 2017, Cardiff Council granted outline planning permission for the nVCC. In September 2020, the Council granted further applications related to access requirements.
- 23 The Welsh Government had approved the enabling works FBC in January 2022.⁶ During 2022, enabling works began on site. However, delays to Financial Close on the nVCC contract arose due to the requirement to first obtain all necessary planning and environment consents which took longer than the Trust had anticipated.
- 24 The presence of dormice required European Protected Species Licences. To obtain these, the Trust needed to demonstrate to Natural Resources Wales that there would be appropriate mitigation to compensate for the loss of dormice habitat. Natural Resources Wales completed the licencing process in September 2023.

4 **Paragraphs 73 to 96** provide further details about the procurement process for the nVCC contract.

5 We have not reviewed the decision for the choice of site which was made in 2017 and was also relevant to rejected requests for judicial review in 2021 (see **Appendix 1**). In its initial Transforming Cancer Services programme proposal in 2014, the Trust had identified a preference for a brownfield site, although it had not identified a specific one.

6 The Trust procured the enabling works contract with a separate contractor using a framework agreement. We have not examined the procurement process or contract management for the enabling works.

- 25 Cardiff Council granted full planning consent for the nVCC in March 2023. In March 2024, the Council agreed the Trust's application for a non-material change to this consent; a bridge – costing £2.6 million – for emergency vehicle access through a neighbouring estate was no longer required. Instead, emergency vehicles will use the construction vehicle route when it is no longer needed for that purpose.
- 26 **Exhibit 1** shows the location of the nVCC and the existing cancer centre. It also sets out arrangements for the transfer of land and buildings between the Trust and Cardiff and Vale University Health Board.

Exhibit 1: the location of the nVCC and the existing cancer centre, and related land transfers

The site for the nVCC, about 1 kilometre north-east of the existing cancer centre, has been in long-term NHS ownership. It is currently planned for the existing centre to be demolished. The Trust has listed the Whitchurch Hospital site for commercial sale.



Land transfers with Cardiff and Vale University Health Board:

- Land and buildings that the Health Board has transferred to the Trust at a cost of £7.8 million.
- Land and buildings required by the Health Board for 10 years with car parking, or until alternative accommodation/sites become available. The Trust has leased this back to the Health Board.
- Land and buildings already in the Trust's ownership.

Source: Audit Wales summary based on Trust papers

The costs of the nVCC contract increased due to the delays in reaching Financial Close

- 27 The costs of building new infrastructure have risen ahead of inflation in recent years due to economic impacts from the COVID-19 pandemic and with a sharp rise in 2022-23 following the start of the war in Ukraine. The delays in reaching Financial Close increased the nVCC's exposure to this price risk. Under the procurement process, ACORN was permitted to uplift the construction cost using a recognised building cost price index for the period between 17 June 2022 (the final tender submission date) and Financial Close.
- 28 The Welsh Government asked the Trust to mitigate cost increases through value engineering. This involved the Trust, with their advisors, looking at design choices such as alternative materials. By Summer 2023, the Trust had identified £5.8 million of savings from the construction cost.
- 29 However, a technical review by NHS Wales Shared Services Partnership Specialist Estates Service in January 2024 led to additional design work, technical requirements, and costs totalling £2.5 million. The Welsh Government requested further value engineering, which identified £1.8 million of savings from the construction cost.
- 30 Notwithstanding these changes, the Trust has had in mind various wider sustainability issues when deciding on its approach to conserving and landscaping the site and in the choice of building materials. The Trust set out to achieve a BREEAM rating of 'Excellent' but now expects to achieve the highest rating of 'Outstanding'.⁷
- 31 Several factors determine the ASP (see **Appendix 2**) and we have not sought to isolate the impact of the identified construction cost savings on it. However, the Trust told us that at the final tender stage of the procurement, the financial model indicated that a 10% change in construction costs led to an 8% change to the ASP.

7 **BREEAM** – the Building Research Establishment Environmental Assessment Method – is a sustainability assessment. The BREEAM rating considers a range of criteria and provides a result of either unclassified, pass, good, very good, excellent, or outstanding.

The Welsh Government's decision to allow the Trust to progress to Financial Close without full FBC approval was reasonable on the balance of risk

- 32 On 17 March 2024, the Welsh Government's Health Strategic Board approved three of the five parts of the FBC – the Strategic Case, the Economic Case, and the Commercial Case. Welsh Government officials also presented advice to Ministers requesting approval for the Trust to enter into a contract with ACORN.⁸
- 33 Ministers provided approval on 19 March 2024 subject to Welsh Government officials being satisfied on some matters of detail. We understand the Welsh Government's Health Strategic Board met on the 25 March 2024 and agreed to allow the Trust to proceed, although that meeting was not minuted. The Trust then reached Financial Close with ACORN on 28 March 2024.
- 34 To support its FBC, the Trust commissioned specialist advisers to compare the costs of the nVCC against similar industry and wider scheme benchmarks. The benchmarking noted that the nVCC fell within the range of the industry standard benchmark and below the wider scheme benchmark when inflation and lifecycle costs such as replacement and maintenance are factored in.
- 35 The Trust also commissioned a separate benchmarking exercise that reviewed the nVCC costs against six recent cancer care hospital projects across England and Scotland. Its adviser noted that the benchmark projects were not on the same scale as the nVCC nor were they procured via private finance schemes. They therefore made certain adjustments to provide a like for like comparison. The adviser concluded that the nVCC was within a reasonable confidence range when compared to the benchmark projects.

8 The advice included a summary of the history of the nVCC project, including contentious issues around the choice of site and clinical model. Given changes in Ministerial responsibility over time, coverage of that history was important.

- 36 The FBC elements deemed less material to the decision to enter into the nVCC contract, and that remained unapproved in March 2024, were:
- The Management Case, pending results of an external review of the Trust's project management capacity for the construction phase (see also **paragraphs 119 to 121**).
 - The Financial Case, due to remaining uncertainty around some non-construction aspects of the nVCC project; mainly equipment capital costs outside the nVCC contract, governance arrangements and, as noted above, the Trust's project management capacity.
- 37 Decision makers had sight of the latest versions of the Management and Financial cases when deciding to progress to Financial Close. Apart from updated coverage of the matters described above, the final versions of these documents did not change materially.
- 38 If the nVCC project had not reached Financial Close during March 2024, ACORN may have needed to renegotiate investment funds at extra cost. Welsh Government officials had advised Ministers that not achieving Financial Close by the end of March 2024 could cause project funders to lose interest, potentially preventing the project from proceeding. Their advice set out that this would lead to reputational damage, costs, and risks to future MIM schemes.
- 39 If the nVCC project had not gone ahead, capital costs of £75.8 million on enabling works and associated projects already incurred would not have been recoverable. ACORN may also have pursued the Trust for costs.
- 40 On the balance of risk, and while not ideal, we think the decision to proceed to Financial Close without approval of the Management and Financial cases was reasonable. With Financial Close achieved, construction work on the nVCC began in May 2024.
- 41 On 1 November 2024, the Welsh Government approved the final FBC elements which it had deferred from March 2024. It also approved more enabling works expenditure relating mainly to water mains diversion.
- 42 The current proposed timetable for the nVCC construction completion and opening for patients is now April 2027, unchanged from what was expected at Financial Close. At the end of the contract in March 2052, ACORN will hand over the maintenance of the nVCC to the Trust, with a requirement that it will be in a sound condition, meaning operationally safe and exhibiting only minor deterioration.

As well as the nVCC contract there are significant wider costs to bring the centre into operation and manage it over 25 years

The nVCC contract will cost a projected £885 million

- 43 At the point of Ministerial approval in March 2024, enabling works had cost £31.4 million. The nVCC capital construction cost had risen to £321.0 million, an increase of 8.2% from ACORN's final tender price and contributing to an assumed maximum ASP of £35.6 million.⁹ However, the final agreed ASP reflected at Financial Close was £33.6 million, which in large part reflected the impact of changing interest rate assumptions around ACORN's financing.
- 44 Factoring in baseline inflation assumptions, ASPs from the Trust to ACORN over the 25-year post-construction period are projected to total £885.0 million. **Exhibit 5** in **Appendix 2** sets out the contractual cash flows arising from the financial model. **Appendix 2** also provides further information about the ASP and how it will be calculated over time. Most of the ASP cost is fixed up front.

Wider costs are expected to be at least £765 million

- 45 The nVCC and the enabling works projects are two component parts of the wider Transforming Cancer Services programme. Other elements central to bringing the nVCC into operation include the 'Integrated Radiotherapy Solution', which is part of a wider digital and equipment project.¹⁰ This includes new radiotherapy treatment machines and digital solutions to deliver cancer care that the Trust will implement at the nVCC.
- 46 **Exhibit 2** sets out the core costs outside of the nVCC contract relevant to managing and maintaining the nVCC over 25 years through to March 2052. Together, those costs are estimated at £765.3 million, but with costs not yet incurred likely to increase with inflation.

⁹ Between the final tender submission date in June 2022 and Financial Close the building cost price index that informed some of the changes in construction costs – see **paragraph 27** – rose by 11.7%. We have included £8.7 million of development costs incurred by ACORN within the £321.0 million capital construction cost.

¹⁰ The 'Integrated Radiotherapy Solution' is an investment into new radiotherapy clinical equipment and associated services such as maintenance, support and digital solutions that will support the delivery of cancer care.

Exhibit 2: estimated core costs outside of the nVCC contract to bring the nVCC into operation and manage it over 25 years post-construction^{1, 2}

Explanation of cost	Cost (£ million)
Revenue costs to operate the nVCC infrastructure and equipment over 25 years including depreciation.	557.8
Capital costs for the nVCC outside of the MIM contract including enabling works, land transfers, equipment, and project development.	154.8
One off revenue costs to transition into the nVCC, including the write-down of existing assets and to run two sites for an expected 22-week period.	42.0
Welsh Government contribution to the Development Bank of Wales to facilitate investment into the MIM.	8.2
Reimbursement of bid costs to an unsuccessful bidder.	1.3
Other Welsh Government costs since 2016, including consultancy and legal fees.	1.2
Total	765.3

Source: Audit Wales analysis of the financial model, full business case and Ministerial advice documentation

Notes:

¹ These figures include the nVCC itself, the enabling works, and the Integrated Radiotherapy Solution but they do not include other Transforming Cancer Services programme projects. Also, the figures do not factor in any capital costs for asset replacement of assets outside the nVCC contract or the costs of cancer services, for example staffing and medicines.

² The figures reflect a 2023-24 price base consistent with the FBC, so costs not yet incurred are likely to increase with inflation.

We estimate it would have otherwise cost at least £600 million to manage the existing centre

- 47 If it did not proceed with the nVCC project, in the absence of any alternative the Trust would have needed to continue managing the existing centre and invest in works to address a maintenance backlog to bring clinical areas to the required standard. We have estimated that this would have otherwise cost at least £600 million over 25 years.¹¹ This would also have been without any additional benefits the nVCC offers.
- 48 The Welsh Government's Chief Economist had a role in assessing the nVCC project's Benefit Cost Ratio. At OBC stage, the ratio was just 0.16. When re-assessed at FBC stage, the ratio increased to 0.94.¹² The Chief Economist had noted that this remained relatively low but advised that this position is not uncommon for similar high value health projects.
- 49 The Trust had identified that when considered with interdependent projects of the Transforming Cancer Services Programme the ratio increases to 3.2. This demonstrates the importance of those projects to the overall success of the nVCC. The Trust also identified that there are several benefits that are not quantified as part of the ratio, such as increased access to clinical trials.

Spending to date is currently over £85 million

- 50 **Exhibit 3** sets out actual expenditure reported by the Trust between April 2014 to March 2025 for the Transforming Cancer Services programme as a whole. This amounted to £85.7 million. Included within the nVCC specific figure is the £7.8 million relating to the acquisition of the land and buildings at the Whitchurch site (see also **Exhibit 1**). The different line items shown also include costs of £22.2 million for professional external advisers.

11 We have calculated this figure building on figures from the Trust's FBC. We used the undiscounted cashflows for the first 25 years of the Trust's economic investment appraisal of the business-as-usual option to make a fair comparison.

12 The Benefit Cost Ratio is an appraisal method that considers whole of life costs and benefits for a project. The Trust appraised the project over a 61-year period. The calculated ratio means that for every £1 spent beyond the business-as-usual option, it is estimated that the nVCC would generate an additional 94p of benefits. When considered with the enabling works, radiotherapy satellite centre and Integrated Radiotherapy Solution projects the ratio increases to 3.2.

Exhibit 3: total expenditure of the Transforming Cancer Services programme relevant to the nVCC, April 2014 to March 2025

Project	Cost (£ million)
nVCC	38.8
Enabling works	38.7
Other projects	5.7
Project management	2.5
Total	85.7

Source: Velindre University NHS Trust (unaudited)

51 Between April 2016 and March 2025, the Welsh Government has also directly incurred expenditure totalling £1.2 million.¹³ Of this, £0.9 million relates to the cost of engaging an external agent acting on behalf of Welsh Government ensuring compliance with MIM policy and providing commercial guidance since 2016.

Use of the MIM

The Welsh Government’s earlier decision to use MIM meant that alternative options were not fully explored at OBC and FBC stage

52 The Welsh Government launched the MIM in February 2017 and announced three pipeline schemes to take it forward, one of which was the nVCC. The nVCC would be the first, and to date only, NHS project to be financed using MIM.

13 Beyond funding the Welsh Government has provided to the Trust to support its expenditure.

- 53 The Welsh Government could not provide us with contemporaneous records setting out why or how it first decided that the nVCC project would be a MIM scheme. However, officials explained that the nVCC was suitable because it met the criteria of:
- a lower complexity construction project;
 - no technical advancement or novel construction methods;
 - a significant scale of around £200 million in capital expenditure; and
 - currently unfunded / not prioritised.
- 54 One of the lessons identified in the National Audit Office's March 2025 report on Private finance for infrastructure is that project approvals and financing decisions should be based on commercial and operational objectives, and not to meet accounting classifications. The Welsh Government and the Trust explained to us that the limited availability of capital budgets, and the opportunity to instead support further capital investment with revenue funding, heavily influenced the rationale for using the MIM.
- 55 The Commercial Case should demonstrate that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers. The Commercial Cases presented by the Trust at OBC and FBC stage, and Welsh Government officials' advice to Ministers at those stages, explained why MIM was being used given constraints on capital funding. However, they did not set out a clear overall case for why the MIM was the optimal procurement route. That is, how it would deliver a well-structured and advantageous deal to the public sector.¹⁴
- 56 Ultimately, because the Welsh Government chose the MIM approach early on, other funding models were not fully explored at the OBC or FBC stages as there was deemed to be no other realistic alternative.¹⁵ Had the Welsh Government chosen to prioritise this project for traditional capital expenditure it could have done so. However, this would have been at the expense of other capital projects, whether within the NHS or across other portfolios.

¹⁴ For example, by setting out how it would address contractual issues such as costing of risks and remedies for non-performance.

¹⁵ Our May 2025 report on The Wales Infrastructure and Investment Strategy includes an overview of sources of funding available to the Welsh Government for infrastructure.

While decision-makers used a ‘Public Sector Comparator’ to justify the value for money of the MIM, aspects of that approach are open to challenge

- 57 HM Treasury ‘Green Book’ guidance states that when a private finance approach is the preferred option, decision-makers should perform a Public Sector Comparator (PSC) analysis. The PSC serves as a fair counterfactual benchmark to assess the social value for money of the chosen approach.
- 58 The Trust commissioned a PSC analysis to support the FBC Economic Case which found the MIM to be favourable. It found that its net present cost was £55 million lower than the PSC. This was a marked improvement over the PSC at the OBC stage.¹⁶
- 59 In May 2024, the Welsh Government wrote to the Senedd Public Accounts and Public Administration Committee stating that the PSC comparison demonstrated that the nVCC MIM scheme remained value for money compared to traditional capital funding. Welsh Government officials and Trust representatives that we interviewed frequently referred to this analysis. The March 2024 Ministerial Advice that preceded Financial Close on the nVCC contract also reflected this analysis.
- 60 Notwithstanding the requirement for a PSC, the outcome should not be the sole basis for considering the merits of the MIM. The PSC also has limitations, as detailed in the National Audit Office’s 2013 Review of the value for money assessment process for the Private Finance Initiative. These limitations include:
- It does not evaluate the value for money of private finance compared to other sources of finance such as government borrowing.
 - The discount rate it uses is typically higher than the cost of public sector borrowing, with the impact of overstating the cost of conventional procurement.
 - Small changes in the inputs and approach can materially affect the outcome of the assessment.

¹⁶ The net present cost is calculated by applying a discount rate to cashflows throughout the project’s life. The net present cost of the MIM was just £2.8 million lower than the PSC at OBC stage.

- 61 Although the assumptions used by the Trust in its assessment were not unreasonable, in our view it would have been helpful for the FBC to have recognised the PSC's limitations and/or presented some sensitivity analysis under different assumptions. Examples of contestable assumptions used by the Trust which affect the PSC calculation were:
- The discount rate used was higher than we had expected based on our understanding of Green Book guidance.¹⁷ The rate used favoured the MIM due to the timing of cashflows; the MIM spreads construction and financing costs over the life of the contract whereas the PSC assumes construction costs are paid through the construction phase. In isolation, this would not have a material impact but in conjunction with other modelling choices may lead to a different outcome.
 - The assessment modelled the expected cashflows arising from operational risks across the life of the project.¹⁸ The Trust and their advisers estimated the likelihood and impact of certain risks occurring. However, these estimates relied largely on professional judgement and were not supported by a robust evidence base. Also, this estimation was initially conducted in 2017 and most recently updated in December 2022, around thirteen months before the final PSC.
 - The cost plan provided by the Trust's cost advisers for the PSC analysis estimated that under a traditional design and build basis, the construction costs could have ended up being £375 million.¹⁹ The Trust's PSC assessment uplifted the construction costs to the midpoint of the construction period to reflect the expected timing of expenditure. However, this approach is inconsistent with the cost plan, which assumes a fixed-price construction contract. This increased the cost inputs used within the assessment.

17 The Trust consciously used a discount rate of 6.09% based on Welsh Government advice and to allow for comparability with the PSC at OBC stage, although that too was higher than the expected discount rate at the time. We had expected the discount rate to be 5.88% to reflect the removal of general inflation using the relevant factors published at the time of the PSC assessment by the Office for Budget Responsibility.

18 Operational risk cashflows are the expected additional costs after the construction phase when things do not go to plan such as when maintenance costs are greater than anticipated.

19 Of the £375 million estimated by the Trust's cost advisers, £49 million related to an allowance for risk.

- 62 To illustrate the point about sensitivity analysis, we carried out a PSC calculation where we changed these three underlying assumptions.²⁰ Although not intended to be a correction or restatement of the Trust's original assessment, we found that the net present cost for the PSC was £7 million lower than the MIM before the cost of operational risk. Therefore, under these different assumptions the MIM would offer value if the cost of operational risks for the PSC exceeded the MIM by £7 million or more.
- 63 Beyond the PSC, final decision-making documentation did not quantify the benefits of the MIM specifically. For example, Welsh Government and Trust officials cite significant risk transfer to the private sector as a key benefit.²¹ At OBC stage, the Trust with their advisers calculated that the overall value of the risk transferred to the private sector was £32.8 million. The value of risk transfer was not re-calculated or presented to decision makers at the FBC stage.
- 64 During our work, various parties also stressed to us that the MIM encourages a collaborative approach between those who will use the building and the contractors who design, build, and maintain it. And they pointed to obligations in the nVCC contract for performance and community benefit outcomes.²² However, such obligations are not exclusive to the MIM, and we would expect to see them considered for any contract of this scale. They are also relevant to the application of the sustainable development principle under the Well-being of Future Generations (Wales) Act 2015.²³

20 For the revised assumptions, we used the discount rate of 5.88% (see **footnote 18**). We removed all operational risk estimates due to the absence of reliable up to date data at the time of the PSC assessment. We also assumed a fixed-price construction contract using costs provided to the Trust by its cost adviser.

21 Risk transfer is the process of transferring risks such as delays and cost overruns to the private sector as part of a contract.

22 **Exhibit 6 in Appendix 2** describes key contractual protections. **Exhibit 7 in Appendix 2** sets out the key performance indicators relating to community benefits that we summarise in **paragraph 84**.

23 The nVCC contract requires that ACORN will assist and cooperate with the Trust to facilitate compliance with the Trust's obligations under the Act. The contract also sets out that ACORN shall comply with the Welsh Government's code of practice on ethical employment in supply chains, which was last updated in January 2025.

The nVCC contract recognises that changes may be needed over time, although the Trust will still need to ensure this contractual flexibility delivers value for money

- 65 For long-term infrastructure projects such as this one, change is almost inevitable. Criticisms of long term private finance initiative contracts have found them to be complex, inflexible and expensive when dealing with change.²⁴ The MIM seeks to address these concerns by establishing the change protocol which features in the standard MIM templates the Trust used. The Trust also has a governance protocol which sets out how it will escalate issues under the change protocol.
- 66 The change protocol for the nVCC contract categorises low, medium, and high value changes.²⁵ Key provisions include:
- The Trust may undertake minor low value works if they are considered low risk and do not conflict with ACORN's planned works.
 - The catalogue of small-works and services for other low value changes is to be revised every three years, and ACORN must communicate and justify any changes to the Trust.
 - For medium and high value changes that the Trust requests, ACORN must provide an estimate for the Trust to consider and approve before implementing.
- 67 The change protocol seeks to ensure value for money by setting limitations for any changes made under it. For example, low and medium value changes use schedules of rates which are linked with building cost indices. High value changes are also required to meet a target cost set by the Trust. The protocol does not, however, cover how the Trust will market test or benchmark the cost of any changes. The Trust has since said that it will carry out financial due diligence on the cost of changes using cost advisers.

24 As demonstrated for example by lessons identified by the National Audit Office in its work on private finance initiatives, summarised in its [PFI and PF2 report](#) in January 2018.

25 Low value changes are pre-determined within a catalogue of small-works and services which were assessed by the Trust's advisors. A high value change is one that exceeds £350,000 or an increase in Annual Service Payment by 2%. A medium value change is neither a high nor low value change.

68 The Trust explained to us that the hospital's design allows for flexibility without necessarily triggering changes under the contract. While primarily intended as a treatment centre, the Trust may need this flexibility if future developments shift the balance between outpatient hospital care and care at home; and if the emphasis changes between treatment and prevention. The design has considered:

- potential internal and external expansion zones;
- adaptive and modular spaces for changes in clinical function; and
- standardising room types so areas can be used for multiple purposes.

The Development Bank of Wales enabled the Welsh Government's investment into the nVCC, although it did so largely in isolation from the Welsh Government and the Trust

69 The Development Bank of Wales played a limited role in the project, focusing solely on deciding whether to invest based on the project's ability to generate enough returns to repay the Welsh Government's capital investment.²⁶ In our view, it could also offer investment banking-style advice, helping to ensure that future MIM projects' risk levels align with the expected rate of return and offer value for money.

70 As part of its investment, the Development Bank recommended a non-executive director to be appointed on ACORN's board. The recommended director was subsequently appointed by ACORN. The Trust and the Welsh Government were not involved in recommending or appointing the non-executive director.

71 We put to the Trust and the Welsh Government that this may have been a missed opportunity for them to have jointly agreed to the recommended appointment. In response, they explained that this was an intentional decision to avoid potential conflicts of interest. For example, if the Trust were to consider terminating the nVCC contract, the director would be bound under the Companies Act 2006 to act in the best interests of the company, ACORN.

72 The Development Bank prepared due diligence reports and an equity investment appraisal shortly before Financial Close. To our knowledge, these were not shared with either the Welsh Government or the Trust and neither the FBC nor supporting Ministerial Advice referred to them. In our view, the Welsh Government and the Trust could have used these reports to inform their rationale for using the MIM more generally.

26 In **Appendix 2**, we set out the cashflows arising from the contract which details how the Welsh Government receives its return on investment.

Procuring the nVCC contract

The Trust used a competitive dialogue procurement process but had to offer to pay certain bid costs to maintain competitive tension

- 73 The procurement regulations in force at the time of the nVCC procurement were the Public Contracts Regulations 2015. Those regulations have since been revoked. The Trust applied a competitive dialogue process; the approach expected under Welsh Government MIM policy.²⁷ The Trust was able to justify its use of this approach against the conditions set out in the 2015 regulations.
- 74 Following initial market engagement over the previous four months, the Trust advertised the full contract notice for the nVCC on 22 April 2021. Three potential contractors submitted a Pre-Qualification Questionnaire (PQQ), confirming their interest in participating in competitive dialogue.
- 75 The Trust evaluated the PQQ returns using the criteria it had outlined alongside the contract notice and in areas such as exclusion grounds, economic and financial standing, and experience.²⁸ The evaluation approach considered whether the potential contractors had provided enough evidence in line with expectations. The process involved six teams looking at distinct aspects of the returns. All bar one of these teams included external advisers.
- 76 Before concluding pre-qualification, and following Ministerial approval, the Trust had issued an updated contract notice on 8 September 2021. This followed feedback from participants expressing concern about bidding costs, with two of the three interested parties indicating that they might withdraw.
- 77 The updated notice made clear that the Trust would reimburse costs for unsuccessful bidders if they submitted a valid, compliant, and genuine final tender. The Trust included the right to use and copy intellectual property from bids as a condition of any payment.

27 The competitive dialogue process is where, following an initial assessment of suitability, contracting authorities engage in discussions with bidders to develop solutions that best meet the authority's needs, especially for complex or innovative projects.

28 The Trust's external advisers provided further updates on economic and financial standing leading up to a final assessment for ACORN in February 2024 before Financial Close.

- 78 Such reimbursement in UK public procurement is not standard practice and should only be considered in exceptional circumstances. The rationale was that it would support value for money and quality by encouraging more bidders and maintaining competitive tension.
- 79 Welsh Government officials' advice to Ministers emphasised the project's unique position, and that the reimbursement of bid costs should not be considered the new norm for MIM policy. The advice also provided an example of where bid costs have been reimbursed elsewhere in the UK.
- 80 On 14 September 2021, the Trust completed its PQQ evaluation, and all three potential contractors passed through to the next stage. However, one bidder withdrew before the competitive dialogue began. The Trust received draft tenders on 14 March 2022 and began competitive dialogue with the remaining two bidders two weeks later. On 27 May 2022, the Trust issued an Invitation to Submit Final Tenders.²⁹
- 81 In April 2024, the Trust made a payment of £1.3 million to the unsuccessful bidder. It has also since refused payment to the bidder that withdrew before competitive dialogue began.

The Trust decided that ACORN had submitted the best tender based mainly on its price competitiveness

- 82 The Trust received final tenders on 17 June 2022 and approved the appointment of ACORN on 20 July 2022. A 'successful participant letter' governed the relationship between the Trust and ACORN before the final nVCC contract. The Trust had identified ACORN as having submitted the most economically advantageous tender, scored against seven award criteria (see **Exhibit 4**).

²⁹ Throughout the process post PQQ, the Trust expected participants to notify any change in circumstances and retained the right to exclude them.

Exhibit 4: award criteria and weighting for the nVCC procurement

Award criteria	Weighting (%)
The hospital – including technical details about design and construction	42
Price	30
Legal – including areas such as having appropriate heads of terms for sub-contractors	7
Community benefits – including how they would be delivered	6
Facilities management – covering maintenance and hand-back protocols	6
Commercial – including details about the structure of a bidder’s financing deal and financial model	6
Strategy, quality, and management – such as key personnel, quality assurance and programme management	3

Source: the Trust’s procurement documents

- 83 ACORN’s price was significantly lower than its competitor. As well as price, ACORN scored better on facilities management and community benefits. ACORN’s competitor scored marginally better across the other four criteria.
- 84 The Trust identified early on in the procurement process that community benefits requirements arising from the contract would contribute to Wales’s national well-being goals. The final nVCC contract has set out the following target areas:
 - Job creation and apprenticeships
 - School engagement
 - Community initiatives
 - Community engagement

- 85 The Trust has agreed key performance indicators with ACORN for both the construction and operational phases in each community benefit target area (see **Exhibit 7** in **Appendix 2**). The Trust has also agreed financial penalties for not meeting them.

The Trust followed legal advice and took appropriate steps in response to concerns about anti-competitive practices that emerged after ACORN's appointment

- 86 Concerns regarding members of ACORN have come under media scrutiny since the Trust announced ACORN as the successful contractor. Specifically, two companies associated with ACORN have been involved in ongoing legal proceedings outside the UK. The two companies are commonly referred to as Kajima and Sacyr. They have each been found guilty of anti-competitive behaviour, but these rulings remain subject to appeal.
- In the case of Kajima, there are criminal and administrative proceedings in Japan against Kajima Corporation which is not a member of ACORN.³⁰ Two of its subsidiaries are members of ACORN but are not party to the legal proceedings.
 - The proceedings against Sacyr relate to a Spanish regulatory decision on 7 July 2022 which found Sacyr Construcción S.A had colluded on public infrastructure tenders. Sacyr Construcción S.A is the financial support provider of Sacyr UK Limited which makes it a member of ACORN.
- 87 These issues have already featured as part of scrutiny by the Senedd's Public Accounts and Public Administration Committee.³¹ We have also looked at how and when the Trust identified and responded to these concerns.

30 The initial judgments against Kajima Corporation for the administrative and criminal proceedings were in December 2020 and March 2021 respectively.

31 The Committee held an oral evidence session with senior officials from the Trust at its meeting on 21 November 2024.

- 88 The exact date the Trust initially became aware of anti-competitive concerns remains unclear. However, the Trust states that it became aware of the concerns relating to Sacyr after the public announcement of the contract award to ACORN in July 2022, at which time the Trust had not yet formalised the contract award. The Trust stated it became aware of the anti-competitive concerns relating to Kajima in February 2023. In both cases, the Trust has confirmed that it became aware via the media and not directly from ACORN or through other due diligence work.
- 89 The Trust received legal advice on the Sacyr concerns originally in September 2022 and then formalised the contract award. The Trust had asked for background information and advice regarding whether any exclusion grounds applied and what steps it needed to take more generally. The Trust sought further, and similar, advice in February 2023 after it became aware of the proceedings against Kajima. It received that advice in April 2023.
- 90 The Trust also obtained further legal advice in June 2023. It had sought assurance on the risk of a successful legal challenge on the procurement outcome and whether the evidence of 'self-cleaning measures' obtained from ACORN was enough to demonstrate compliance with the Public Contracts Regulations 2015. Under the regulations, self-cleaning measures require a contractor to prove it has:
- paid or undertaken to pay compensation in respect of any damage caused by the criminal offence or misconduct;
 - clarified the facts and circumstances in a comprehensive manner by actively collaborating with the investigating authorities; and
 - taken concrete technical, organisational and personnel measures that are appropriate to prevent further criminal offences or misconduct.
- 91 The Trust's legal advice set out that the evidence obtained provided an appropriate level of compliance. This was despite there having been no obligation for the Trust to have requested evidence at that stage.
- 92 The legal advice concluded that there was a low risk of a successful challenge to the nVCC procurement outcome. The advice also set out that the PQQ evaluation approach was consistent with the requirements of the 2015 regulations and that ACORN's PQQ responses were appropriate – with there being no obligation for the relevant members of ACORN to have disclosed details about the ongoing legal cases described above – given that there have been no final binding judgements.

- 93 The Trust's legal advice sets out there were no grounds for exclusion. This means that if the Trust had identified the anti-competitive concerns earlier through additional due diligence, ACORN could still have participated in the procurement. The Trust could also have faced legal challenge from ACORN had it sought to exclude it from the process without just cause.
- 94 The nVCC contract includes additional information sharing requirements in respect of the Sacyr proceedings. Despite the earlier action taken by the Trust to seek assurances from Kajima, the contract does not include provisions relating to information sharing on the Kajima case. This is on the basis that the proceedings relate to Kajima Corporation that is not directly involved with the project.
- 95 The Trust's legal advisers played a significant role throughout the procurement process, providing various documented legal reports and assessments including advice on the anti-competitive concerns. We found that there was a clear audit trail around how the Trust responded to these issues once identified.
- 96 We understand why there could be public concern about the appointment of a contractor with an association to anti-competitive practices, even if these events have occurred outside the UK. In February 2025, the Procurement Act 2023 came into force. This new legislation widens the definitions for mandatory exclusions and extends these exclusions to include connected persons and offences that do not require a conviction. We cannot comment on whether the Trust's approach and legal advice would have been any different under this new regime.

Business case process and project management

The Trust followed established business case processes satisfactorily enough, although key documents could have provided greater assurance around the sustainable development principle

- 97 HM Treasury and Welsh Government Better Business Cases guidance, first published in July 2018, sets out how departments should plan programmes and projects. It builds on generic UK wide HM Treasury guidance set out in the Green Book and its five case model.³²
- 98 The framework is designed to support sound and defensible decision-making. Although use of the Green Book is mandatory, it is to be used proportionately with consideration to the cost, benefits, and risks of the proposal.
- 99 We have already noted how the Welsh Government approved distinct parts of the FBC at separate times to enable Financial Close on the nVCC contract (see **paragraphs 32 to 42**). And we have pointed to some gaps in coverage of the business cases regarding consideration of options other than MIM, and limitations in some of the analysis supporting the MIM option (see **paragraphs 52 to 64**).
- 100 We identified some other areas of the FBC which, while not affecting the final decisions, could have been addressed better in our view. These included setting out more clearly:
- the level of involvement of external specialists throughout the business case development;
 - how project objectives would be monitored in a way that aligns with the Trust's wider strategic objectives; and
 - the project's impact on the Trust's financial statements, along with its impact on the financial statements of other public bodies.³³

32 As touched on in earlier sections of this report, the five case model covers the Strategic, Economic, Commercial, Financial and Management cases.

33 These include commissioning health boards across Wales that will contribute towards the increased revenue costs of operating the nVCC. The FBC includes confirmation of their support and approvals around their financial contributions.

- 101 Despite this, we consider that the Trust can demonstrate that it has applied the established five case model approach satisfactorily enough through the OBC and FBC stages. Business case development was regularly scrutinised by the Welsh Government's Health Strategic Board. In February 2024, the Trust also obtained additional external assurance from a healthcare infrastructure consultant on its application of the methodology.
- 102 In our May 2025 report on The Wales Infrastructure Investment Strategy we described how the Welsh Government's framework had not been updated to reflect that Strategy. The Strategy itself had set out 16 intended strategic outcomes linked to the national well-being goals under the Well-being of Future Generations (Wales) Act 2015. The Welsh Government developed the Strategy with the intention of making the Act a key driver of its approach to infrastructure investment.
- 103 Overall, we think the Trust can demonstrate how it has had its obligations under the Act in mind as it has developed the nVCC project, with some clear examples of how the sustainable development principle and the associated five ways of working have been / will be applied to it.³⁴ Many of these considerations are implicit within the business case commentary and the work that has gone around establishing the nVCC contract.³⁵
- 104 Nevertheless, the existing business case guidance and templates do not direct bodies to address the sustainable development principle explicitly. Similarly, Ministerial advice supporting key decisions has not made a feature of this. By way of example, we think:
- key documents could have made stronger links between the nVCC project and the wider well-being objectives of both the Trust and the Welsh Government, beyond health policy objectives; and
 - that benefits set out in the FBC Economic Case could have been categorised into short-term, medium-term, and long-term.

34 The five ways of working being long-term, prevention, integration, collaboration, and involvement.

35 For example, a long-term view is inherent in the MIM finance model and the consideration that has been given to building in flexibility to respond to possible changes in demand and treatments that cannot be foreseen now.

105 In response to recommendations in our report on the Wales Infrastructure Investment Strategy, the Welsh Government aims to review the business case guidance working with HM Treasury. As part of this review, we think there is an opportunity to consider how the guidance and templates can better address the application of the sustainable development principle and its relevance to value for money. Meanwhile, issues around the coverage of Ministerial Advice are relevant to themes in the Welsh Government's Well-being of Future Generations Continuous learning and improvement plan for 2023 to 2025.³⁶

There has been appropriate governance, scrutiny, and expert and stakeholder input throughout the stages of the nVCC project that we examined

- 106 Developing a project on the scale of the nVCC, arranging MIM finance, and procuring a contractor under the MIM model has been challenging. It has also gone well beyond the Trust's usual areas of focus.
- 107 The Trust established a dedicated Project Management Office to support the development and delivery of the project. For over a decade it has built capacity and capability, appointing managers with relevant experience. However, the project has still required significant input from external advisers, and at a considerable overall cost (see **paragraph 50**). In our view, there is scope for the Welsh Government to look at opportunities for greater knowledge transfer to reduce the reliance on external advice in future MIM projects if this approach remains in use over time.³⁷
- 108 The Trust has sought to apply recognised good practice in project management, with appropriate controls and independent gateway assurance reviews organised by the Welsh Government. There have also been various internal audit reviews at the Trust and at the Welsh Government.
- 109 In addition, arrangements under the Welsh Government's MIM process included Commercial Approval Point reviews. Those reviews involved independent experts who examined the commercial aspects of the scheme – including affordability, deliverability, and value for money – at five specified points before Financial Close.

36 This plan represented the Welsh Government's response to the Future Generations Commissioner's December 2022 review into the Welsh Government's implementation of the Act.

37 We would recognise that the use of external consultants is likely to be necessary and appropriate to some degree in any large capital infrastructure project.

- 110 Generally, these various review processes have not identified issues of fundamental concern. Where they set out recommended actions, we found that these had largely been acted on and with their implementation followed up as part of wider governance and scrutiny processes.
- 111 Various parts of the Welsh Government and NHS Wales have worked together to provide advice and scrutiny through the nVCC project. Overall governance has involved three levels:
- Level one – Trust operational: various workstreams that have evolved over time and an nVCC project board.
 - Level two – Trust corporate: including its Board and nVCC project scrutiny committee.³⁸
 - Level three – Welsh Government strategy and policy, including its Health Strategic and Health Infrastructure Investment boards, and input from its MIM Programme Office.³⁹
- 112 These structures and related processes appear to have functioned reasonably overall. However, based on feedback that we received during our work, the nVCC project could have benefitted from setting out the respective roles and responsibilities of the key public sector parties involved more clearly. For example, we think a memorandum of understanding with key public sector parties (see **Appendix 4**) could have been agreed earlier in the decision-making process to address this.
- 113 We have also observed that before the Welsh Government approved the FBC, the Welsh Government's Health Strategic Board approved the MIM elements of the business case whereas its Health Infrastructure Investment Board approved the traditional capital bid elements, including project team costs. In our view, a one-stop approval mechanism may have streamlined the approvals process.

38 The Trust's Board approved the OBC and FBC before these documents went to the Welsh Government for its final decisions. The nVCC project scrutiny sub-committee has replaced the Transforming Cancer Services Programme scrutiny sub-committee from May 2025. The Trust's Audit Committee has also considered the nVCC project where issues fall within its remit.

39 The MIM Programme Office provided technical and legal expertise to the Trust. The MIM Programme Office has set the commercial policy and ensures that policy is complied with. HM Treasury and the National Audit Office have previously identified six key functions in a [report on Managing complex capital investment programmes utilising private finance](#) in 2010. That guidance recommended that all six functions are undertaken by a single unit. The MIM Programme Office largely addresses these functions. It does not, however, have capacity to run individual projects MIM projects itself, and therefore adopts an oversight role.

- 114 The regional clinical model for the nVCC within the Transforming Cancer Services programme is a matter of some debate and some clinicians believe the Trust's cancer services should be co-located at an acute hospital. However, the existing centre already operates within a regional network and co-location was deemed as an unachievable option within the timeframe in which the existing centre requires replacement.
- 115 The Trust had commissioned an independent review of the regional network by the Nuffield Trust which reported in 2020. The '[Nuffield Advice](#)' made recommendations for improving the existing and proposed network to address patient safety concerns. The Strategic Cases in the OBC and FBC refer to this context. The recommendations affect the regional network including plans for the nVCC, dependent projects within the Transforming Cancer Services programme, and district general hospitals within the region.
- 116 The Trust had also been providing reports to the south-east Wales Collaborative Cancer Leadership Group. Among other things, this Group, established in 2019, provided regional leadership to the Transforming Cancer Services programme. The Group had also agreed to take forward recommendations from the Nuffield Advice.
- 117 The Group was reformed in 2023 to create a single regional cancer programme board as part of wider regional NHS planning arrangements. Actions flowing from the Nuffield Advice recommendations are part of the regional board's work programme.
- 118 The Trust established a specific nVCC Communication and Engagement Strategy in October 2023 which sets out the various key stakeholders and communication methods to improve involvement. We recognise that the Trust took a range of action to engage with stakeholders at earlier points in the nVCC project, although the FBC did not rehearse this in any detail.

The Trust has changed how it is managing and overseeing the nVCC project for the construction phase in response to an external report

- 119 We have not considered progress with and oversight of construction as part of the audit work that informs this report. However, in February 2024, one of the Commercial Approval Point reviews (see **paragraph 109**) raised concerns about the Trust's management capacity for the construction phase. Following this, the Trust commissioned a further external review focused on governance and capabilities.

- 120 The Welsh Government delayed its approval of the FBC Management Case until after the governance and capabilities review reported in June 2024 (see also **paragraphs 32 to 42**). The review made eleven recommendations to strengthen capability and streamline governance arrangements, three of which would also improve collaboration between the Trust and the Welsh Government. Although the Trust had not actioned all the recommendations before it finalised the Management Case it committed to implementing them in full. The Trust has since decided not to take forward one specific action that it considers would not be cost-effective.
- 121 The Trust could not fill some specialist roles in its Project Management Office for the construction phase before Financial Close because the necessary funding was conditional on the nVCC project going ahead. The FBC identified these roles as vacant, but the Trust has since filled them.
- 122 The Commercial Approval Point review in February 2024 also recommended implementing a scheme of delegation to identify decisions the Trust could take during the construction phase without first having to refer them for Welsh Government approval. The external review of governance and capabilities found that a scheme of delegation was being developed and gave a high priority to its implementation. It has since been established.
- 123 There is some published information available on progress with construction through Trust papers, in particular from its nVCC project scrutiny sub-committee. Recent papers indicate that while the Trust is fulfilling its obligations, construction has encountered delays but with efforts to accelerate progress underway.
- 124 Financially, the Trust is reporting that the project remains on track and within budget. The Trust has given the project an overall amber status rating, which indicates that the Trust has identified risks but is managing them.⁴⁰
- 125 The decommissioning and potential disposal of surplus land and buildings, including the existing cancer centre, is subject to its own business case. This has not yet been approved. While these developments may lead to a return for the public purse, this will be determined by the next steps that are yet to be worked through. The Trust has announced that it has currently listed the Whitchurch site for commercial sale.

40 The Trust has adopted a red, amber, green rating approach to rate the status of the project.



Recommendations

For the Welsh Government

- R1** In updating better business case guidance, the Welsh Government should set clear expectations about coverage of:
- how, when assessing the use of private finance, this assessment should include coverage of both benefits and drawbacks and recognise any limitations of the assessment method or the assumptions that inform it (see **paragraphs 52 to 64**);
 - the level of involvement of external specialists throughout the business case development (see **paragraph 100**);
 - a project's impact on financial statements, including for any public bodies that are contributing towards it (see **paragraph 100**); and
 - how proposals will contribute to wider strategic objectives and how the sustainable development principle and its associated ways of working have been applied (see **paragraphs 100 to 105**).

R2 The Welsh Government should work with the Trust and other public bodies involved to learn, and share more widely, lessons from the nVCC project that can be applied to future large-scale infrastructure projects. Among other things, issues for this exercise to reflect on include:

- opportunities to streamline processes, saving time and potentially cost, in the context of the long history of the nVCC project (see **paragraphs 14 to 42 and 113**);
- how the Development Bank of Wales might be more involved, and at an earlier stage, to provide advice over proposed private financing deals (see **paragraphs 69 to 72**);
- opportunities to encourage knowledge transfer and public sector capacity building to reduce the reliance on external advice (see **paragraph 107**); and
- how the roles and responsibilities of the key public bodies involved with projects, including those with planning responsibilities, can be set out clearly up-front (see **paragraph 22 to 25 and 112**).

For the Trust

R3 To provide ongoing assurance around value for money, the Trust should establish a clearly documented procedure to ensure that the advice that it plans to get to help assess changes made under the nVCC contract includes benchmarking and market testing (see **paragraph 67**).

R4 The Trust should review and update its project objectives and key performance indicators for the nVCC project to make clear how they align with and contribute to its wider strategic objectives (see **paragraph 100**).



Appendices

- 1 About our work
- 2 About the nVCC contract
- 3 Cost estimates for the nVCC at different times
- 4 Public sector parties featured in this report and other key terms

1 About our work

Scope of the audit

Our main audit objectives were to:

- Provide insight and assurance in relation to the Welsh Government's and the Trust's decision-making processes.
- Explain the status of the nVCC project and associated costs.
- Provide independent information in relation to matters that have been the subject of some public and political debate.
- Identify learning points in relation to public sector capital project management and financing.

We are aware that a body of clinicians and some in the local community have raised concerns about the nVCC project. We have emphasised from the outset of our work that decisions about the project and its contracting arrangements have been for the bodies involved to make. The Auditor General has no powers to intervene in the decision-making itself.

Where issues raised with us by other parties are relevant to the scope of our work, we have kept them in mind. However, we have formed our own view based on the evidence we have reviewed and taking account of wider laws and procedural guidance relevant to the decision-making process.

In 2021, an individual launched a legal challenge to the Welsh Government's approval of the Outline Business Case, requesting a judicial review of the decision. The challenge cited three main grounds, summarised as follows:

- That there had been a breach of the 'Tameside' duty⁴¹, in particular around enquiries on the feasibility of co-location as part of the future development of the University Hospital of Wales.
- That the decision did not comply with biodiversity requirements under the Environment (Wales) Act 2016.
- That the decision did not comply with duties under the Well-being of Future Generations (Wales) Act 2015.

⁴¹ The Tameside duty is commonly described as the duty for decision makers to make sufficient inquiry. Decision makers must take reasonable steps to acquaint themselves with the relevant information and to make sufficient enquiries.

The request for a review was rejected in September 2021. The same individual renewed their application for review, which was rejected in November 2021. A later March 2022 judgement on the assessment of costs summarises the earlier background.

Our focus was on developments around and since the approval of the Outline Business Case for the nVCC in March 2021, although we touch on certain earlier events.⁴² And while the nVCC project is part of the Trust's wider Transforming Cancer Services in south-east Wales programme and we set out some of its wider costs, our focus has been on the nVCC project itself.

We have drawn on information from earlier documentation, for example around cost estimates, but we did not set out to examine the full history of the project. The many documents we have reviewed include specialist advice and reports that public bodies involved have commissioned from other organisations. We have not sought to second guess that analysis. However, we have considered how different assumptions would affect the results for the Public Sector Comparator for the MIM (see **Methods** below).

Also, we have not examined progress with the ongoing construction at this stage although we touch on certain related matters.

Separate to this review, we have identified the nVCC as a potential risk for material misstatement and therefore as an area of focus for our annual audit of the Trust's financial statements. To date, we have not identified any specific concerns impacting on our overall audit opinions.

⁴² The Trust has also published a timeline of events relating to the nVCC project starting from 2010. The timeline includes redacted versions of certain key decision making documents.

Audit questions and criteria

Questions

Our audit addressed the following key questions:

- Does the business case process demonstrate that, in general terms HM Treasury guidance and accepted good practice has been followed?
- Does the detail of core documentation supporting decision making provide assurance that relevant factors have been considered properly in making the decision?
- Does decision making about, and the general management of, the project demonstrate that the sustainable development principle has been applied?
- Has the decision-making process included an appropriate level of assurance, scrutiny, and challenge?
- Can a transparent and competitive procurement process be demonstrated?
- Can the Welsh Government and the Trust demonstrate why the MIM is the most appropriate delivery mechanism for the project?

Criteria

We based our audit criteria on resources including, but not limited to:

- HM Treasury's guidance on appraisal and evaluation in central government ('the Green Book') and associated guidance.
- NHS Wales Infrastructure Investment Guidance from the Welsh Government.
- National Audit Office good practice guides and published reports on the use of private finance for infrastructure.
- The better business cases: investment decision-making framework guidance published by HM Treasury and the Welsh Government.
- Audit Wales internal guidance, including our 'positive indicators' which are an illustrative set of characteristics that describe how bodies could apply the sustainable development principle effectively. We have used these indicators to inform previous sustainable development principle examinations under the Well-being of Future Generations (Wales) Act 2015. We developed the positive indicators through engagement with public bodies and informed by advice and guidance from the Future Generations Commissioner for Wales.

Methods

Document review

We reviewed a broad range of documentation relating to decision-making for the nVCC, including:

- meeting papers and minutes for the Welsh Government's Infrastructure Investment Board and Health Strategic Board;
- meeting papers and minutes of the Trust's Board and Transforming Cancer Services/nVCC Scrutiny Sub-Committee;
- meeting papers and minutes of the Development Bank of Wales Investment Committee and due diligence documentation from the Development Bank;
- Welsh Government Ministerial Advice briefings;
- the final approved business cases for the new Velindre cancer centre and earlier unapproved iterations;
- Welsh Government project review reports;
- Welsh Government and NHS Wales Shared Services Partnership internal audit reports – for the Welsh Government and the Trust respectively;
- procurement assessment and award reports; and
- other expert professional advice and reports commissioned by the Welsh Government, the Trust, and the Development Bank.

We have also considered oral and written evidence provided by the Welsh Government and the Trust to the Senedd Public Accounts and Public Administration Committee since May 2023.

Semi-structured interviews

We interviewed a selection of Welsh Government officials from the Welsh Government's Treasury and NHS Capital, Estates and Facilities departments.

We also interviewed various senior staff and board members from the Trust.

Site visit

While we have not examined progress with construction, we visited the construction site in March 2025 to better understand the context.

Financial analysis

We undertook a high-level analysis of the financial models and financial analyses that the Welsh Government and the Trust used to inform decision making. More specifically we:

- Analysed costs incurred and expected costs over time, based on unaudited financial information provided by the Welsh Government and the Trust. We rebased historical cost estimates, such as from the OBC, to reflect prices as of 31 March 2024 for the purpose of comparison.⁴³
- Recreated the Public Sector Comparator under different assumptions.

We reviewed unaudited financial information provided by the Welsh Government and the Trust.

⁴³ We have based our real terms calculations on HM Treasury's GDP deflator. We used the deflators issued in March 2025 to reflect prices as of 31 March 2024 to allow for a fair comparison with the final nVCC contract that the Trust entered into on the 28 March 2024. The GDP deflator can be viewed as a measure of general inflation in the domestic economy and may differ to construction price inflation. For example, we noted in our [May 2025 report on The Wales Infrastructure Investment Strategy](#) that the costs of building new infrastructure had risen ahead of inflation over the period 2020-21 to 2023-24 with a sharp rise in 2022-23.

2 About the nVCC contract

This Appendix sets out further information about the Trust's contract with ACORN for the nVCC. It includes information about:

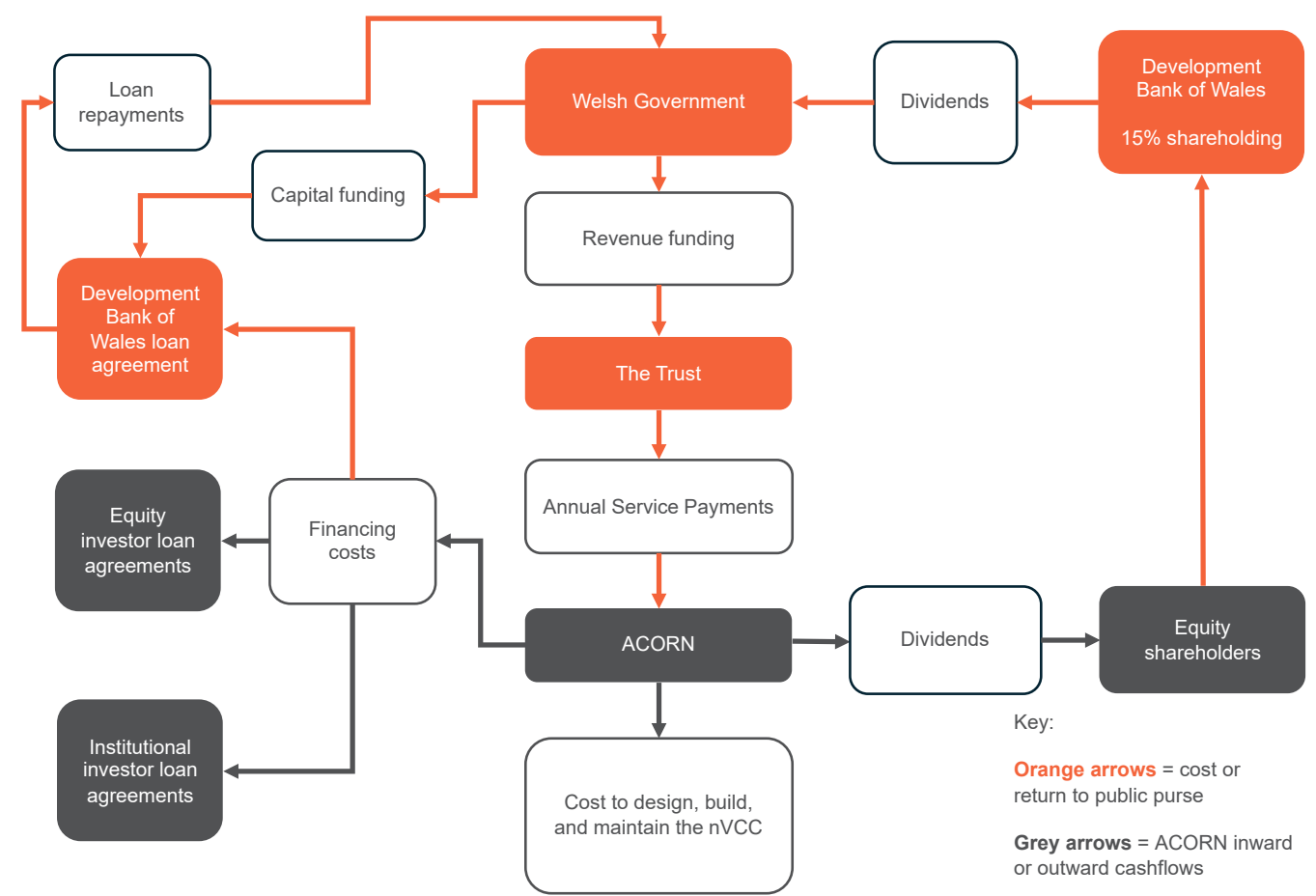
- cashflows arising from the contract;
- the Annual Service Payment;
- key contractual protections; and
- community benefit key performance indicators.

Cashflows arising from the contract

Exhibit 5 summarises the expected contractual cashflows and demonstrates how money is returned to the Welsh Government as part of its co-investment with ACORN into the nVCC project. The Welsh Government provided £8.2 million in repayable capital funding for the Development Bank of Wales to facilitate this investment on its behalf. The Welsh Government expects to receive its return by:

- repayment of a loan agreement between ACORN and the Development Bank of Wales; and
- a 15% share of any profits generated by ACORN as an equity shareholder.

Exhibit 5: contractual cashflows arising from the nVCC contract



Source: Audit Wales analysis of the financial model and the Development Bank of Wales records

Note: This diagram covers the baseline position of the contract at Financial Close. ACORN are responsible for putting in place the financing arrangements of the scheme which included obtaining loans from institutional investors and equity shareholders which include the Development Bank of Wales.

The Annual Service Payment to ACORN

Overview

The final financial model agreed at Financial Close generates the ASP. At Financial Close, the ASP was calculated to be £33.6 million.

The ASP covers the following elements:

- Repayment of the financing package put in place by ACORN to fund its up-front costs:
 - Interest and principal repayments on debt finance; and
 - Shareholders return on equity.
- Maintenance costs for the nVCC.
- Running costs of the company set up by ACORN to manage the project.

The Trust will pay the ASP through a monthly service payment that becomes payable on a gradual basis as construction phases complete.

Indexation of the ASP

A proportion of the ASP will inflate each year in line with movements with the Retail Prices Index All Items Excluding Mortgage Interest.

At Financial Close, the proportion of the ASP subject to indexation is 10.15%. This proportion reflects the underlying costs that are expected to increase with inflation that is operating and lifecycle costs.

Over 25 years, the projected total ASP cost is £885 million, which assumes inflation of 2.5% per annum. The final full year ASP – in 2052 – is expected to be around £37.0 million.

Deductions and adjustments from the ASP

The Trust can make deductions from the monthly service payments if:

- ACORN does not meet the required performance, such as the required service standards.
- Areas of the cancer centre become unavailable.
- ACORN fails to meet community benefit KPIs.
- ACORN fails to meet energy and emissions targets.

Adjustments to the ASP may be necessary, for example if the Trust implements a major refurbishment or expansion.

Costs outside the ASP

The monthly service payment will include other ‘pass-through costs’ incurred by ACORN and paid for by the Trust on an actual basis. These costs are utilities, insurances, and rates.

The Trust may also be liable for additional costs if certain risks arise that count as compensation events under the contract. These limited circumstances reflect risk items that the Trust either cannot transfer to ACORN or cannot do so at a value for money price. For example, if there are delays with enabling works that impact ACORN.

Key contractual protections

Exhibit 6 summarises five key areas of protection for the Trust:

- Changes and approvals.
- Performance and maintenance.
- Information and transparency.
- Financial and legal.
- Governance and oversight.

Exhibit 6: overview of key areas of protections in the nVCC contract

Performance and maintenance	
Contractual protection	Description
Snagging and defects	The Trust can rectify unaddressed defects and recover costs from ACORN.
Monitoring and deductions	The Trust will monitor performance and can apply deductions for failures.
Persistent breach	The Trust can terminate the contract for persistent breaches.
Authority step-in rights	The Trust can step-in and perform ACORN’s obligations in certain circumstances, such as when there are material service interruptions or health and safety risks.

Changes and approvals	
Contractual protection	Description
Change protocol	The Trust can request and make changes under the protocol. ACORN will respond to this with a cost and time for implementing the change. The Trust is not obliged to continue with the change.
Change in control	Any change in control of ACORN and its holding company requires prior written approval from the Trust.
Change in financing	The Trust must provide written consent for ACORN for any refinancing and is entitled to a share of any refinancing gains.

Information and transparency	
Contractual protection	Description
Record provisions	These outline the requirements for the creation, maintenance, access, and retention of records by ACORN.
Access to information	The Trust has rights to access documents and explanations for audits and regulatory compliance.

Financial and legal	
Contractual protection	Description
Availability deductions	The Trust can apply deductions from the ASP where certain areas of the facility are not available for use.
Termination rights	The Trust can terminate the contract for various defaults, including insolvency, health and safety breaches, and corruption.
Indemnities	ACORN indemnifies the Trust against losses from personal injury, property damage, and third-party claims.

Financial and legal	
Contractual protection	Description
Insurance requirements	ACORN must maintain adequate insurance.
Compensation events	The Trust is protected from paying compensation to ACORN unless specific conditions are met. Compensation events will typically occur when the Trust has not fulfilled its responsibilities.
Step-in rights	Rights are granted to the funders to intervene if ACORN defaults, before the Trust can terminate the contract. These give the funders a chance to rescue or restructure the project before it collapses.
Governance and oversight	
Contractual protection	Description
Liaison and reporting	Regular liaison procedures through a liaison committee and biennial reviews ensure ongoing oversight.
Independent Tester contract	The Independent Tester, contracted by the Trust, acts as a neutral third party to assess compliance with construction and delivery standards.

Source: Audit Wales summary based on the nVCC contract

Community benefit key performance indicators

Exhibit 7 sets out the community benefit key performance indicators within the nVCC contract. These sit alongside a range of other performance indicators, for example around energy consumption. The following definitions apply for the community benefit KPIs:

- Person weeks: means the employment of a person for five days (or 40 hours) in connection with the project.
- Not in education, employment, or training: means an individual who has not been in regular paid employment and has been out of full-time education or training for the previous six consecutive months or more.
- Disadvantaged worker: means someone who meets at least one of several criteria. Examples of these criteria include being between 15 and 24 years of age or being a single adult with one or more dependents.
- Pupil interactions: means an interaction with one school pupil for a minimum of one hour in a structured group environment for a lesson, assembly, or similar educational activity. For example, a lesson of one hour for 30 pupils equals 30 pupil interactions.
- School engagement – STEM: means science, technology, engineering, and mathematics career related engagement with school pupils. This includes, but is not limited to, attendance at career fairs or interviews and delivered in person or on a virtual basis, but excludes separately counted pupil interactions.
- Community engagement: means any ACORN communication or interaction with the community including – but not limited to – the circulation of newsletters, presentations, or meetings with community groups.
- Community initiatives: means an initiative leaving a lasting legacy within the community, including – but not limited to – regeneration, the Welsh language and culture, and community cohesion.

Exhibit 7: community benefit key performance indicators for the nVCC contract

Target area	Construction phase	Operational term
Jobs created (previously not in education, employment, or training or disadvantaged worker)	12,923 person weeks	97 person weeks per annum
Apprentices	6,213 person weeks	47 person weeks per annum
Pupil interactions	7,455 hours	30 hours per annum
School engagement – STEM	2,485 hours	19 hours per annum
Community initiatives	20	4 per annum
Community engagements	12	Not required

Source: Audit Wales summary based on the nVCC contract

Note: For the jobs created key performance indicator, only up to 3,231 person weeks during the construction phase and 24 person weeks per annum during the operation phase can come from disadvantaged workers not otherwise counted as not in education, employment or training.

3 Cost estimates for the nVCC at different times

Exhibit 8 sets out the estimated or agreed construction costs for the nVCC, and where applicable the indicative or agreed ASP, at specific points in time. Under the nVCC contract, the Trust pays for construction costs as part of the ASP.

Exhibit 8: estimated construction costs and indicative ASPs for the nVCC at significant points in time since 2010 (£ millions)^{1, 2}

	October 2010 Original nVCC proposal	December 2014 Initial Transforming Cancer Services programme proposals	March 2021 OBC for the nVCC	September 2021 End of pre-qualification for the nVCC procurement	June 2022 End of the nVCC procurement	March 2024 Financial Close for the nVCC
Construction cost	240.0	210.0	180.0	200.0	280.0	321.0
Adjusted construction cost [23/24 prices]	327.4	276.0	204.0	226.7	296.5	321.0
Indicative ASP	-	-	16.9	22.5	25.7	33.6
Adjusted indicative ASP [23/24 prices]			19.2	25.5	27.2	33.6

Source: Audit Wales analysis of the Trust's documents

Notes:

¹ At the points shown before the Outline Business Case, the Welsh Government had not launched the MIM so there were no estimates for that financing model. Also, the construction cost quoted for the December 2014 estimate includes enabling works, such as roads and bridges to provide an access to the site, that we have not been able to separate out from the overall estimate. We have adjusted historical cost estimates for inflation using HM Treasury's GDP deflator to apply a common price base (see also **Appendix 1**).

² The construction costs represent the cost to design and build the nVCC and does not include capital equipment, project delivery costs, or contingencies.

4 Public sector parties featured in this report and other key terms

Exhibit 9 sets out the role of the key public sector parties involved in decision-making for the nVCC that we mention in this report. Alongside their involvement, there has been a range of other expert professional advice from the private sector. **Exhibit 10** lists key terms used across multiple sections of this report. Where we have used other technical terms only in isolated sections of the report we have explained them at that point.

Exhibit 9: key public sector parties involved in the nVCC decision-making process

Party	Responsibilities
Cardiff and Vale University Health Board	Original owner of the Whitchurch Hospital and nVCC site and agreed land transfers to the Trust.
Cardiff Council	The Local Planning Authority for the nVCC site and responsible for regulating development and deciding on planning applications.
Commissioning health boards	Assessing and agreeing to the financial affordability settlement in relation to the additional non-MIM revenue costs associated with operating the nVCC.
Development Bank of Wales	Investing into the MIM contract on behalf of the Welsh Government and undertaking due diligence on certain legal, financial, and technical aspects of the project as part of its investor role.
Natural Resources Wales	Granting European Protected Species Licences to the Trust.

Party	Responsibilities
NHS South-east Wales Collaborative Cancer Leadership Group / now the Regional Cancer Programme Board	Focuses on enhancing collaboration and leadership of cancer care in the region by designing, developing, and prioritising the future cancer programme which includes arrangements of the nVCC.
NHS Wales Shared Services Partnership – Internal Audit	Providing independent assurance to the Trust across a range of risk areas and at various stages, including around procurement and governance processes.
NHS Wales Shared Services Partnership – Specialist Estates Services	Providing advice and support to the Welsh Government and the Trust. This included advice on equipment and technical reviews during the design phase.
Velindre University NHS Trust / the Trust	The contracting authority for the nVCC. Delivering cancer services and managing the nVCC project, including ongoing contract management with ACORN. At an operational level, a Project Board manages the nVCC and other Transforming Cancer Services programme workstreams. The Project Board reports to a scrutiny sub-committee for scrutiny and challenge. The Project Board escalates decision making beyond its delegated authority to the Trust's Board.
Welsh Government Chief Economist	Provided scrutiny and challenge on the Trust's FBC, which was reflected in advice to Ministers.
Welsh Government Health Strategic Board	Making recommendations to Ministers regarding strategic decision making. Providing challenge and scrutiny throughout the decision-making process.

Party	Responsibilities
Welsh Government Infrastructure Investment Board for Health and Social Services	Making recommendations to Ministers for projects with capital funding requirements and ensuring projects comply with the five case model.
Welsh Government Internal Audit Services	Providing independent assurance to the Welsh Government across a range risk areas and at various stages, including around the MIM. Also provided advisory reports.
Welsh Government Mutual Investment Model Programme Office	Ensuring MIM schemes comply Office for National Statistics classifications and agreeing any derogations from standard MIM policy.
Welsh Ministers	The ultimate decision makers, providing approval for the Trust to enter into the MIM contract and agreeing budget allocations.

Source: Audit Wales summary

Exhibit 10: key terms used across multiple sections of this report

Term	Description
ACORN Consortium / ACORN	The nVCC MIM contractor trading under the special purpose vehicle company <u>Acorn Velindre Limited</u> . The consortium of companies brings together Kajima Partnerships Limited, Sacyr Infrastructure UK Ltd, Aberdeen European Infrastructure GP IV Limited, Sacyr UK Limited, Kier Facilities Ltd, Hydrock Consultants Limited, BAC Engineering Consultancy Group SL, Ingho Facility Management SL, and White Arkitekter AB.
Advice to Ministers / Ministerial Advice	The written advice that Welsh Government officials present to Ministers to enable them to make a lawful decision.

Term	Description
Annual Service Payment / ASP	The annual payment the Trust will pay to ACORN for the nVCC. The final financial model agreed at Financial Close generated the ASP. See also Appendix 2 .
Commercial Case	Part of the five case model. Demonstrates that the preferred option will result in a viable procurement and a well-structured deal between the public sector and its service providers.
Community benefits	Also known as social value clauses. These are conditions of contract in public sector procurement to achieve positive social, economic, environmental, and cultural outcomes.
Discount rate	A percentage rate applied to a future value or cost to reflect the present value of money. HM Treasury Green Book guidance sets the discount rate.
Economic Case	Part of the five case model. Identifies that the proposal that delivers best public value to society, including consideration of wider social and environmental effects.
Enabling works	The range of infrastructure works including roads, bridges and access works to enable a shovel ready site for the construction of the nVCC.
Financial Case	Part of the five case model. Demonstrates the affordability and funding of the preferred option, including the support of stakeholders and customers, as required.
Financial Close	The process and point at which all financial, construction and service agreements were in place for the nVCC project to proceed. Formalised by the Trust entering into the nVCC contract with ACORN.

Term	Description
Financial model	The computer spreadsheet model for the nVCC project incorporating statements of ACORN's cashflows, including expenditure, revenues, financing, and taxation throughout the project term.
Five case model	A framework for the development and presentation of a business case, comprised of the strategic, economic, commercial, financial and management cases.
Full Business Case / FBC	Identifies the most economically advantageous option following procurement, confirms affordability, and puts in place the detailed arrangements for successful delivery.
Management Case	Part of the five case model. Demonstrates that robust arrangements are in place for the delivery, monitoring, and evaluation of the scheme, including feedback into the organisation's strategic planning cycle.
Mutual Investment Model / MIM	A Welsh Government initiative where private sector partners build and maintain public assets. Once operational, the relevant public body will pay a regular fee from their revenue budget to the private partner. The fee will cover the cost of construction, maintenance, and financing of the project.
New Velindre Cancer Centre / nVCC	The new facility in Whitchurch, Cardiff, which will replace the existing centre located nearby.
Outline Business Case / OBC	Identifies the option offering best public value, ascertains the procurement approach and funding requirements, and puts in place the arrangements for successful delivery before taking a procurement to the market.
Private finance	A government funding method which uses private sector funds to fund public sector projects. Examples of private finance include the MIM and Private Finance Initiative.

Term	Description
Public Sector Comparator / PSC	A way to compare the cost of funding a project directly by the public sector with the cost of doing it through private finance, such as the MIM. Assumes the same level of service and maintenance and includes adjustments for risk and tax to make the comparison fair but is also influenced by other assumptions.
Strategic Case	Part of the five case model. Makes the case for change and demonstrates how it provides strategic fit.
Sustainable development principle	Set out in the <u>Well-being of Future Generations (Wales) Act 2015</u> . Means acting 'in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs'. To act in that manner, a public body must take account of five ways of working commonly referred to as long-term, integration, involvement, collaboration, and prevention.
The nVCC contract	The legal project agreement between the Trust and ACORN to design, build, maintain and finance the new Velindre cancer centre.
Transforming Cancer Services programme	The Trust's Transforming Cancer Services in south-east Wales programme, which includes seven projects: • Enabling works for the nVCC. • Constructing and equipping the nVCC. • Digital and equipment. • Radiotherapy satellite centre at Nevill Hall Hospital, Abergavenny. • Outreach facilities delivering cancer services embedded in other health boards. • Service delivery and transition. • Decommissioning of buildings no longer required following nVCC construction.

Source: Audit Wales summary

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.



Audit Wales

1 Capital Quarter

Tyndall Street

Cardiff CF10 4BZ

Tel: 029 2032 0500

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

AUDIT COMMITTEE

2025/26 Internal Audit Progress Report

DATE OF MEETING	03/03/2026
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	Eifion Jones, Deputy Head of Internal Audit
PRESENTED BY	Stephen Chaney, Head of Internal Audit
APPROVED BY	Stephen Chaney, Head of Internal Audit
EXECUTIVE SUMMARY	PROGRESS: Whilst engagement during our audit work has typically been positive, we continue to experience some challenges with overdue management responses. Consequently, there are several reports that were overdue for management responses, including a couple of legacy / longer overdue reports that have just been finalised. We had been actively engaging with our clients to bring these to a conclusion.



	KEY PERFORMANCE INDICATORS: Most KPIs for 2025/26 are currently GREEN, but the timely management response KPI for 2025/26 remains RED.

RECOMMENDATION / ACTIONS	We ask the Committee to NOTE the 2025/26 internal audit progress update (appendix 1).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/a

APPENDICES	
1.	2025/26 Internal Audit Progress Update – 23 February 2026

1. SITUATION / BACKGROUND

We provide regular progress updates against the Annual Internal Audit Plan.

2. ASSESSMENT

The progress update report for the 2025/26 Internal Audit Plan delivery is at Appendix 1. A summary of key matters is included on page 3 of the progress report.

Pertinent points to note:

- All KPIs are currently RAG rated **GREEN** for 2025/26, with the exception of the timely management responses KPI, which is **RED**.
- Eight reports are final and four in fieldwork (although a couple are close to draft report stage).

- Further details on progress can be found in the progress update report (Appendix 1).

3. SUMMARY OF MATTERS FOR CONSIDERATION

We ask the Committee to **NOTE** the 2025/26 internal audit progress update (appendix 1).

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 - BOARD ASSURANCE FRAMEWORK (BAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 - Organisational and Clinical Governance Internal Audit reports are linked to the BAF in the Annual Internal Audit Plan and through the cover paper for each individual report, where applicable.												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply												
	<table> <tr><td>Safe</td><td>☒</td></tr> <tr><td>Timely</td><td>☒</td></tr> <tr><td>Effective</td><td>☒</td></tr> <tr><td>Equitable</td><td>☒</td></tr> <tr><td>Efficient</td><td>☒</td></tr> <tr><td>Patient Centred</td><td>☒</td></tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs and through the cover paper for each individual report, where applicable.													



SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information:</i> https://www.gov.wales/socio-economic-duty-overview	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audit reports are linked to the Trust Risk Register in the Annual Internal Audit Plan and through the cover paper for each individual report, where applicable.
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services

2025/26 Internal Audit Progress Update and Key Performance Indicators

Velindre University NHS Trust

23 February 2026



Contents

Executive Summary.....	3
2025/26 Summary Position.....	4
Draft Reports Issued and Awaiting Management Response.....	5
2025/26 Final Reports by Assurance Rating.....	6

Executive Summary

Progress

The following reports have been included for the March 2026 Audit Committee:

- * AI / Robotics
- * Medical Job Planning
- * Commissioning Arrangements
- * Cyber Security
- * nVCC Integrated Planning

We continue to get good engagement on the 2025/26 plan and are on track for delivery of the Annual Opinion.

Status	No. of Audits
5. Final Report	8
3. Fieldwork	4
2. Planning Complete	1
1. Planning or yet to start	2
Total	15

Draft Reports Awaiting Responses

At the time of writing this progress report, there were no reports awaiting management responses and executive sign off (see page 5).

2025/26 Key Performance Indicators

Most KPIs are currently reporting as **GREEN**.

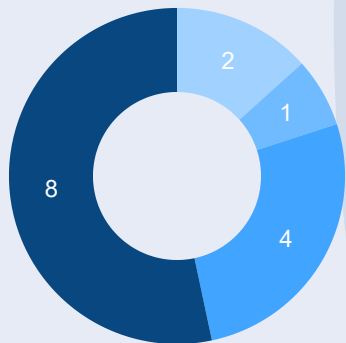
It should be noted that the KPI for timely management responses to draft reports is **RED** with only 38% compliance.

Other Activities

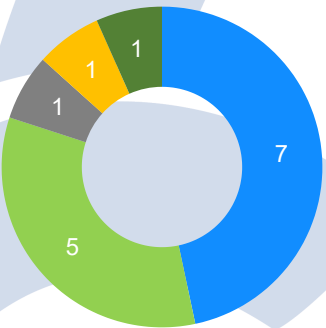
- * Regular meetings with the Director of Finance.
- * Individual audit planning meetings with Trust Directors.
- * Attendance at Trust Board and Committee meetings and the All-Wales Board Secretaries and Directors of Finance meetings.
- * Attendance at Project meetings for TCS and PMF. Attendance as an observer at the Trust's Integrated Quality & Safety Group.

2025/26 Summary Position

Plan year
2025/26

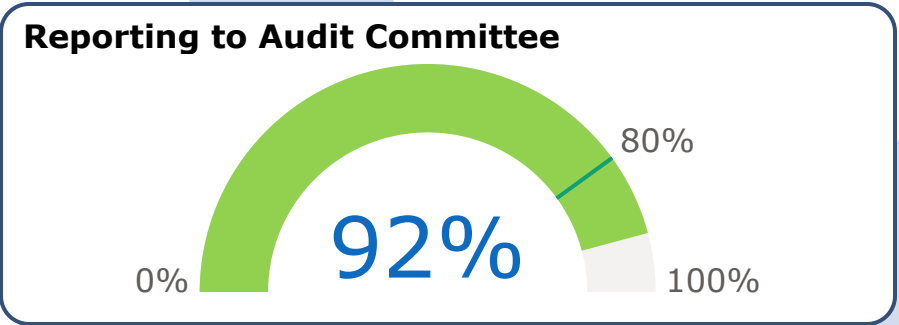
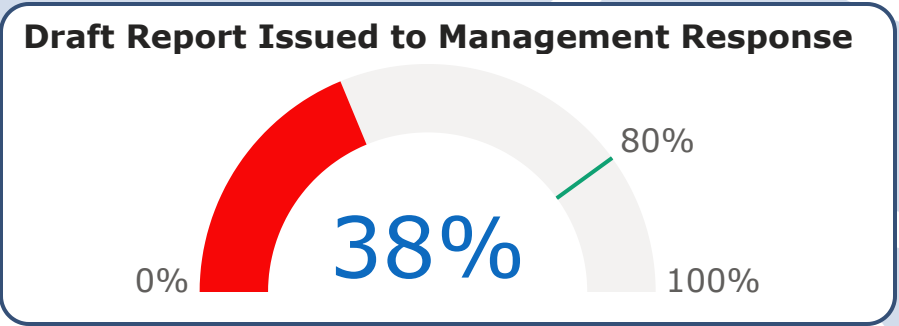
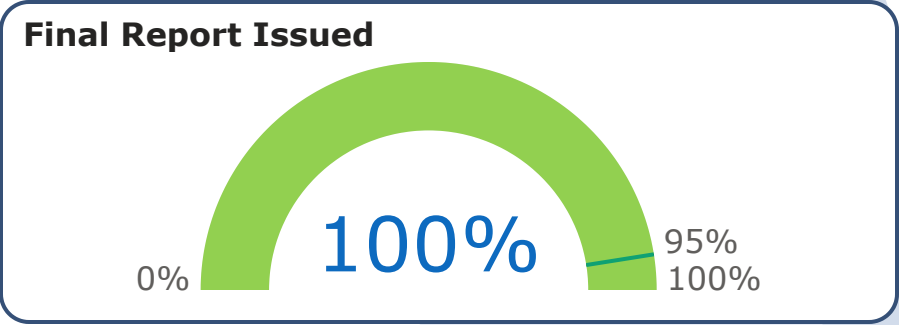


- Status**
- 1. Planning or yet to...
 - 2. Planning Complete
 - 3. Fieldwork
 - 5. Final Report



- Assurance Rating**
- TBD
 - Reasonable
 - Advisory
 - Limited
 - Substantial

Cumulative KPIs



Draft Reports Issued and Awaiting Management Response

Plan Year	Audit	Client Lead	Draft Report Issued	Management Response Due	Working Days Until Response Due

Note: The final report due date is generated upon receipt of management responses. Reports remain at the draft report stage until Audit & Assurance has quality reviewed the management responses and the final report is issued.

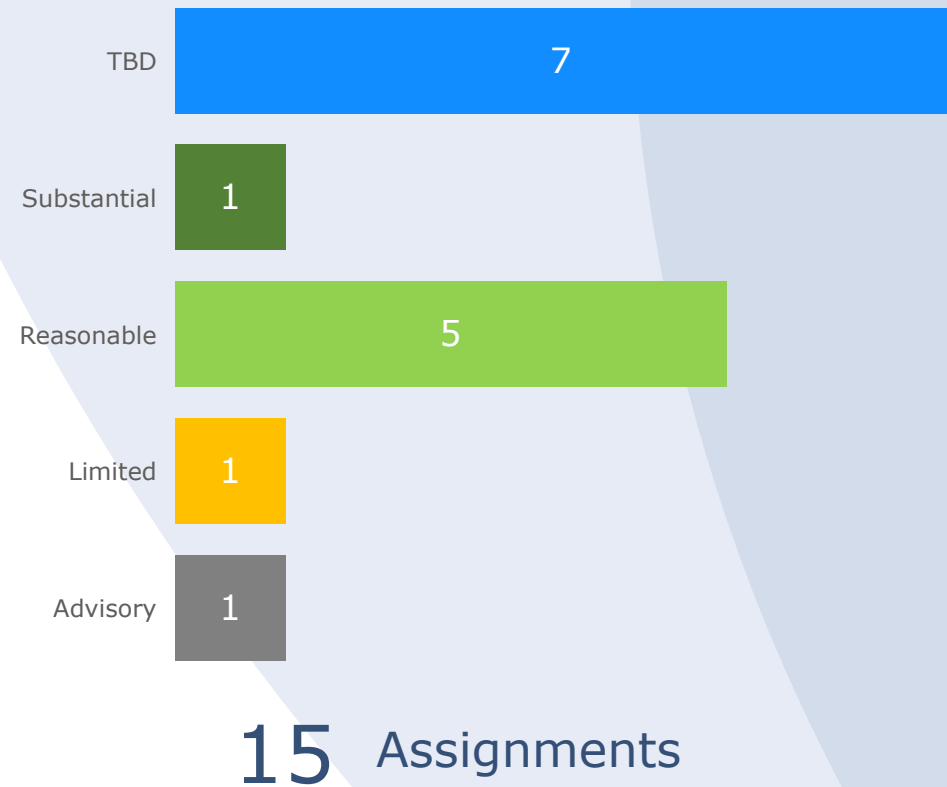
RAG key for calendar days until response / final report due

RAG	Days remaining	Management response received
	More than 5 working days until management response / final report is due	Timely response KPI met
	5 working days or less until management response / final report is due	N/a
	Management response / final report overdue	Timely response KPI not met

2025/26 Final Reports by Assurance Rating

Audits by Assurance Rating

Click an assurance rating to filter the list of audits



Rating	Plan year	Audit	Final report issued
	2025/26	Commissioning Arrangements	23 February 2026
	2025/26	AI / Robotics	19 February 2026
	2025/26	Medical Job Planning	17 February 2026
	2025/26	Cyber Security	30 January 2026
	2025/26	nVCC Integrated Planning	16 December 2025
	2025/26	Organisational Culture and Wellbeing	21 November 2025
	2025/26	nVCC Contract Delivery (Construction)	10 November 2025
	2025/26	nVCC Risk Management	10 November 2025
	2025/26	Estates Assurance Asbestos Management	
	2025/26	Follow-up of Previous Audit Recommendations	
	2025/26	Partnership Arrangements / Regional Working	
	2025/26	Quality and Safety Governance	
	2025/26	Service Capacity	
	2025/26	Trust Assurance Framework (TAF) and Trust Risk Register (TRR) Alignment (Assurance)	
	2025/26	Trust Strategic Planning	

AUDIT COMMITTEE

Internal Audit 2025/26 Medical Job Planning

DATE OF MEETING	03/03/2026
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	Eifion Jones, Deputy Head of Internal Audit
PRESENTED BY	Stephen Chaney, NWSSP Head of Internal Audit
APPROVED BY	Stephen Chaney, NWSSP Head of Internal Audit
EXECUTIVE SUMMARY	The purpose of this report is to present the Medical Job Planning Internal Audit report. Report Assurance Rating: Limited This audit sought to evaluate and determine the adequacy of the systems and controls in place for the management of medical job planning. Whilst limited assurance has been provided, based on the testing completed at the time of the fieldwork, there has been significant improvement

	since the conclusion of the audit. Overall, our conclusions were based on our assessment of the management of the associated risks during the audit. In particular, the achievement of the required completion level set by the Welsh Government. As the Trust was implementing a new system, this brought additional challenges and delays to achieving the intended outcome. If the job planning completion rate that is present now was in place during the audit, this would have had a positive bearing on the overall assurance rating, recognising that we identified other matters arising too.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE and receive for ASSURANCE the contents of the Internal Audit report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
N/a – 7 levels of assurance not considered in this Internal Audit Report	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	VEL-2526-02 Medical Job Planning Internal Audit Report

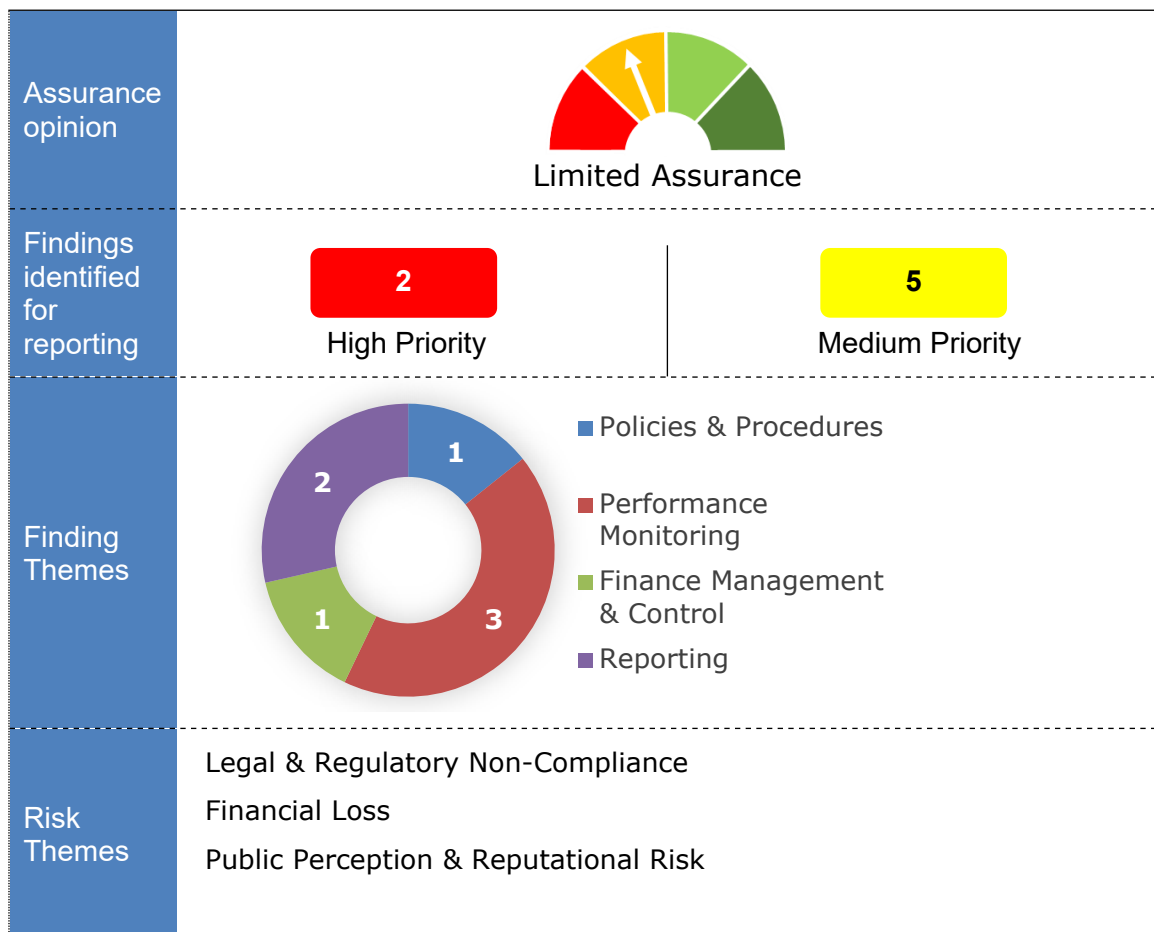
1. SITUATION

The audit was undertaken as part of the agreed 2025/26 Internal Audit Plan, following the agreed deferment from the 2024/25 Internal Audit Plan.

2. BACKGROUND

This audit sought to evaluate and determine the adequacy of the systems and controls in place for the management of medical job planning.

3. ASSESSMENT



4. SUMMARY OF MATTERS FOR CONSIDERATION

Ref	Finding title	Priority	Theme	Appropriate action agreed
1	Policies and Procedures	Medium	Policies and Procedures	Yes
2	Job Planning and Reporting Compliance	High	Performance Monitoring	Yes
3	Quality of Approved Job Plans	High	Performance Monitoring	Yes
4	Discrepancies on the L2P Report	Medium	Performance Monitoring	Yes
5	Reconciliation with ESR	Medium	Financial Management and Control	Yes
6	Reporting	Medium	Reporting	Yes
7	Monitoring and Escalation	Medium	Reporting	Yes

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 - BOARD ASSURANCE FRAMEWORK (BAF)	Workforce
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 ☒ This review may contribute towards assurance over the above Health & Care Quality Standards

6. RISKS

For this section, we have considered whether:

- the internal audit report is linked to any risks in the Trust Risk Register present to the most recent Quality, Safety & Performance Committee meeting; and/or*
- the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
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?	No
All risks must be evidenced and consistent with those recorded in Datix	

Medical Job Planning

Final Internal Audit Report

2025/26

Velindre University NHS Trust



Limited Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	10

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

VEL-2526-02

August - September 2025

February 2026

March 2026

Jacinta Abraham, Executive Medical Director

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place for the management of medical job planning.

Overview

Job planning became a key aspect of consultant roles with the agreement of the 2003 amendment to the National Consultant Contract in Wales. Job plans are mandatory and align the objectives of the NHS and employing organisation with agreed outcomes to allow consultants and the wider NHS team to plan and deliver safe, responsive, efficient and high-quality care. A job plan is a professional and contractual obligation for consultants to set out their duties, accountabilities and outcomes of their role. In addition, it is used to establish the support and resources required for the coming year.

The L2P system has been implemented in Velindre University NHS Trust (the 'Trust') since September 2024, with a one year roll out plan. The L2P system tracks consultants' work for the Trust, divided into Direct Clinical Care (DCC), Supporting Professional Activities (SPA), Additional NHS Responsibilities (ANR), External Duties, and Private Practice.

Welsh Government (WG) had set a target for 90% of job plans to be in place by the end of September 2025. Historically, the Trust has achieved this target, with a compliance rate of 90.32% in July 2024, pre L2P implementation. However, compliance was at 54% in August 2025, during the time of our fieldwork testing. This position was consistent with the challenges faced by other NHS Wales organisations.

In addition to changing how job plans are recorded, the Trust has taken steps to enhance job planning compliance and quality, including submitting a comprehensive paper to the Executive Management Board (EMB), as highlighted within objective one.

The recent appointment of new Clinical Directors and General Managers along with the planned relaunch of Trust guidance demonstrates the Trust's focus and accountability, ensuring consultants fully complete their job plans in a timely and consistent manner. Consequently, following the completion of our fieldwork testing, the compliance rate has risen to 88% (February 2026).

Overall, we have concluded limited assurance on this area, based on the testing conclusions at the time of our audit and in particular, the significance of audit objective two, as this represented the key output from the job planning process. However, whilst we have not repeated our original testing, the Trust's February 2026 compliance rate would indicate that matter arising two (high priority) should now be recognised as implemented. This would represent a reduced risk profile from our original audit findings. Therefore, it is likely that this improvement if maintained would have a positive impact on the audit opinion if revisited.

Based on our fieldwork testing, the key matters contributing to the limited assurance are:

- The job planning completion rate remained short of the Welsh Government target.
- Personal and speciality objectives were not fully completed within job plans but is recognised that some aspects were captured within appraisals, job planning discussions and other documents.

Other matters requiring attention are:

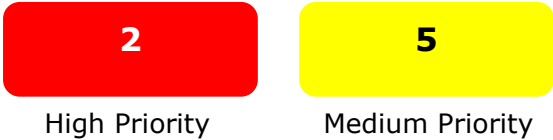
- The current Trust guidance is dated 2014, and this has been progressing through the review process for some time, as it was supposed to have been launched in October 2025. However, this was delayed and has now been approved by the EMB and is currently being reviewed by the LNC with anticipated implementation in January 2026.
- Examples were observed where job plan session records did not match ESR details.
- Job planning compliance rates were regularly reported, but at the time of the audit, there were no discussions on how to achieve the Welsh Government's target – or managing the associated risk of not achieving the target.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

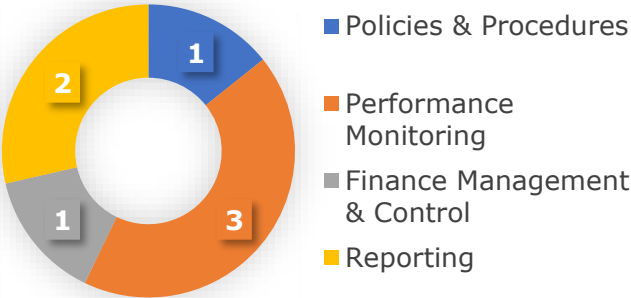
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There were relevant and up to date procedures in place that were available to all relevant staff and align to the All-Wales guidance	1	Reasonable
2	Job Plans accurately reflected both the individual and organisation activity requirements and were completed in a timely manner	2,3,4	Limited
3	Completed job plans reconcile to system records and session payments were correct	4,5	Reasonable
4	The completion rates of job plans were monitored and reported to an appropriate forum, with further escalation if there was low compliance	6,7	Reasonable

Management Actions



Themes



Risk Types

- Legal & Regulatory Non-Compliance
- Financial Loss
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There were relevant and up to date procedures in place that were available to all relevant staff and align to the All-Wales guidance

Reasonable

Overview / Summary of Observations

The 2014 “Consultant and Specialty and Associate Specialist Doctor Job Planning Guidance” was outdated, especially regarding staff roles and procedures. A review showed it no longer reflected current practices, as the Trust was transitioning from using Excel-based job planning to the L2P system for greater consistency and transparency. We were advised the Trust uses the principles of job planning outlined in the ‘Effective Job Planning for Consultants’ guidance, which is publicly available on the NHS Employers Wales website.

The revised guidance titled ‘Policy and Procedure for Medical Consultant Job Planning’ has been reviewed for compliance with the All-Wales guidance and is now in the formal approval process. The updated document incorporates key elements such as the alignment with the consultant contract and the Trust’s strategic objectives and clearly outlines roles and responsibilities, including the newly established Job Planning Consistency Committee - this committee will play a pivotal role in overseeing the implementation of job planning and ensuring adherence to best practices across the Trust. The policy was scheduled for relaunch in Q4 2025/26; however, this has been pushed back to Q1 2026/27 as it will need to align with the national policy on which work has recently commenced. Currently, the outdated guidance is not available on the Trust’s intranet; once agreed, the new revised guidance should be on the intranet to ensure all staff are aware of the process and to ensure visibility.

Key Findings		Risk & Impact	Agreed Management Action
1	Policies and Procedures The Trust should ensure the new Job Planning Guidance is approved and disseminated across the organisation as soon as possible. This is to ensure all consultants and other key staff understand the expectations in terms of the job planning process. The revised guidance should be on the Trust intranet site to ensure all staff are aware of what the process entails and who they need to contact if they have any queries or questions.	The Trust is not fulfilling its obligations in relation to job planning.	Agreed Action: 1.1 Complete the sign-off process for the new Job Planning Policy. 1.2 Publish the final policy on the Trust intranet and circulate to all doctors via email and presentation at SMSC.
	Expected Evidence of Implementation: 1.1 Finalised policy 1.2 Finalised policy will be available to all on the Trust intranet.		
	Theme: Policies & Procedures	Medium Priority Control Design	Executive Lead: Executive Medical Director Officer: Associate Medical Director - Workforce Target Implementation Date: 30 June 2026

Overview / Summary of Observations

A job plan serves as a vital framework for consultants, detailing their responsibilities, accountabilities, and expected outcomes within their roles. It is a professional and contractual commitment that facilitates the establishment of necessary support and resources for the upcoming year and there is adequate SPA (Supporting Professional Activity) time for it to be completed by consultants.

As of August 2025, the compliance rate was 69.01% of consultants that had a current plan and 54.93% that had a signed job plan, a slight increase on the previous month’s performance. Both compliance figures appear on a workforce dashboard which was shared in different reporting forums. However, the Welsh Government has set a target of achieving 90% compliance of completed plans by the end of September 2025.

For validity, job plans must be signed by the consultant, clinical director, and Job Planning Governance Team, ensuring mutual agreement and preventing disputes over pay or workload. The L2P system, introduced in September 2024, was gradually replacing the previous Excel spreadsheet-based process. All job plans are now managed through L2P, which calculates sessional values and generates compliance reports.

Consultants exceeding twelve sessions were reviewed by the senior medical leadership and going forward these will be reviewed in the newly established Job Planning Consistency Committee. The Amendment to the National Consultant Contract in Wales (2003) and the Trust’s updated ‘Policy and Procedure for Medical Consultant Job Planning’ stipulate that job plans must incorporate personal outcomes that align with organisational objectives. The review of job plans revealed gaps in these areas, highlighting the need to prioritise their completion to ensure plans are accurate and comprehensive.

Key Findings		Risk & Impact	Agreed Management Action
2	Job Planning reporting and compliance As of August 2025, the job plan compliance rate for the Trust was reported as 69.01% for consultants with current plans and 54.93% with a signed job plan. The Welsh Government's 90% target has not been met – see Finding 7 too. Approximately 85.19% (23) of the job plans reported as ‘in progress’ had a status date greater than 180 days in July 2025, suggesting they have been in progress for some time. 15 job plans were tested from the L2P job plans report July 2024 to July 2025 with 11 classed as complete, 3 awaiting signatures and 1 in progress. 9 job plans were not fully signed due to them awaiting signatures by one or more parties – see finding 6 too. The L2P report should be reviewed to ensure it reflects the true position.	The Trust not fulfilling its contractual regulatory obligations in relation to job planning.	Agreed Action: 2.1 Consultants with an incomplete current job plan should be promptly reviewed, agreed and signed by all parties involved. As of 5/2/25, job plan compliance rate for VUNHST stands at 88% - related to the delivery of the action plan. Expected Evidence of Implementation: 2.1 A reduction in overdue and incomplete job plans on the L2P system and corresponding increase in compliance.

		High Priority	Executive Lead: Executive Medical Director Officer: Directorate Clinical Directors & General Managers Target Implementation Date: 31 January 2026
	Theme: Performance Monitoring	Control Operation	
3	Quality of approved Job Plans Our testing of 15 approved job plans showed: - Of the 15 job plans reviewed, 12 did not include completed specialty objectives. - In addition, 12 lacked fully completed personal objectives; most included either no specific information or only referenced the standard statutory and mandatory compliance requirements without additional detail. It was noted there was one from the sample was completed fully to a high standard of what should be completed in a job plan. With two others completed to a reasonable standard but still required further information for completeness. These aspects need to be improved to ensure contractual obligations are adhered to and plans are completed correctly.	Job plans not fully reflecting responsibilities, outcomes and expectations resulting in an operational risk to the Trust.	Agreed Action: 3.1 Anonymised example of separate SMART objectives created and shared with Directorate Clinical Directors and General Managers. 3.2 Service outcomes to be identified by each Directorate with support from the AMD Workforce and Head of Medical Services.
		High Priority	Expected Evidence of Implementation: Review of job plans going forward will evidence standardised service objectives in the separate 'Objectives' tab.
	Theme: Performance Monitoring	Control Operation	Executive Lead: Executive Medical Director Officer: Associate Medical Director - Workforce Target Implementation Date: 31 March 2026

Overview / Summary of Observations

The L2P system, implemented as a stand-alone solution for recording job plans, has been operational within the Trust since September 2024. The system operated independently from the Electronic Staff Record (ESR) and payroll system.

A sample of 15 job plans were reviewed from July 2024 to July 2025, alongside data extracted from the L2P system and a report from ESR.

The ESR report was supplemented by manual input of sessional information based on the payroll data for the corresponding month. Each month, a payroll download was cross-referenced against the approved establishment to verify that sessional payments were accurate and aligned with contractual sessions.

All changes to job plan contractual sessions must be actioned by the Medical Services team, in accordance with an established standard operating procedure (SOP) designed to guide and document the process. These changes were entered into the Staff Movement Application (SMA), which facilitates payroll adjustments. Each modification was recorded on both the Changes Form spreadsheet and the Consultant Reconciliation Master spreadsheet. The Medical Staffing Team conducted reconciliation checks to confirm that all agreed changes had been accurately processed and reflected in payroll.

With the increased accuracy of the L2P sessions, variances between contractual and calculated sessions are more likely and are attributable to issues such as rounding, annualised hours and/ or minor variations to sessions worked. Whilst minor discrepancies will be covered by the 0.25 session tolerance applied, it is important that a record is maintained of any investigation where there is a greater variance or patterns / trends that emerge with the variances identified.

Key Findings		Risk & Impact	Agreed Management Action								
4	Discrepancies on the L2P report Management advised that any variance between the L2P report and the job plans greater than 0.25 sessions were investigated. Whilst 61 of the 76 consultants had contracted job plans that did not match the calculated job plans – the significant variances can be largely attributed to the job plans that were recorded as in progress. Of the 76 consultants, 40 had job plans recorded as complete or awaiting signature. The following was observed: <table><tr><td>Variance in Sessions</td><td>No.</td></tr><tr><td>No variance</td><td>8</td></tr><tr><td>Within recognised tolerance of 0.25 sessions</td><td>27</td></tr><tr><td>Equal to or greater than 0.25 session</td><td>5*</td></tr></table>	Variance in Sessions	No.	No variance	8	Within recognised tolerance of 0.25 sessions	27	Equal to or greater than 0.25 session	5*	The job plan record is incomplete or requiring additional manual checks	Agreed Action: 4.1 Ensure that no job plans exceeding the 0.25 tolerance have final 'Job Planning Governance' sign-off going forwards.
	Variance in Sessions	No.									
No variance	8										
Within recognised tolerance of 0.25 sessions	27										
Equal to or greater than 0.25 session	5*										
	Expected Evidence of Implementation: All job plans to be within the 0.25 tolerance between contracted and calculated sessions going forwards.										

	* Note two relate to job plans awaiting signature and the incorrect version being held on L2P. The largest variance observed was 1.5 sessions and related to a job plan awaiting signature, with the remaining four being less than 0.5 of a session. A record should be maintained of any investigation of variances greater than the agreed 0.25 tolerance or any variance pattern identified. Note: Contracted sessions are defined within the job plan and are aligned to pay. Calculated sessions refer to activities that the consultant has recorded within L2P.		
		Medium Priority	Executive Lead: Executive Medical Director Officer: Executive Medical Business Manager Target Implementation Date: 31 January 2026
	Theme: Performance Monitoring	Control Design	
5	Reconciliation with ESR Testing completed of the job plans and L2P found the following inaccuracies when reconciling to ESR: 2 job plans out of 15 did not reconcile with ESR. We were advised this was an administrative issue relating to in year changes to paid sessions not being updated on L2P, rather than the other way round. Any discrepancies also need to be robustly investigated.	The L2P System is not reflective of the records retained in ESR	Agreed Action: 5.1 Update session/pay changes SOP to include updating the job plan on L2P to ensure records are aligned.
		Medium Priority	Expected Evidence of Implementation: No discrepancy between ESR/payroll sessions and what is recorded in the job plan on L2P.
			Executive Lead: Executive Medical Director Officer: Head of Medical Services Target Implementation Date: 31 March 2026
	Theme: Finance Management & Control	Control Design	

Objective 4: The completion rates of job plans were monitored and reported to an appropriate forum, with further escalation if there was low compliance

Reasonable

Overview / Summary of Observations

Job planning compliance was routinely reported through an established governance structure. It was a standing agenda item at directorate meetings involving the Head of Medical Services and Clinical Directors. Additionally, job planning was reviewed as part of the Workforce Dashboard, reported quarterly at the Medical Workforce Group. This included a report on consultants with a 'current plan' and ones with a 'signed plan'. As part of the reporting process, it was confirmed that information from L2P along with the legacy Excel spreadsheet from the old process were used, 'current plans' also included ones awaiting signatures. This was not accurate, as the 'signed plans' were the ones that were complete and should be included within the compliance reporting.

This information formed part of workforce reports which were submitted to the Senior Leadership Teams of both Velindre Cancer Centre (VCC) and Welsh Blood Service (WBS). The structure has recently changed, and this dashboard is reported to the VCS Divisional Board. When appropriate, updates should be escalated to the Executive Management Board (EMB), Quality Safety and Performance Committee (QSP), and the Trust Board when appropriate.

While the review confirmed reporting of job planning compliance rates, it identified a lack of documented escalation for low compliance. Furthermore, there was limited evidence of a structured action plan outlining how the Trust intends to achieve the Welsh Government's target of 90% compliance rate. Notably, the associated risk does not appear to be formally recorded on the Trust Risk Register, which raises concerns about visibility and accountability.

Key Findings		Risk & Impact	Agreed Management Action
6	Reporting Job plans awaiting signatures were classed as complete and compliant. A job plan can only be noted as complete when agreed and signed by all relevant parties - as detailed in the Amendment to the National Consultant Contract in Wales (2003). Reporting should therefore be updated accordingly.	Inaccurate compliance information reported to Welsh Government. Reputational risk to the Trust.	Agreed Action: 6.1 Report column headings will be amended to 'Complete i.e. fully signed off on L2P' and 'Agreed at job plan meeting i.e. not yet fully signed off' to give greater clarity.
		Medium Priority	Expected Evidence of Implementation: Report column headings will be amended to 'Complete i.e. fully signed off on L2P' and 'Agreed i.e. agreed at meeting'.
	Theme: Reporting	Control Design	Executive Lead: Executive Medical Director Officer: Executive Medical Business Manager Target Implementation Date: 31 January 2026
7	Monitoring and escalation There was a governance structure in place and reporting on the job planning compliance rates, however there was limited	Reputational risk if escalation doesn't take place when	Agreed Action: 7.1 Record the risk of low compliance and not achieving the national target on the Trust Risk Register.

	evidence of a structured plan to achieve the Welsh Government target compliance. Additionally, the associated risk of low compliance and not achieving the national target did not appear to be formally recorded on the Trust Risk Register.	compliance is low and there is no accountability.	Expected Evidence of Implementation: Risk of low compliance and not achieving the national target recorded on the Trust Risk Register.
		Medium Priority	Executive Lead: Executive Medical Director Officer: Executive Medical Business Manager
	Theme: Reporting	Control Operation	Target Implementation Date: 31 March 2026

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Velindre University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



AUDIT COMMITTEE

Internal Audit 2025/26 Commissioning Arrangements

DATE OF MEETING	03/03/2026
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	Eifion Jones, Deputy Head of Internal Audit
PRESENTED BY	Stephen Chaney, NWSSP Head of Internal Audit
APPROVED BY	Stephen Chaney, NWSSP Head of Internal Audit
EXECUTIVE SUMMARY	The purpose of this report is to present the Commissioning Arrangements Internal Audit report. Report Assurance Rating: Reasonable This review assessed the adequacy of the systems and controls in place in relation to the management of the commissioning of Trust services.

	There remains significant uncertainty regarding the future LTA funding position due to delays and lack of agreement on the contract rebasing process. This has contributed to emerging financial pressures for the Trust and limits the ability to reliably forecast future income.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE and receive for ASSURANCE the contents of the Internal Audit report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
N/a – 7 levels of assurance not considered in this Internal Audit Report	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	VEL-2526-08 Commissioning Arrangements Internal Audit Report

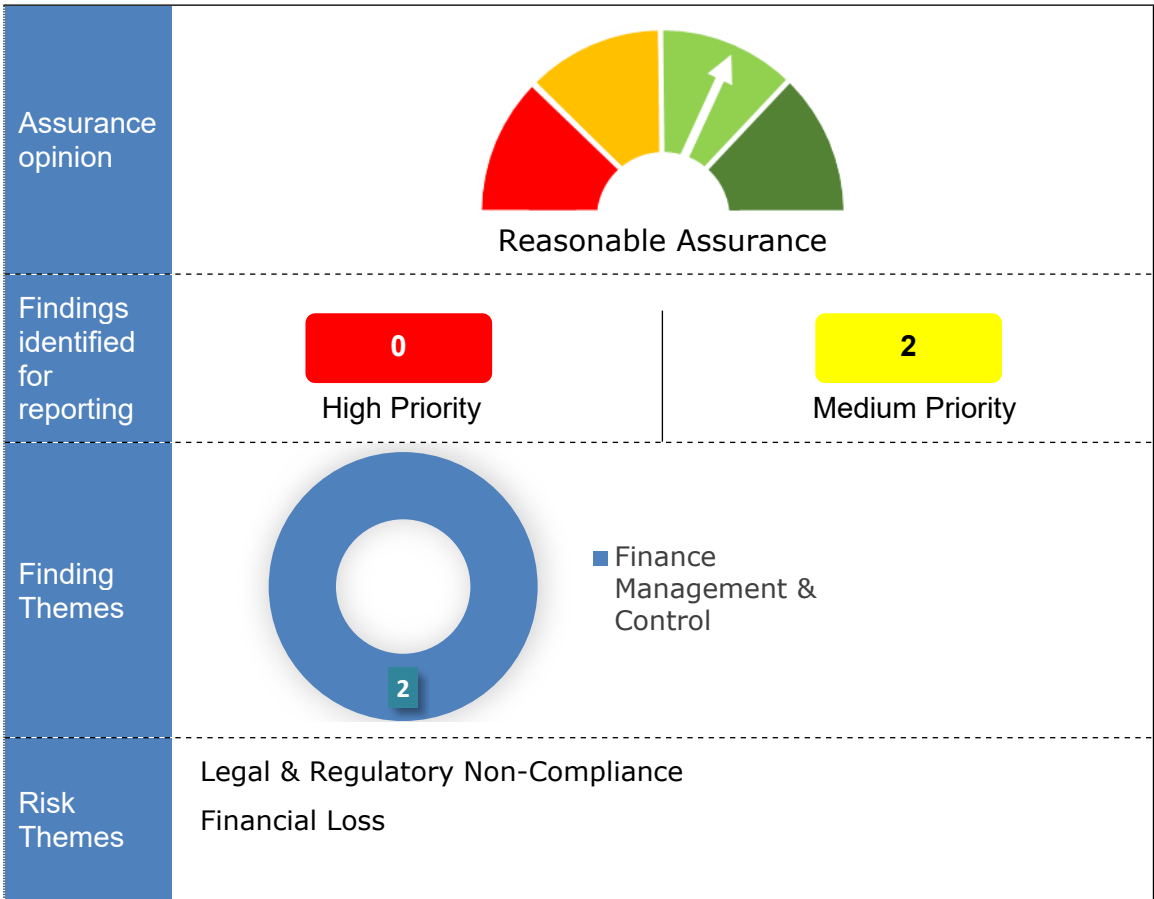
1. SITUATION

The audit was undertaken as part of the agreed 2025/26 Internal Audit Plan.

2. BACKGROUND

This review assessed the adequacy of the systems and controls in place in relation to the management of the commissioning of Trust services.

3. ASSESSMENT



4. SUMMARY OF MATTERS FOR CONSIDERATION

Ref	Finding title	Priority	Theme	Appropriate action agreed
1	Service Improvement Funding	Medium	Finance Management and Control	Yes
2	LTA Funding	Medium	Finance Management and Control	Yes

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 - BOARD ASSURANCE FRAMEWORK (BAF)	Finance
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 ☒ This review may contribute towards assurance over the above Health & Care Quality Standards Quality Domains and Enablers, due to the nature of risks.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: https://www.gov.wales/socio-economic-duty-overview	Not required for Internal Audit reports
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
	Not required for Internal Audit reports
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

For this section, we have considered whether:

- the internal audit report is linked to any risks in the Trust Risk Register present to the most recent Quality, Safety & Performance Committee meeting; and/or*
- the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
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?	No
All risks must be evidenced and consistent with those recorded in Datix	

Commissioning Arrangements

Final Internal Audit Report

2025/26

Velindre University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	8

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

VEL-2526-08

December 2025 - February 2026

February 2026

March 2026

Matthew Bunce, Executive Director of Finance

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

Health boards are responsible for planning and delivering NHS services for their populations, which includes the commissioning of services from other organisations where needed. On this basis, Velindre University NHS Trust (the 'Trust') provides specialist cancer services across South-East Wales and specialist blood services across the whole of Wales, via Velindre Cancer Centre and the Welsh Blood Service, respectively.

Services provided by the Trust must be continuously reviewed and enhanced to ensure they effectively meet the evolving needs of patients. A robust commissioning process is critical in supporting and complementing existing services, while enabling the Trust to respond proactively to emerging demands and service gaps.

This review assessed the adequacy of the systems and controls in place in relation to the management of the commissioning of Trust services.

Overview

We have concluded reasonable assurance on this area, primarily due to the strong alignment with strategic and statutory requirements and sound contractual arrangements and ongoing monitoring and reporting.

The matters requiring management attention include:

- Service developments and capacity expansions have taken place without confirmed recurrent funding from commissioners and/ or Welsh Government, contributing to emerging financial pressures for the Trust.
- There is a lack of clarity surrounding future Long Term Agreement (LTA) funding from Commissioners.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Consideration should be given to whether the issues in this report should be separately identified at the risk register (rather than being part of an overarching risk).
- The most recent Integrated Medium-Term Plan (IMTP) for 2025–28, although approved by the Board, has not been published on the appropriate section of the Trust's website.
- The terms of reference for the Collective Commissioning Group have not yet been finalised.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Commissioning process aligns with strategic objectives and statutory requirements.		-	Substantial
2	There is a robust and transparent governance, decision making and approval process in place.		1	Reasonable
3	Best value is achieved and demonstrated through effective monitoring, reporting and management.		2	Reasonable
4	Adequate internal controls are in place to identify/ manage key risks and to prevent fraud, error, and inefficiencies in the commissioning process.		-	Substantial

Management Actions



High Priority



Medium Priority

Themes



■ Finance
Management &
Control

Risk Types

Legal & Regulatory Non-Compliance

Financial Loss

Findings & Agreed Action Plan

Objective 1: Commissioning process aligns with strategic objectives and statutory requirements.	Substantial

Our review found that commissioning-related arrangements are clearly embedded within the Trust’s wider strategic planning framework. The Trust’s Integrated Medium-Term Plan (IMTP), Strategic Plan, and Clinical & Scientific Strategy collectively set out how services align with the needs of commissioners and Welsh Government priorities, demonstrating that commissioning principles are appropriately understood and applied across the organisation. There is also clear evidence that the IMTP and supporting documents are routinely scrutinised and approved at a Board level, providing assurance that strategic alignment is maintained through formal governance channels.

The Trust has also demonstrated compliance with Welsh Government policies and planning requirements, supported by a comprehensive cross-referenced document showing systematic mapping of national expectations to planned actions. This reflects a structured approach to ensuring that commissioning-related commitments are integrated into strategic plans.

However, the review noted that the most recent IMTPs have yet to be published on the appropriate section of the Trust’s website, resulting in outdated information being publicly available. While this does not affect internal strategic alignment, it represents a small transparency gap that should be addressed. Overall, the Trust’s commissioning arrangements are strategically coherent and supported by clear governance processes.

Commissioning-related governance is well-established within the Trust’s wider governance and accountability framework. Roles, responsibilities and escalation routes are clearly articulated through Standing Orders, Standing Financial Instructions and the Scheme of Delegation, and commissioning matters are routinely considered through established reporting to the Board and its committees. Evidence from finance reports, performance updates and Board papers confirms that key issues such as Long Term Agreement (LTA) income, activity trends, contract rebasing discussions and commissioner funding decisions are brought forward for scrutiny and oversight, supporting informed and transparent decision making.

The processes for approving commissioning decisions were also found to be appropriate, with LTA consistently authorised by senior representatives from both the Trust and health boards. This demonstrates that formal decision-making controls are being observed and that commissioning-linked agreements are subject to appropriate governance checks.

However, the review also identified a developing governance risk linked to funding. It was identified that service developments or capacity expansions had been progressed on the basis of anticipated commissioner or Welsh Government support, but recurrent funding was not subsequently forthcoming. These decisions, whilst made with the intention of improving service levels, have contributed to financial pressures now being managed by the Trust. This underlines the need for strengthened governance discipline around ensuring the financial sustainability of commissioning-linked decisions, particularly where commissioner intent or contract mechanisms remain uncertain.

Additionally, the terms of reference for the newly established Collective Commissioning Group (CCG) have not yet been finalised and no review schedule has been documented. As the CCG plays an increasingly prominent role in discussing and coordinating commissioning arrangements, formalising its governance documentation will enhance clarity and provide greater assurance over its long-term operation.

Overall, governance and decision-making arrangements relating to commissioning are functioning effectively, but opportunities exist to strengthen assurance through finalising the CCG’s terms of reference and ensuring that future commissioning decisions fully consider funding certainty and associated financial risks.

Key Findings		Risk & Impact	Agreed Management Action
1	Service Improvement Funding Service developments and capacity expansions have, in some cases, been initiated without confirmed recurrent funding from commissioning health boards or Welsh Government. This has contributed to additional financial pressures for the Trust.	Services commissioned do not align with the Trust’s strategic goals. Unclear accountability or conflict of interest in processes. Services do not demonstrate good value.	Agreed Action: The Trust has previously invested in service developments and capacity expansion based on anticipated growth recovered through marginal income. Per the IMTP marginal income growth during 2026-27 will be held to support prior investment choices. Also, per the IMTP there is clear direction that there will be no further investment into service without funding being agreed. The CCG TOR have now been updated and signed off at the meeting held on the 27th January. Expected Evidence of Implementation: 2026/27 IMTP (Board Sign Off), CCG ToR.

		Medium Priority	Officer: Deputy Director of Finance / Head of Finance Business Partnering
	Theme: Finance Management & Control	Control Design	Target Implementation Date: End of March 2026

Objective 3: Best value is achieved and demonstrated through effective monitoring, reporting and management.

Reasonable

A comprehensive performance monitoring framework is in place within the Trust, and supports effective oversight of commissioned services. Key performance indicators covering quality, safety, timeliness, efficiency and equity, are clearly defined and are subject to routine reporting through the Performance Management Framework. These indicators are aligned with Welsh Government requirements and the Trust's strategic objectives.

The Value Intelligence Centre and associated Value-Based Healthcare workstreams further support the Trust in linking activity, outcomes and resource use, reinforcing the connection between commissioning, performance, and value.

Commissioning activities are also clearly documented within the annual LTAs, which set out service expectations, activity levels and funding arrangements.

However, the review identified ongoing uncertainty relating to the LTA contract rebasing process, and several commissioner decisions not to support proposed service developments have contributed to emerging financial pressures. While reporting arrangements themselves are comprehensive, these external factors highlight the importance of strengthening forward-looking financial planning and ensuring that uncertainties in commissioning income are consistently captured and reflected in decision-making.

Overall, the Trust's monitoring arrangements are robust and provide reasonable assurance, but sustained attention will be needed to manage the financial and operational implications of commissioning-related funding risks.

Key Findings		Risk & Impact	Agreed Management Action
2	LTA Funding There remains significant uncertainty regarding the future LTA funding position due to delays and lack of agreement on the contract rebasing process. This uncertainty, combined with commissioners not supporting certain service developments, has contributed to emerging financial pressures for the Trust and limits the ability to reliably forecast future income.	Unclear accountability or conflict of interest in processes. Services do not demonstrate good value.	Agreed Action: A Deputy Director of Finance Task and Finish group has been established to review and agree the principles for commissioning arrangements with the first meeting taking place on the 27 th February. The Trust provides a schedule of the actual and forecast LTA activity which is provided to the Trust commissioners and discussed at the CCG. Expected Evidence of Implementation: Outcome of Commissioning principles agreed as part of task and finish group. Per finding one marginal income will be held during 2026/27 to support prior service developments and capacity expansion. No

			further service developments to commence without prior funding being agreed.
		Medium Priority	Officer: Deputy Director of Finance / Head of Finance Business Partnering
	Theme: Finance Management & Control	Control Operation	Target Implementation Date: End of Quarter 2 2027/28

Objective 4: Adequate internal controls are in place to identify/ manage key risks and to prevent fraud, error, and inefficiencies in the commissioning process.

Substantial

The Trust has established a structured and well-defined approach to risk management, with regular updates to the Trust's Risk Register and clear thresholds for escalation to Board and committee level. Commissioning-related risks are not held within a standalone register; however, material risk, particularly those relating to financial sustainability, are captured within the Board Assurance Framework and monitored regularly. Divisional and corporate risk processes, combined with escalation mechanisms, provide confidence that risks are appropriately identified, assessed and managed.

Our review confirmed that escalation and de-escalation processes are operating as intended, with recent register updates demonstrating active review, closure and adjustment of risk scores in line with established procedures. The Trust may wish to consider whether the issues identified at this report require separate identification within the risk register.

The Trust also benefits from a range of operational safeguards, including internal audits, clinical compliance checks and routine monitoring through the Performance Management Framework, which together provide ongoing assurance over activities relevant to commissioned services.

While commissioning is not subject to a dedicated audit programme, the combination of organisational risk management, operational assurance activity and reporting of financial risks provides adequate coverage of areas linked to the commissioning process.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Velindre University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



AUDIT COMMITTEE

Internal Audit 2025/26 nVCC Integrated Planning

DATE OF MEETING	03/03/2026
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	Melanie Goodman, Audit Manager
PRESENTED BY	Melanie Goodman, Audit Manager
APPROVED BY	Stephen Chaney, NWSSP Head of Internal Audit
EXECUTIVE SUMMARY	The purpose of this report is to present the 2025/26 new Velindre Cancer Centre (nVCC) Integrated planning Internal Audit report. Report Assurance Rating: Reasonable This audit originated from the 2025/26 nVCC Audit Plan, and focused on the integrated planning arrangements operating at the project.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE and receive for ASSURANCE the contents of the Internal Audit report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
N/a – 7 levels of assurance not considered in this Internal Audit Report	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	VEL-SSU-2526-14 nVCC Integrated Planning Internal Audit Report

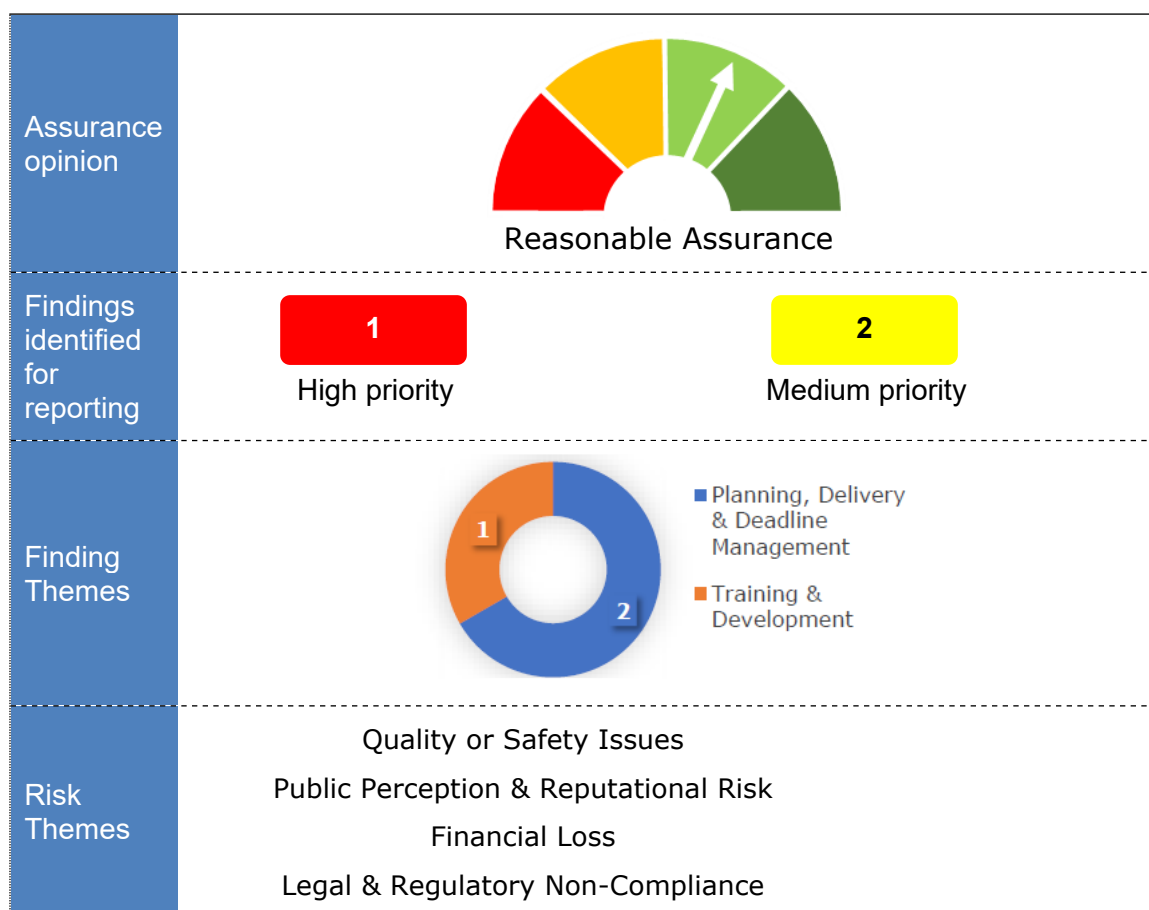
1. SITUATION

The audit was undertaken as part of the agreed 2025/26 nVCC Audit Plan.

2. BACKGROUND

The audit sought to ensure that appropriate management and control arrangements were in place (and effectively applied) at the New Velindre Cancer Centre (nVCC) project, to ensure the operation of effective risk management processes. The audit was commissioned in accordance with the agreed Audit Plan (and associated fee) provided within the approved Full Business Case for this project.

3. ASSESSMENT



4. SUMMARY OF MATTERS FOR CONSIDERATION

Summary of Key Findings

Ref	Finding title	Priority	Theme	Appropriate action agreed
1	Project Planner Role	Medium	Training & Development	Yes
2	Further System Development	High	Planning, Delivery & Deadline Management	Yes
3	Commissioning Plan Review	Medium	Planning, Delivery & Deadline Management	Yes

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)	01 - Service Capacity
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 ☒ This review may contribute towards assurance over the above Health & Care Quality Standards

6. RISKS

For this section, we have considered whether:

- *the internal audit report is linked to any risks in the Trust Risk Register present to the most recent Quality, Safety & Performance Committee meeting; and/or*
- *the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	No related risk on the Trust Risk Register. Risks identified in the audit linked to the high and medium priority findings and themes below: • A review of the role and relationships with of external Project Planner; • Further development of the planning system, with processes in place to monitor progression and quality of information; • An agreed process for review of the Phase 1 Commissioning Plan.
WHAT IS THE CURRENT RISK SCORE	Linked to the 3 recommendations (one high, 2 medium priority) in the Internal Audit report.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The agreed actions in the Internal Audit report should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the target completion dates identified in the Internal Audit report.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

nVCC Integrated Planning

Final Internal Audit Report

2025/26

Velindre University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	11

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

VEL-SSU-2526-14

November 2025

16th December 2025

March 2026

Carl James, Executive Director of Strategy & Planning & Interim Chief Executive

Huw Richards, Head of Internal Audit

Melanie Goodman, Audit Manager



Executive Summary

Purpose

The audit sought to ensure that appropriate management and control arrangements were in place at the New Velindre Cancer Centre (nVCC) project, to ensure the development of an effective integrated planning process. The audit was commissioned in accordance with the agreed Audit Plan (and associated fee) provided within the approved Full Business Case for this project.

Overview

The PWC '*Governance & Capabilities*' review (June 2024) highlighted the need for a robust integrated project planning process (including use of appropriate scheduling technology). In response, the Trust commissioned specialist external advisers to deliver the planning service for the project, with this commencing in November 2024.

From November 2024 onwards the project had a planning system and working processes in place, and we recognise that this was evidenced by PWC when undertaking their follow up exercise in May 2025. However, on review with the new Senior Responsible Officer (SRO) in June 2025, it was determined that the processes had become unwieldy and were not providing the level of control and assurance the project needed. Following a period of review and consideration of alternative processes, in conjunction with the appointed advisers, the current planning system was initiated in August 2025 (including allocation of a new Project Planner from the advisory service) and following a period of initial data entry and system set-up, has been 'live' since October 2025.

We have concluded **reasonable assurance** in this area. The audit recognises the early stage of implementation of the new planning system and supporting processes, and assurance has not been measured against any expectation that the process would be fully embedded at this time. However, at this stage of the project, halfway through the construction period and with detailed commissioning planning now underway, it is critical that this process can deliver on its objectives. We consider that the new process is robustly designed to facilitate effective monitoring and reporting of key project milestones. There was clear commitment to the process at a senior leadership level, the central Project Management Office (PMO) and from the external advisers. Assurance was reduced at this time noting the amount of work still to do before the schedule is fully developed, and recognising some concerns flagged at workstream level, which will need to be addressed to ensure effective operation.

The key matters requiring management attention are:

- Consideration of opportunities to improve the relationship between the workstreams and the Project Planner;
- Ongoing development of the planning system at pace; and
- Confirmation of the process for reviewing the Phase 1 Commissioning Plan.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The '*nVCC Schedule Management Procedure*' would benefit from providing definition of Levels 1/2/3;
- Procedure reference 4.2 should be updated to appropriately reflect coverage of the current planning system. The project should ensure that milestone / delivery data held in prior schedules is appropriately retained for future reference if required;
- Management could consider the feasibility and potential benefits of certain project team members having access to the P6 planning system for direct interrogation/reporting.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	The requirements for the integrated planning process have been clearly defined and communicated.	-	Substantial
2	Roles and responsibilities have been clearly established.	1	Reasonable
3	The planning system is set up and populated in line with the defined requirements, is accurate and up to date, and with appropriate linkage between each "level" of the plan, (to be confirmed by sample testing).	2	Limited
4	The plan is being developed sufficiently by the Workstreams in managing activities to support the key milestones.	1,2,3	Reasonable
5	The design and operation of the plan supports effective monitoring and reporting and enables accurate and timely early warning and communication with key stakeholders (e.g. Project Board, Trust operational services, Project Co., Welsh Government). (The scope does not however include assessment of Project Co.'s planning processes, or those of the Trust's operational services).	-	Substantial



Findings & Agreed Action Plan

Objective 1: Defined Process	Substantial

Overview / Summary of Observations

The planning process had been clearly defined in the comprehensive '*nVCC Schedule Management Procedure*,' which had recently been updated to reflect the new process and was approved by the project Senior Leadership Team on 12th November 2025, mid-way through audit fieldwork.

The Procedure was comprehensive and had been reviewed by the external advisers to confirm accuracy of the detail, particularly in terms of their role in providing the Project Planner role.

The approved document had been distributed to the project team and was also to be located on SharePoint for central access.

From our audit fieldwork, we found the Procedure to be well understood by the workstreams, and we did not identify any notable deviations from the described processes.

Whilst we have not raised any key findings in relation to the Procedure, we note a small number of points for enhancement, as detailed in the Executive Summary.

Overview / Summary of Observations

The 'nVCC Schedule Management Procedure' clearly defines the roles and responsibilities of the key parties, and includes a RACI (Responsible, Accountable, Consulted, Informed) matrix for clarity.

The planning process is centrally controlled by the Project Management Office (PMO) via the recently implemented project control's function.

The key role of Project Planner is delivered by externally appointed advisers, and as noted in the Executive Summary, a new Project Planner was assigned to the project in August 2025. The wider advisory team provides contingency cover, additional knowledge/expertise where needed, and senior level oversight of the contract.

All parties interviewed during the audit were clear as to their assigned responsibilities in the process.

Some concerns were highlighted by workstream project managers in respect of the Project Planner role, centred around the integration of this key role into the project team (noting the generally off-site nature of the service provision) and the level of commitment to increasing project-specific knowledge at the required pace to effectively support the development of technical project planning. Management may wish to consider how relations can be improved to ensure this does not pose a barrier to effective system implementation.

Noting that a small number of quality issues with the Milestones added to the planning system have been identified in the sample testing discussed at *Objective 3*, further consideration could also be given to how the requirements of the Project Control Manager role (in respect of assuring quality of the schedule – see Procedure section 2.1) can be delivered – see *Key Finding 2*.

Key Findings		Risk & Impact	Agreed Management Action
1	Project Planner Role Recognising the concerns voiced by some workstreams in respect of the Project Planner role, management may wish to consider opportunities for improving the relationship between the parties, potentially including: • Opportunities for greater 'induction' of the Project Planner into the project team to build relationships with team members. • Any potential for increased on-site presence of the Project Planner.	Poor relationships may reduce the effectiveness of implementation of the new system. Insufficient project-specific knowledge may hinder effective project planning and the support available to the workstreams and	Agreed Action: Discussion with workstreams and the advisers have confirmed that overall, the relationship is excellent. This audit has helpfully identified an unreasonable expectation of the advisers to provide expert knowledge of the workstreams' deliverables and activity. We have clarified that the advisers' role is to provide integrated planning support and not content creation. We will continue to support workstreams with specialist technical advice in their respective areas from other specialist advisors. Complete

- Obtaining clarity as to the boundaries of the Project Planner role in terms of developing project-specific expertise, and communication with the workstreams as to what these boundaries will be. Agreement as to the methods and timeline for the Project Planner to bridge any gaps identified, to facilitate support of the workstreams in their detailed planning activities. - Additional communication to workstreams of the benefits of the new process over the old. Note that this audit has not sought to validate any of the concerns voiced, but we feel that without action the workstream concerns have the potential to impact the effectiveness of the new planning process going forward.	reduce the value for money achieved from the commission.	Expected Evidence of Implementation: Record of meetings and communications.
Theme: Training & Development	Medium Priority Control Operation	Executive Lead: Carl James, Executive Director of Strategy & Planning & Interim Chief Executive Officer: Mark Trumper, Senior Responsible Officer Target Implementation Date: 15/12/2025

Overview / Summary of Observations**System Design**

The new planning system sought to resolve a number of issues with the prior system, including an improved focus on the most important (Trust-controlled) project milestones, reduced focus on Project Co. construction milestones (noting these are not controlled by the Trust) and introducing a change control process to ensure milestone dates can only be moved following appropriate scrutiny and approval (change control will be separately reviewed at the next audit in the 2025/26 plan).

The new schedule is managed via the Oracle Primavera P6 system, controlled by the Project Planner, with interface between P6 and the project team via Excel-based exports for monitoring and reporting purposes (see *Objective 5*). Whilst a Key Finding has not been raised, some parties interviewed during the audit expressed an interest in having direct access to P6 for interrogation and reporting purposes, and management may wish to give further consideration to the feasibility and any potential benefits of this.

The structure had been set up as follows:

- 57 Level 1 'Key Milestones': The most significant project Milestones, which if missed would have significant impact on project completion, inter-dependent projects, or operational delivery. These can only be changed in agreement with key parties such as the Chief Operating Officer (lead for operational readiness) and with approval from key forums.
- 187 Level 2 Milestones: Secondary project Milestones that are within the Project's ability to control and move if required, subject to change control.
- Level 3 Activities: At the discretion of the workstreams to develop supporting activities to link to the delivery of the Level 1 and 2 Milestones. These will not be subject to change control, but for the system to be effective, will require monitoring to identify any potential slippage at the earliest opportunity, to alert management to potential risks to Level 1 and 2 delivery.

As noted in *Objective 1*, the levels had not been formally described within the Procedure.

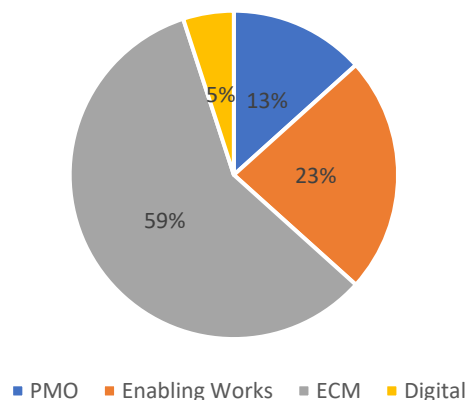
System Development Progress

The new planning system was initiated in August 2025, and following a period of data input, had been 'live' for circa one month at the time of the audit. We note that whilst the Level 1 and 2 Milestones were largely static at the time of review, there was ongoing activity in this area, including input of Project Agreement Obligations following a recent review by external advisers of the Deal Diary (the project's record of all Project Agreement Obligations for compliance monitoring), and addition of further Digital Milestones.

Analysis provided by the Project Planner confirmed the extent of development work still to do, by identifying that of the 244 Level 1 and 2 Milestones, 95 were currently without any supporting Level 3 activities. Whilst recognising 26 construction Milestones were intentionally unlinked, the remainder required development. It is recognised that in some cases, primarily in the Equipment, Commissioning & Migration (ECM) workstream, further development of Level 3 activities was contingent on receipt of Project Co. Commissioning plans, which was scheduled for later in the year.

The breakdown of un-linked Milestones by workstream (excluding construction) is as follows:

Missing Links



Digital activities were generally under-developed, with the Project Planner reporting that 121 out of 266 Level 3 activities had very long activity durations. There were a small number of instances of activities spanning the whole delivery programme (with 700+ days duration), which appears to be ineffective as a progress monitoring tool.

Conversely, we note that once ECM activities are fully developed, there will be a significant number against which progress will need to be monitored on an ongoing basis. This will present a challenge for the Workstream and the Project Planner if the system is to be maintained, and care should be taken that the activities added will be of benefit to the Workstream.

Audit testing sampled 25 (circa 10%) of the Level 1 and 2 Milestones to review the accuracy of inclusions within the system. Whilst all baseline dates had been accurately documented, we did find 3 (12%) instances where the Milestone descriptor appeared insufficient to enable accurate monitoring. These may be isolated instances but indicates the system would benefit from ongoing quality checks and assurance.

We also reviewed several upcoming milestones and found that, with one exception (linked to the above test), all were up to date or subject to ongoing change control.

In summary, the new system was well designed, and whilst meaningful progress has been made in setting it up, there is still important work to be completed. This is now time-critical to ensure the project has an effective planning tool in place through to completion. In line with our assurance definitions therefore, these more significant matters require management attention and may have a moderate impact on residual risk exposure until resolved.

Key Findings		Risk & Impact	Agreed Management Action
2	Further System Development We identified several areas where further system development was required, including:	The project does not have a sufficiently developed planning tool with which to monitor progress	Agreed Action: Workstreams will link all their level 3 milestones by 31 January 2026 (<i>except commissioning plan due by 31/03/26</i>) to assure any risks to level 1 or 2 milestones become evident as soon as delays occur.

- Ensuring all Milestones (where relevant) are supported by Level 3 activities as soon as possible. - Further development of Digital Level 3 activities to support effective monitoring and reporting of progress. - Confirming action has been taken to address the three Milestones identified during Audit testing as having inaccurate descriptors (MLS1017, MLS1064 and MLS1207). The project should ensure that it has processes in place to monitor progression of the above, and that continued attention be given to the accuracy of existing inputs at Levels 1 and 2. The role of the Project Control Manager in assuring quality should be further developed in this regard. Noting the Procedure requirement (10.1) that <i>"The project schedule shall contain appropriately detailed level 3 activities within all workstreams; where a workstream has asked for less detail this will be captured for Project Director approval"</i>, where there is specific concern around the level of development of Level 3 activities, e.g. Digital, this should be further explored.	and identify slippage and associated risks.	- To support monitoring of progression with level 3 milestone development and the QA role of the Integrated Project Manager:- - The advisers and the Project Planner will - provide the Project Control Manager with the monthly Quality report produced by Acumen fuse (diagnostic software). - continue to copy the project controls team into all update meetings and all updates issued to workstreams. - The Integrated Control Manager and the Project Control Team will use this to - track progress on linking milestone to supporting level 3 activities - to monitor the regularity of updates and provision of updated schedules back to the workstreams. - As a basis for discussion with workstreams and the advisers. - The Project Controls Team will review the Digital level 2 milestones to ensure any delays to deliverables are disclosed early and their potential impact on other workstreams is immediately visible. - Descriptors of milestones 1017, 1064, and 1207 will be updated to give a more accurate description. <u>In progress and will be completed no later than 31 January 2026.</u> Expected Evidence of Implementation: Development of linked level 3 activities on the schedule. Receipt of Fuse Acumen quality reports. Correction to descriptors for milestones 1017, 1064 and 1207. Records of Digital workstream review. Executive Lead: Carl James, Executive Director of Strategy & Planning & Interim Chief Executive and Carl Taylor, Chief Digital Officer Officer: Mark Trumper, Senior Responsible Officer Target Implementation Date: 31/01/2025
Theme: Planning, Delivery & Deadline Management	Control Operation	

Overview / Summary of Observations

We met with the core workstreams engaged with the planning process to inform our audit: Design & Construction, Equipment, Commissioning & Migration (ECM) and Digital, as well as the Project Management Office (PMO) and Commercial Activity Group, as key supporting functions.

All parties had a good understanding of their responsibilities in respect of the planning process, however held varying views on the benefits of the new system. These have already been outlined at *Key Finding 1*.

We have also already noted at *Key Finding 2* that the workstreams have made varying degrees of progress in respect of populating the Level 3 activities (but recognise in some cases, with ECM, further progress is constrained by the need to await plans from Project Co.).

Whilst the Commercial Group did not need to develop any Level 3 activities itself, it had facilitated a recent review of the Deal Diary, and relevant Project Agreement obligations were being entered into the planning system during the audit. This will enable the Commercial Group to monitor and report workstream progress against the contractual obligations.

Noting the forthcoming issue of the Phase 1 Commissioning Plan by Project Co. (expected December 2025), arrangements for the analysis/interrogation of the Plan (against existing Milestones and activities) by the ECM Workstream, in conjunction with the advisers, needed to be determined.

Key Findings		Risk & Impact	Agreed Management Action
3	Process for review of the Commissioning Plan The Phase 1 Commissioning Plan was due to be issued by Project Co. in December 2025, from which point the Trust will have a 15-day Project Agreement obligation to respond with comments. The ECM Workstream anticipates that this review period will require interrogation of the Plan alongside existing Milestones/activities in the planning system. At the time of the audit, we were advised that the requirements had not yet been discussed with the Project Planner. Noting concerns raised by the workstreams re the Project Planner’s current level of project-specific technical knowledge (see <i>Key Finding 1</i>), ECM have suggested an alternative adviser (currently engaged for other advisory services at the project), may be better placed to undertake this work (and thereafter, to potentially continue to provide support in this area).	Project Agreement obligations may not be achieved. The Trust may miss opportunities to influence the Commissioning Plan.	Agreed Action: The Integrated Controls Team have confirmed with the ECM workstream that timely and adequate arrangement are in place to review the Acorn Commissioning Plan. This is being delivered through a combination of the workstream expertise supplemented by specialist knowledge from external advisers. Once Project Co's deliverable has been agreed the revised outputs will be adopted by the Integrated Project Plan. Complete – This clarification is part of BAU activity associated with a programme of this complexity and length.

The plan for the upcoming 15-day review period should be confirmed asap, to ensure key parties are available and understand the Workstream's requirements and how best these can be supported.		
		Expected Evidence of Implementation: Summary of discussions and outcomes.
	Medium Priority	Executive Lead: Carl James, Executive Director of Strategy & Planning & Interim Chief Executive Officer: Mark Trumper, Senior Responsible Officer Target Implementation Date: 15/12/2025
Theme: Planning, Delivery & Deadline Management	Control Operation	

Overview / Summary of Observations

Noting the new planning system had only been 'live' from October 2025, there was one cycle of monitoring and reporting to evidence to date.

The workstreams and Project Planner had initiated routine processes for the updating of Milestone and activity progress, which will be taken forward on a monthly basis.

There was an aim that in time the Project Planner would increase their project-specific knowledge, and this would enhance the level of support and advice to be provided to workstreams during this monthly process (for example, in relation to understanding of the associated impacts on the wider plan if individual dates are missed/amended). *Key Finding 1* discusses this development process further.

The Project Planner was providing regular Excel-based reports from the system to the PMO and workstreams, enabling easy manipulation and review in a familiar format.

The Senior Leadership Team had re-centred their weekly agenda around the core project control functions of the project plan (of Level 1 and 2 Milestones) and risk register, leading by example in ensuring all progress discussions were based on these core documents. A key objective was to ensure early notification of potential slippage against Milestones, in order that mitigating measures could be implemented in a timely manner where possible.

The project plan was reported to Project Board for the first time in October 2025, with the report clearly highlighting any dates which have slipped, and this should prove a useful tool for informing Members of progress and generating scrutiny and discussion going forward.

The project plan also supports communication with wider stakeholders, with the Chief Operating Officer being involved in the setting of Level 1 and 2 Milestones to ensure they reflect wider Trust activity, control processes ensuring appropriate inclusion of relevant parties from related projects in decisions to change milestones, and awareness of progress via the reporting to Project Board (via the nVCC Project Plan and key interfaces reported from the Steering Group). Whilst outside the scope of this review, we were also advised that there was an intention to develop operational milestones in a similar format to the nVCC plan, to support joined up monitoring and reporting.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Velindre University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



AUDIT COMMITTEE

Internal Audit 2025/26 AI and Robotics

DATE OF MEETING	03/03/2026
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	Eifion Jones, Deputy Head of Internal Audit
PRESENTED BY	Stephen Chaney, NWSSP Head of Internal Audit
APPROVED BY	Stephen Chaney, NWSSP Head of Internal Audit
EXECUTIVE SUMMARY	The purpose of this report is to present the AI / Robotics Internal Audit report. Report Assurance Rating: Reasonable This audit sought to ensure appropriate processes are embedded to maximise the benefit from evolving technologies, including artificial intelligence and robotic process automation.

	The Trust has a clear intent to improve the use of AI and automation and the relevant governance structures are being established appropriately.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE and receive for ASSURANCE the contents of the Internal Audit report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
N/a – 7 levels of assurance not considered in this Internal Audit Report	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	VEL-2526-10 AI / Robotics Internal Audit Report

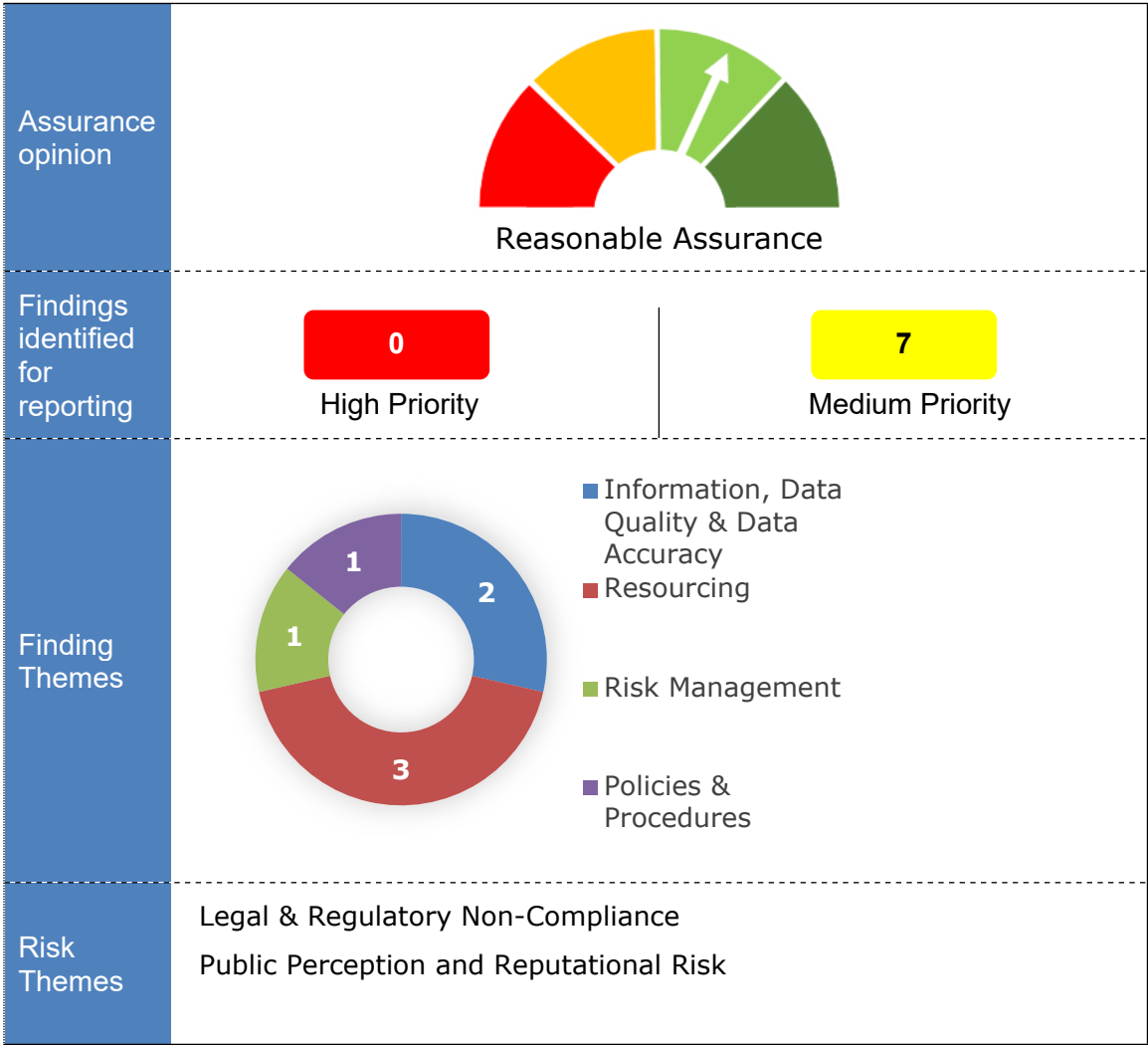
1. SITUATION

The audit was undertaken as part of the agreed 2025/26 Internal Audit Plan.

2. BACKGROUND

This audit sought to ensure appropriate processes are embedded to maximise the benefit from evolving technologies, including artificial intelligence and robotic process automation.

3. ASSESSMENT



4. SUMMARY OF MATTERS FOR CONSIDERATION

Ref	Finding title	Priority	Theme	Appropriate action agreed
1	Automation Benefits	Medium	Information Data Quality and Data Accuracy	Yes
2	AI Delivery Roadmap	Medium	Resourcing	Yes
3	AI Risk	Medium	Risk Management	Yes
4	Automation Procedures	Medium	Policies and Procedures	Yes
5	Process Baselineing	Medium	Resourcing	Yes
6	Testing	Medium	Information Data Quality and Data Accuracy	Yes
7	Departmental Continuity	Medium	Resourcing	Yes

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 - BOARD ASSURANCE FRAMEWORK (BAF)	Digital
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 ☒
	This review may contribute towards assurance over the above Health & Care Quality Standards Quality Domains and Enablers, due to the nature of risks.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information:</i> https://www.gov.wales/socio-economic-duty-overview	Not required
	Not required for Internal Audit reports
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals:	
• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
	Not required for Internal Audit reports

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

6. RISKS

For this section, we have considered whether:

- the internal audit report is linked to any risks in the Trust Risk Register present to the most recent Quality, Safety & Performance Committee meeting; and/or*
- the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
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?	No
All risks must be evidenced and consistent with those recorded in Datix	

AI / Robotics

Final Internal Audit Report

2025/26

Velindre University NHS Trust



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	12

Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead
Audit Team

VEL-2526-10
October - November 2025
19th February 2026
March 2026
Carl James, Interim CEO
Stephen Chaney, Head of Internal Audit
Martyn Lewis, IT Audit Manager

Executive Summary

Purpose

To ensure appropriate processes are embedded to maximise the benefit from evolving technologies, including artificial intelligence and robotic process automation.

Overview

We have concluded reasonable assurance on this area. The Trust has a clear intent to improve the use of AI and automation and the relevant governance structures are being established appropriately. The matters requiring management attention include:

- There is no formal tracking and reporting of benefits associated with automation, although we note a benefits framework for automation is being drafted. Increased reporting on the benefits from automation may enable better linking to resource provision and drive adoption.
- The draft AI Strategic Framework sets out key actions to take forward. However, we note that as yet the actions are not being progressed, with no delivery roadmap in place that defines the resource needs for delivering increased, appropriate AI use within the organisation.
- Although the assurance framework includes a strategic risk in relation to new technologies, there is no recording of more detailed risks in relation to the inappropriate use of AI within the Trust's risk registers.
- There are no SOPs detailing how to develop automated processes and nothing available for the wider organisation. We note that currently the team is small enabling visibility and direct management, however as automation increases within the Trust this will not be possible.
- Not all of the proposed automated processes are baselined, in terms of recording the resource required to complete the process. This reduces the ability of the team to effectively target their resource at the most valuable processes, and to demonstrate the benefits from automation.
- Although we were informed that testing of automated processes is undertaken, with the extent and detail depending on the specific process, this was not recorded for the sample tested and the process definition document has no section to record and approve testing prior to deployment.
- Although the requirement for departmental continuity planning to ensure that failed automations can be managed is raised during the design stage, there is no validation of this and nothing requiring a formal statement of compliance prior to going live.

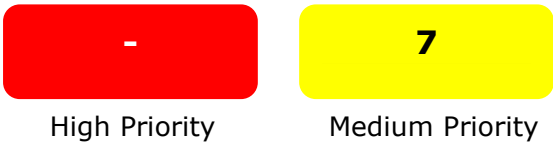
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The AI Strategic Framework could be improved with increased detail on the risk management aspects, the process for continual improvement, the detail over how Patient and Public Involvement (PPI) Panel will operate and the processes for benchmarking and learning from external organisations.
- The AI Policy should be issued as soon as possible.
- Consider estimating the cost of operating the more complex AI models within the Microsoft tenancy under any proposed new contract and ensuring that AI monitoring is embedded prior to the implementation of the new contract.
- Ensure that the procedures for automation clearly state the basis for prioritising proposals for automation.
- Consider including within the automation SOP the need to add timeouts within process flows to identify hanging processes.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use	1, 2	Reasonable
2	Appropriate controls and guidance are in place for the use of AI which protects information, accounts used for AI and RPA and ensures that models are accurate, free from bias and protect information	3, 4	Reasonable
3	An appropriate process is in place to control the creation of robots and the resource use, with an assessment process to ensure only suitable processes are automated and benefits are defined and realised	5	Reasonable
4	Appropriate processes are in place to fully document the design of automated process and test the final product.	6	Reasonable
5	The operation of robots is monitored to ensure they operate as expected	-	Substantial
6	An appropriate process is in place to ensure that changes to the environment in which the robot operates are assessed for the impact on the robot, and changes to robots are recorded	-	Substantial
7	Appropriate continuity planning is in place to enable the organisation to operate in the event of the failure of the robot	7	Reasonable

Management Actions



Themes



Risk Types

- Public Perception & Reputational Risk
- Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The use of evolving technology is included within organisation plans, with appropriate resources available to develop their use	Reasonable

Overview / Summary of Observations

The Trust Strategy (Destination 2033) notes that digital excellence is a key support function, with a need to increase the speed of deployment of new technologies and an intent to deliver the Digital Strategy, which whilst not specifically including AI, does state an intent to be more efficient by automation of manual processes.

Both AI and robotic process automation (RPA) are also included within the Digital IMTP with an RPA work plan, inclusion within the Insights Driven Services theme and a stated priority to set out the Trust position regarding AI, although there is no workplan or aim to develop its use.

An automation team is in place which has recruited to build the skill base, with additional recruitment ongoing, although we note that the funded project manager and business analyst resource are not yet in place. The Automation Manager has assessed the resource requirements for both development and business as usual against the ITIL framework and we note that there is currently limited capacity for expanding the use of automation.

The automation work has two strands, Blus Prism (BP) and Power Automate (PA) with the automation proposals split to ensure BP is used appropriately. A contract has been signed with Blue Prism for RPA, which we note has taken longer than anticipated and as yet there are no active automations using this.

There are a number of automated processes using Power Automate, and the Automation Manager is liaising with other departments to identify possibilities. We also note that BP automations will be replicated within PA to establish the true need for BP given the higher costs involved.

The implementation of automation has produced benefits, both quantitative, such as material cost savings, and qualitative such as an increase in first time blood donor retention. However apart from specific, ad-hoc reporting there is no formal tracking and reporting of benefits associated with automation, although we note a benefits framework for automation is being drafted. Increased reporting on the benefits from automation may enable better linking to resource provision and drive adoption.

There is limited use of AI within the Trust at present, although we note a small number of AI software in use within Medical Physics, the use of Copilot, and a willingness to improve the use of AI across the Trust. Resourcing remains low with limited AI skills in place, however we note work and connections with universities to access skills.

The AI work is overseen by the Clinical and Scientific Board which is ensuring an appropriate strategy and guidance in place, and our review of the operation of this confirmed that it is actively driving forward and overseeing the use of AI within the Trust.

There is a draft AI Strategic Framework in place which sets out the aims, vision and purpose for AI within the Trust, as well as setting out the governance framework and key actions to take forward, including the establishment of an AI Oversight Board. Although we note that as yet the actions are not being progressed, with no delivery roadmap in place which defines the resource needs as this is waiting for the Framework approval.

We also note that the Framework lacks detail on the risk management aspects, the process for continual improvement, the detail over how Patient and Public Involvement (PPI) Panel will operate and the processes for benchmarking and learning form external organisations.

Key Findings		Risk & Impact	Agreed Management Action
1	Automation Benefits Apart from specific, ad-hoc reporting there is no formal tracking and reporting of benefits associated with automation, although we note a benefits framework for automation is being drafted. Increased reporting on the benefits from automation may enable better linking to resource provision and drive adoption.	Without clear articulation of benefits the access to increased resource for automation may be delayed.	Agreed Action: Formalise and complete framework, agree and sign off required. - AD Digital Delivery. Retrospectively apply the framework to all processes. Increased visibility of automation benefits by linking benefits outcomes to wider Digital Services SharePoint. Place a control to ensure benefits are recorded during scoping phase.
		Medium Priority	Expected Evidence of Implementation: Agreed framework in place Benefits tracked for exiting processes New scopes include benefits
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Power Platform Manager Target Implementation Date: End of June 2026 for retrospective calculations
2	AI Delivery Roadmap The draft AI Strategic Framework sets out key actions to take forward. However, we note that as yet the actions are not being progressed, with no delivery roadmap in place which defines the resource needs for delivering increase, appropriate AI use within the organisation.	Without a clear, resourced roadmap the use of AI may be delayed	Agreed Action: A roadmap will be produced setting out a roadmap which contains actions such as Strategy development and implementation, Policy development and implementation, ICO support mechanisms, DPIA template upgrade to include AI and SOP for the use of AI across the Trust.
		Medium Priority	Expected Evidence of Implementation: Evidence in the shape of a covering document setting out all contents of a roadmap, supported by an Appendix setting out the roadmap itself as a project plan type approach to delivery.
	Theme: Resourcing	Control Operation	Officer: Ian Bevan - Head of Information Governance Target Implementation Date: 1st March 2026

Overview / Summary of Observations

The draft AI Strategic Framework contains key items in relation to guidance and governance for AI, noting the need to ensure compliance with regulations, the need to properly evaluate AI products and notes the need to prevent bias and ensure transparency.

There is no full awareness or record of who is using AI, although we note that an action within the Clinical & Scientific Board (C&SB) was to undertake a baseline assessment of AI currently in use and its effectiveness.

Currently, there is no guidance for staff in relation to the use of AI, including Copilot and we note staff are using Chat GPT, alongside other commercial AI offerings. The Trust's Head of Information Governance is leading the governance aspects of AI, and has contributed to the development of external / Welsh Government guidance. We note that no NHS Wales organisation has formal full guidance in place covering AI, however there is a draft AI Policy in place which sets out the guidelines for the development, implementation, and monitoring of AI systems to protect personal data, uphold ethical standards, and mitigate potential risks.

We reviewed the AI Policy and fed back some items for consideration for future iterations of the Policy, such as improving references to the AI Strategic Framework and AI Oversight Board and adding more robust requirements for recording the use of AI tools, risk assessment and patient and public involvement.

The unguided use of AI increases the risk of data leakage and of inappropriate or inaccurate models being used. However, although the Board Assurance Framework includes a strategic risk in relation to new technologies, there is no recording of more detailed risks in relation to the inappropriate use of AI within Trust risk registers.

There is some use of AI within Radiotherapy, which commenced several years ago. Although there was no Trust guidance in place, we note that there was consideration of guidance from professional bodies (MHRA and IRMA) over the use of medical devices / software. The AI in use has been assessed to ensure that the outputs are appropriate and suitable for use in a clinical setting, although we note this assessment was over the outputs and not an assessment of the models themselves.

We further note that as part of the procurement of equipment, which includes AI software, a key question was asked to explain the algorithm and the data used to train the models. However, we were informed that no company has done this, as such it is a black box approach. As this is a requirement within the Strategic Framework the Trust may hit challenges in this area going forward.

There is a process to monitor the use of AI within the Microsoft tenancy, and access to public AI tools is trackable via the firewall, with high risk sites being blocked. The monitoring tool shows the use of copilot across all the apps and includes premium and standard licences. We note that the tool shows the use of AI credits, and although these have been deprecated, there is likely to be an equivalent within the new contract. Given that the more complex use of AI such as large language models (LLMs) has a higher cost attached to it, the monitoring process should be fully embedded in advance of any chargeable contract and the Trust should consider evaluating the cost of current usage in the future contract.

There is an automation departmental SharePoint site which contains some guidance for developers, including a naming convention and guidance on the development lifecycle. There are also template documents in place for defining and developing automated processes. We also note that there are key governance documents in place including a cloud security risks assessment and a DPIA.

However, there are no SOPs for how to develop automations and there is nothing available for the wider organisation. Currently, the team is small, enabling visibility and direct management of automation. However, as automation use further increases within the Trust this will not be possible.

We also note that a governance wrapper is being developed for automation, in particular by citizen developers which will use a questionnaire to capture full information, enable risk assessment and automatically provide the user with a link to MS training packages.

Key Findings		Risk & Impact	Agreed Management Action
3	AI Risk	The risks associated with AI use may not be fully quantified and managed appropriately	Agreed Action: A risk will be produced and recorded in the BAF that sets out: the risk domain, the risk description and impact should the risk be realised.
			Expected Evidence of Implementation: The risk will be as set out in IG space, there is a risk to caused by, impact will be.
		Medium Priority	Officer: Head of Information Governance
	Theme: Risk Management	Control Operation	Target Implementation Date: 31st Jan 2026
4	Automation Procedures	There is a risk that automations may be developed that impact on information security or organisational resilience.	Agreed Action: Write and agree wider than digital SOPs for automation. Formalise digital SOP's for automation development team.
			Expected Evidence of Implementation: A catalogue of SOPs and safeguards in place to govern the use of these tools. Complemented by training and resources for citizen developers
		Medium Priority	Officer: Power Platform Manager
	Theme: Policies & Procedures	Control Operation	Target Implementation Date: 31st March 2026

Overview / Summary of Observations

Creation of automated processes is currently limited to the Automation Team and a small number of departments / individuals.

There is a process for defining the process to be automated, using the process definition document. This aims to capture the “as is” process, the reason for automation and baseline the process to be automated in terms of the current resource used. The document also identifies any dependencies, the target systems and any exceptions to processing.

As noted above there are no formal procedures that state this document must be used, however our testing confirmed that it was used for each of the sampled automated processes.

Our testing also noted that not all the proposed processes are baselined in terms of recording the resource, in particular time taken in completing the process. This reduces the ability of the team to effectively target their resource for the most valuable processes, and to demonstrate the benefits from automation. We note that this is partially due to the absence of a business analyst in the team, and partly due to a wider lack of clarity over how savings will be treated.

Potential automations are currently identified in a number of ways, including from the relevant department, from Digital and from senior management. We note that there is work ongoing to develop an entry point for requests to provide a greater level of formality and provision of information to enable better assessment of requests.

There is a large list of processes for automation and current team capacity is insufficient to deliver these. As such the team focus on the risk areas for the Trust and requests from senior management. As noted previously there are no formal procedures in place which would set out the basis for prioritisation going forward, and as such there is a lack of clarity.

Key Findings		Risk & Impact	Agreed Management Action
5	Process Baselining	The benefits from automation may not be maximised	Agreed Action: Control in place to capture process baseline, in the project scoping phase. Retrospectively calculate process resource baseline for existing automation projects.
			Expected Evidence of Implementation: Future project scopes contain process baseline
		Medium Priority	Officer: Power Platform Manager Target Implementation Date: 28th Feb 2026 End of June for retrospective calculations
	Theme: Resourcing	Control Operation	

Overview / Summary of Observations

The full design of automated processes is recorded within the process delivery documents, which provides more detail and greater technical detail over the process. Our testing confirmed that this document is appropriately used and records the contributors, identifies the sign off requirements, the target systems and accounts used along with a data flow through the process.

Approval to deploy automated processes requires sign off by the Automation Manager, the relevant user expert and the Cyber Security Team.

There are separate environments for development, test, and production, with automated processes moving through the stages appropriately. We note that control over this process is being improved with a move to a management environment which enables a defined pipeline for moves to be set which better tracks the moves and prevents changes being made within the production environment.

Although we were informed that testing is undertaken, with the extent and detail depending on the specific process, this was not recorded for the sample tested and the process definition document has no section to record and sign off on testing prior to deployment.

Key Findings		Risk & Impact	Agreed Management Action
6	Testing Although we were informed that testing is undertaken, with the extent and detail depending on the specific process, this was not recorded for the sample tested and the process definition document has no section to record and sign off on testing prior to deployment.	There is a risk that untested processes contain errors which may be deployed	Agreed Action: Control in place to capture and sign-off specific testing conducted within Process Delivery document.
			Expected Evidence of Implementation: Future Process Delivery Documents to contain testing section and sign-off
		Medium Priority	Officer: Power Platform Manager Target Implementation Date: 28th Feb 2026
Theme: Information, Data Quality & Data Accuracy		Control Operation	

Overview / Summary of Observations

There are processes in place for monitoring the operation of automated processes. For Blue Prism this will be within its own command centre which enables live monitoring of all processes, and for power automate a monitoring tool has been developed in-house. We further note the intent to develop a command centre for the power automate tool, which would enable greater visibility and monitoring.

The process delivery documentation sets out the full designed process and as such can be used to triage faults.

We reviewed the monitoring environment and note that it tracks all processes, with each broken down into sub-flows. The tool records each time a flow is run, the success or failure of that flow, together with the tables used and the code.

The tool keeps an error log which is retained for 30 days to enable any necessary investigation into errors and there is clarity over the logic and code for the monitoring.

There is an alert process for failures, with any failed processes triggering an automatic post into the RPA team channel and we noted evidence of investigation and updates within the channel.

The current monitoring and alert process is retrospective, with notification of failures provided once completed. There is currently no monitoring or warning in place that would identify processes that are 'stalling' or utilising too many resources. Currently the Automation Team is small, which enables visibility, however as automation rolls out the potential to miss such processes may increase. We note that the monitoring tool records the time of each process which would enable an estimated run time to be defined as part of testing and a timeout built into the process flow.

Objective 6: An appropriate process is in place to ensure that changes to the environment in which the robot operates are assessed for the impact on the robot, and changes to robots are recorded.

Substantial

Overview / Summary of Observations

Automated processes are highly sensitive to changes in the environment such as the underlying application user interfaces or platforms. Frequent system updates can break bots, leading to a continuous cycle of rework and maintenance.

The Automation Manager is aware of this risk. There are controls in place to minimise these and our testing confirmed that dependencies for the automated processes are included within the process design documentation.

During the automated process design and development process users are told to ensure that the Digital Team are notified of any changes, and this is included within the training provided to the citizen developers for power automate.

In the main, the automated process utilise forms, which are controlled by digital and assigned to a service account in order to prevent unapproved changes, with an expectation that any changes are requested via the service desk (Halo).

Changes are managed within the Halo change management tool, which enables notifications to be provided to the Automation Team for both local changes and for wider, environmental changes such as network adjustments.

We also note the existence of a technical subgroup, chaired by the Automation Manager, which acts as a forum for discussion and notification of changes for NHS Wales, e.g. from Microsoft or DHCW, which can then be passed to the Automation Team for review.

Overview / Summary of Observations

The automation of manual process enables the release of time within operational departments, this time is then allocated to new tasks. In the case of a failure of automation there may be a need to once again manually complete the process.

Currently, the use and development of automation within the Trust is at an early stage. As part of the process development, the issue of continuity within departments using automated processes is raised by the Automation Manager, noting that they must have a continuity plan in place to manage the risk of the automation failing. However, this is not checked and there is no formal confirmation of a plan prior to going live.

From an overall perspective the resource in place for automation is currently low, and this is reflected within the risk register which notes the low resource and the risk to the resilience of the service.

Key Findings		Risk & Impact	Agreed Management Action
7	Departmental Continuity	Failed processes may impact on operational delivery.	Agreed Action: Control in place for business continuity plans to have been confirmed by service owner.
			Expected Evidence of Implementation: Future Process Delivery Document to contain business continuity sign-offs
		Medium Priority	Officer: Power Platform Manager Target Implementation Date: 28th Feb 2026
Theme: Resourcing		Control Operation	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Velindre University NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



AUDIT COMMITTEE

Counter Fraud Progress Report

DATE OF MEETING	03/03/2026
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	HENRY BALES
PRESENTED BY	Henry Bales – Head Counter Fraud
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The counter fraud progress report provides a breakdown of the work carried out by the team during the period 20/11/2025 – 10/02/2026. The report breaks down the areas of work into the most relevant work streams that align with the NHS Counter Fraud Authority requirements for compliance. These areas are: Infrastructure Promotion, Awareness and Education



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

	Prevention National Fraud Initiative Referrals and Investigations Significant Overpayments of Salary

RECOMMENDATION / ACTIONS	It is recommended that the committee note the counter fraud progress report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE	
Level 6 – The organisation has good compliance with the Government Functional Standards for Counter Fraud and the NHS Counter Fraud Authority's standards. The actions that had been identified in relation to fraud awareness have been implemented and the desired outcome has been achieved. Fraud awareness is now mandated and uptake is steadily increasing. Uptake will be tracked over time in order to gain evidence of sustained success.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	
	Velindre P4 Counter Fraud Progress Report - Public

1. SITUATION

The purpose of the Counter Fraud Progress Report is to provide the committee with a breakdown of the work carried out by the Local Counter Fraud team on behalf of the organisation during the relevant period. The report's style has been adopted, in consultation with the Director of Finance. This report consists of:

- a. Counter Fraud Progress Report - Public

2. BACKGROUND

In compliance with the NHS CFA standards Counter Fraud is a standing item at Audit Committee. Regular progress reports are written and presented by the counter fraud manager. The provision is overseen by the Director of Finance within the organisation. The report seeks to highlight all work carried out by the team and breaks this down into proactive and reactive areas.

3. ASSESSMENT

It is proposed that the report is noted.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

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.	☐



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

- 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

There are no specific quality and safety implications related to the activity outlined in this report.

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].

Click or tap here to enter text

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:

For more information:
<https://www.gov.wales/socio-economic-duty-overview>

Choose an item

[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].

Click or tap here to enter text



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	<i>The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated</i>
	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.
	<i>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.</i>
	<i>Narrative in this section should be clear on the following:</i>
	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 <i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i> The Counter Fraud Progress report has no disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religious belief or Welsh language. Counter Fraud work is applicable to all members of staff equally and is aimed at ensuring there are appropriate measures in place to deter, detect, prevent and investigate fraud.
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 <i>[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].</i>

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?	
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	<i>[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].</i>



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	<i>[In this section, explain in no more than 3 succinct points what the barriers to implementation are].</i>
All risks must be evidenced and consistent with those recorded in Datix	



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Counter Fraud Progress Report

20/11/2025 – 10/02/2026

Public

HENRY BALES
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction	3
2. Progress	3
Infrastructure	3
Promotion, Awareness and Educational Activity	3
Fraud Prevention Notice	4
National Fraud Initiative	4
3. Referrals & Investigations	6
4. Significant Salary Overpayments	7

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Velindre UNHST.

This report relates to activity for the reporting period 20/11/2025 – 10/02/2026.

2. Progress

Infrastructure

The below activity has taken place -

- i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.
- ii. Continued maintenance of Counter Fraud digital platform – Members of the Audit Committee are encouraged to visit the site at the link/QR code here. The site can also be accessed via the VUNHST intranet site within the finance SharePoint pages.

[Counter Fraud - Home \(sharepoint.com\)](#)



Promotion, Awareness and Educational Activity

E- Learning/Mandated Awareness – Counter fraud has now been made a mandated training course on ESR. Data provided for completion rate up to the 31st of December 2025 for Velindre shows a compliance figure of 75%.

In person sessions continue to be delivered. With two sessions given in this reporting period to 22 members of staff.

International Fraud Awareness Week – through IFAW digital communications were publicised throughout the week. The various articles can be viewed from the links below:

[International Fraud Awareness Week - November 16-22](#)

[International Fraud Awareness Week 2025 - Working Elsewhere Whilst Sick](#)

[International Fraud Awareness Week 2025 - Timesheet/Expenses Fraud](#)

[International Fraud Awareness Week 2025 - Overpayments](#)

[Fraudbusters!](#)

Stay Safe This Christmas Fraud Article – The festive period can be one of heightened risk of fraud both personally and as an organisation. With this in mind a special Christmas fraud awareness article was published with information on how to stay safe and some common types of fraud at this time of year. The article can be viewed here: [Stay Safe This Christmas: Fraud Awareness Tips for NHS Staff](#).

Prevention

Fraud Prevention Notice – (3)

Three Fraud Prevention Notices produced by Counter Fraud Authority relating to Payment Terminal Fraud, Virtual Credit Cards and Payment Diversion Fraud. They have been reviewed no new risks or actions identified.

National Fraud Initiative

A detailed breakdown of the matches and work completed on the NFI exercise is provided in this section. For the purpose of this report the NFI matches have been separated into reports which the Counter Fraud Department review and those that NWSSP Accounts Payable review.

The Counter Fraud Department review the reports in Table 1, these are the payroll related reports, which match individuals on VUNHST payroll with other factors. E.g.

“Payroll to Payroll” matches employees on VUNHST payroll who are also on another organisation’s payroll.

Table 2 provides the reports covered by NWSSP accounts payable, these look at invoices and payments made by the organisation.

NFI categorise reports that are most important by listing them as “Key”. Within some NFI reports matches are given a risk score or risk profile by the system, however, not all reports have this. Where relevant, information has been provided in Table 1 and 2.

Table 1 shows the work completed by the Counter Fraud department against the NFI reports. The Counter Fraud department have reviewed all matches in all payroll reports. No issues were identified for VUNHST. A total of 34 matches were reviewed.

Table 2 shows the work completed by NWSSP against the relevant NFI reports. The methodology that is utilised is the same for all NHS Wales organisations, which is only key reports are reviewed and within these reports all high-risk matches will be reviewed. This is a risk-based approach that has been developed over previous NFI cycles. This year, of all matches reviewed no issues have been identified. The remaining matches and reports are ‘not selected for investigation’ based on the methodology used.

NB: Audit Wales are conducting a piece of work across Wales (NHS and wider public sector) to look at the methodologies used in completing NFI and will report their findings back when complete. Any recommendations will be reviewed and taken into consideration in future NFI cycles.

Table 1 – NFI reports covered by Counter Fraud Team

Report ID	Report Name	Key Report	No. of Matches	No. Matches Reviewed	Outcome from Report
66	Payroll to Payroll - NI	Yes	16 (1 Very High Risk)	16	All matches reviewed No issues identified
78	Payroll to Pension	No	17	17	All matches reviewed No issues identified
752	Procurement – Payroll to Companies House Director	Yes	1	1	All matches reviewed No issues identified

Table 2 – NFI reports covered by NWSSP

Report ID	Report Name	Key Report	No. of Matches	No. Matches Reviewed	Outcome from Report
700	Duplicate creditors by creditor reference	No	437	0	Report not reviewed
702	Duplicate creditors by address detail	No	26	0	Report not reviewed
703	Duplicate creditors by bank account number	No	19	0	Report not reviewed
707	Duplicate records by reference, amount and creditor reference	No	7	0	Report not reviewed
708	Duplicate records by amount and creditor reference	Yes	748 (129 – 75% Risk Score)	129 (All 75% risk score matches reviewed)	No issues identified on reviewed matches
709	Vat Overpaid	No	5926	0	Report not reviewed
712	Duplicate records by postcode, invoice date and amount but different creditor reference and invoice number	Yes	69 (4 – 75% Risk Score)	7 (All 75% risk score matches reviewed)	No issues identified on reviewed matches
713	Duplicate records by postcode, invoice amount but different creditor reference and invoice number and date	Yes	4	4	All matches reviewed No issues identified

3. Referrals & Investigations

There have been three referrals made to counter fraud this period. One request for advice and two referrals of potential fraud. One has been closed following initial review the other remains in initial review stage.

The one open investigation has been transferred to the NHS Counter Fraud Authority for continued investigation; the counter fraud team have kept this open to provide assistance if required.

4. Significant Salary Overpayments

The All-Wales Salary Overpayments Policy requires that the Counter Fraud team review all “significant” salary overpayments prior the employee being informed of the issue. The Counter Fraud team have a five-day window to carry out an initial assessment of the surrounding circumstances on the digital dashboard and decide whether the matter will be formally investigated as a financial crime.

“Significant” overpayments are defined in the policy as overpayments that have a total value of over £5,000 and have been ongoing for a period of over 3 months.

There have been no significant salary overpayments reported to counter fraud this period.

AUDIT COMMITTEE

Counter Fraud Annual Plan

DATE OF MEETING	03/03/2025
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	HENRY BALES
PRESENTED BY	Henry Bales – Head Counter Fraud
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The counter fraud annual plan provides an overview of the workstreams to be carried out by the counter fraud team on behalf of Velindre University NHS Trust for the year 2026-27.
RECOMMENDATION / ACTIONS	It is recommended that the Audit Committee approve the counter fraud annual plan.

GOVERNANCE ROUTE



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

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

APPENDICES	
	Counter Fraud Annual Plan 2026/27

1. SITUATION

The NHS Counter Fraud Authority requires that an Annual work plan is created in relation to the counter fraud work to be carried out by counter fraud teams for their organisations. The workplan must directly align with Government Functional Standard GovS 013: Counter Fraud. This plan adheres to that principle and provides an overview of the areas of work that will be carried out on behalf of the organisation for 2026/27.

2. BACKGROUND

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud**. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and has a duty to ensure the effective implementation of the NHS Counter Fraud Requirements. Local Counter Fraud Teams must adhere to these requirements and report their work against them. As a result, an Annual Workplan identifying how these requirements will be met is produced and submitted to DoF and Audit Committee for their approval.

3. ASSESSMENT

It is proposed that the report is approved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A



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) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
	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). <i>[Please include narrative to explain the selected domain in no more than 3 succinct points].</i> Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Choose an item <i>[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].</i> Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities If more than one Well-being Goal applies please list below: <i>The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated</i> 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. <i>This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from</i>



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

	<i>the Matters for Consideration and any associated Business Case.</i> 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://nhs.wales365.sharepoint.com/sites/VEL/_layouts/15/Default.aspx	Not required - please outline why this is not required <i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i> The Counter Fraud Progress report has no disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religious belief or Welsh language. Counter Fraud work is applicable to all members of staff equally and is aimed at ensuring there are appropriate measures in place to deter, detect, prevent and investigate fraud.



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
	<i>[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].</i>

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

NHS WALES

Velindre University NHS Trust

COUNTER FRAUD WORK PLAN
2026/2027

Henry Bales
Manager Counter Fraud

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Team on behalf of Velindre University NHS Trust (VUNHST) to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Executive Director of Finance as below.

The NHS Wales Shared Service Partnership (NWSSP) is hosted by VUNHST. NWSSP has its own Counter Fraud Manager and Counter Fraud work plan and is accountable for counter fraud within NWSSP returning its own Government Functional Standard Return each year to the NHS Counter Fraud Authority.

Workplan prepared by:

Counter Fraud Manager – Henry Bales

Workplan agreed by:

Executive Director of Finance – Matthew Bunce

Date:

WORKPLAN 2026-27

Countering fraud, bribery and corruption is fundamental to safeguarding the resources of Velindre University NHS Trust. The threat of economic crime continues to evolve in both scale and complexity, driven by increasingly sophisticated methods, digital vulnerabilities, and operational pressures that can create opportunities for exploitation.

This Annual Counter Fraud Work Plan for 2026/27 sets out a comprehensive programme of proactive and reactive activity designed to strengthen the Trust's resilience against fraud. Velindre University NHS Trust is required to comply with the Government Functional Standard 013: Counter Fraud (GovS 013), and compliance is assessed annually through a structured self-assessment process. To support continued compliance and provide assurance to senior management and the Audit Committee, all elements of this work plan are mapped directly against the requirements of GovS 013 as set out by the NHS Counter Fraud Authority ([NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority](#)).

The NHS Wales Fighting Fraud Strategy (2026–2030) has been drafted and is expected to be approved for implementation during the 2026/27 financial year. In anticipation of this, the work plan has been aligned to the draft strategic framework. Accordingly, all planned activities for 2026/27 are organised under the five strategic pillars of the NHS Wales strategy:

- **Prevent** – strengthening systems and controls, reducing opportunities for fraud, and promoting awareness across all staff groups.
- **Detect** – using intelligence, data, and proactive work to identify anomalies and fraud risks early.
- **Respond** – investigating allegations effectively, applying appropriate sanctions, and recovering losses.
- **Build Capability** – ensuring the Local Counter Fraud Specialist (LCFS) function is skilled, accredited, and equipped to meet emerging threats.
- **Collaborate** – working in partnership with NHS bodies, NHS Counter Fraud Service Wales (NHSCFSW), the NHS Counter Fraud Authority (NHSCFA), and other stakeholders to ensure consistent, system-wide protection.

Together, these pillars provide a clear and coherent framework for delivering meaningful counter fraud outcomes. This plan outlines the specific activities, resource allocation, intended outputs and areas of priority for the year ahead. It is designed to be dynamic and responsive, enabling adaptations where emerging risks, intelligence or organisational needs require changes in approach. Through

this work plan, the Trust reaffirms its commitment to maintaining high standards of probity, strengthening public confidence, and ensuring that services provided to patients across Wales are protected from the harms caused by fraud.

Velindre University NHS Trust contracts Cardiff and Vale University Health Board (CAVUHB) to provide its counter fraud service via a formal service-level agreement. The CAVUHB Counter Fraud Team comprises four full-time accredited counter fraud professionals, one Manager, one Deputy Manager and two Local Counter Fraud Specialists, who collectively provide counter fraud services to five NHS Wales organisations. Under the terms of the SLA, Velindre receives 100 days of counter fraud provision each year. These days are delivered flexibly across the team, ensuring that the Trust benefits from a broad range of skills and expertise while maintaining the capacity to respond effectively to the unpredictable nature of counter fraud work.

Resource Provision

Resource Provision for VUNHST	Days Planned 2026/27
Counter Fraud Manager and LCFS provision from CAVUHB	100

Resource by Activity

Activity	Days Planned 2026/27
Proactive	70
Reactive	30
Total	100

GovS 013 returns submitted annually to the NHSCFA require organisations to categorise counter fraud activity as either Proactive or Reactive.

Proactive activity includes work designed to prevent and deter fraud, such as fraud awareness training, corporate induction, development of e-learning, local proactive exercises, data analysis, and fraud risk assessments.

Reactive activity includes work undertaken in response to referrals and intelligence, such as investigations, evidence gathering, case management, and system weakness reporting arising from proven or suspected fraud.

The NHSCFA emphasises that Proactive work should not be absorbed by Reactive activity and strongly encourages organisations to ring-fence proactive days to maintain an appropriate balance between prevention and investigation. However, due to the dynamic and unpredictable nature of counter fraud work, this plan is designed to remain flexible and responsive to emerging risks, organisational priorities, and fluctuations in referral demand.

Where changes to the planned allocation of days are necessary, they will be discussed with the Executive Director of Finance at the earliest opportunity and reported to the Audit Committee. Any adjustments to overall days delivered or resourcing priorities will be reflected in quarterly progress updates and the end-of-year Annual Report.

Counter Fraud Activities for 2026/27

Below are set out the activities that the counter fraud department will complete on behalf of VUNHST, these have been organised into the 5 new strategic areas from the NHS Wales Fighting Fraud Strategy. The activities have been mapped against the NHS Requirements/GovS 013.

PREVENT		
<i>Assess the risk, strengthen systems and controls and promote awareness to stop fraud before it occurs.</i>		
TASK / OBJECTIVE	REQUIREMENT / STANDARD	PROPOSED DELIVERY
Policy and Response Plan – This is in place within the organisation and sets out roles and responsibilities, reporting routes and processes within the organisation. Annual review of Counter Fraud, Bribery & Corruption Policy and Response Plan. (Policy scheduled for approval following update Q4 2025/26).	GovS 013 – Requirements 3 & 4	Q4
Fraud Risk Management Programme – Maintain a live Fraud Risk Profile using the GCFP methodology; record risks on DATIX/risk registers; time-bound follow-ups on mitigation actions.	GovS 013 – Requirements 2, 3 & 5	Throughout Year

Reporting Routes visibility & evaluation – Maintain local reporting route. Periodically review usage and reporting numbers. Conduct a survey during the year. Refresh publicity if gaps identified.	GovS 013 – Requirements 7 & 11	Throughout Year
DOI / Gifts & Hospitality Registers and Policy – Review of policy and completion rates. Review any high-risk records (combining with NFI matches where appropriate)	GovS 013 – Requirements 5 & 12	Throughout Year
Awareness Activity – Present at induction events across three sites (Velindre Cancer Centre, Welsh Blood Service and Headquarters). One session will be provided every month cycling around the three sites. These are arranged by the Corporate Governance Team. These sessions will be recorded on ESR. Continue to promote the e-learning course and monitor completion rate. Sessions and e-learning aim to increase awareness of fraud, how it can occur, what to do if you suspect fraud and what potential consequences of fraud are.	GovS 013 – Requirements 7 & 11	Throughout Year
Lessons Learnt – Identify and disseminate lessons learned from investigations and proactive exercises.	GovS 013 – Requirements 3, 5 & 6	Throughout Year

DETECT		
<i>Use data, intelligence and advanced analytics to help prioritise resources and link fraud risks early.</i>		
TASK / OBJECTIVE	REQUIREMENT / STANDARD	PROPOSED DELIVERY
National Fraud Initiative – fully participate in the exercise. Ensure data is submitted and all organisational details are up to date. Ensure response and completion methodology meets best practice (Audit Wales Report expected during the year)	GovS 013 – Requirements 3, 5 & 10	Throughout Year

National and Local Proactive Exercises – Fully participate in any national proactive exercises as set out by NHSCFSW and NHSCFA. Plan and execute local exercises as identified from risk / incident trends or as directed by the organisation (Audit Committee or Executive Director of Finance)	GovS 013 – Requirements 3, 5 & 10	Throughout Year
Data Analytics – Identify and complete data analytics exercises locally or in partnership with NHSCFA Project Athena, where available.	GovS 013 – Requirements 3, 5 & 10	Throughout Year
Intelligence – Respond to intelligence reports and fraud prevention notices received. Ensuring appropriate action is taken for each report.	GovS 013 – Requirements 3 & 10	Throughout Year

RESPOND		
<i>Investigate thoroughly, recover losses, and apply appropriate sanctions swiftly.</i>		
TASK / OBJECTIVE	REQUIREMENT / STANDARD	PROPOSED DELIVERY
Investigations and investigation management – Conduct investigations in line with NHSCFA Fraud Manual and legal requirements. Investigation oversight and management to be provided by Manager/Deputy Manager. Seek appropriate sanctions for cases.	GovS 013 – Requirements 6, 8 & 9	Throughout Year
Recording and Reporting – Record all cases/activities, losses, recoveries, preventions and outcomes on CLUE, report to organisation through Audit Committee and report via quarterly Welsh Government returns and annual functional standard returns. Maintain record / data in a format compatible with various reporting requirements.	GovS 013 – Requirements 5, 6 & 8	Throughout Year

Response to Reports and Requests – provide timely response to reports of potential fraud, requests from external partners for assistance and requests for advice from VUNHST staff.	GovS 013 – Requirements 6, 7 & 10	Throughout Year

BUILD CAPABILITY		
<i>Invest in our people by providing specialist training and equipping counter fraud teams with latest tools and technology.</i>		
TASK / OBJECTIVE	REQUIREMENT / STANDARD	PROPOSED DELIVERY
Maintain a fully accredited skilled team – Ensure staffing level is maintained at 4 fully accredited counter fraud specialists. Each member of the team to have a CPD and development plan. Maintain compliance with ESR mandated training. Attendance at NHS CFA/CFSW events and forums. Continue to monitor the development of the Government Counter Fraud Profession and the anticipated upcoming requirements for staff to obtain membership through completion of new training. Ensure training is obtained and completed when available.	GovS 013 – Requirements 9 & 11	Throughout Year
CLUE Competence and quality reviews – Monthly (minimum) reviews of quality and timeliness of CLUE entries. Target refresher training where needed.	GovS 013 – Requirements 5 & 6	Throughout Year
Tools and Equipment – Ensure that the team maintains access to appropriate workspace and equipment required for the role. Look at best practice and equipment predicted lifespans to ensure plans are in place to maintain and improve access to equipment and software. Ensure compliance with information governance standards.	GovS 013 – Requirement 9	Throughout Year

COLLABORATE

Foster strong partnerships across NHS Wales, other Welsh public bodies, Welsh Government, and UK agencies such as HMRC and DWP to share intelligence and best practice.

TASK / OBJECTIVE	REQUIREMENT / STANDARD	PROPOSED DELIVERY
Governance and Assurance – Regular meeting with Executive Director of Finance. Quarterly reports and presentation to Audit Committee. Meetings with Counter Fraud Champion, Audit Committee Chair and Independent Members as required. Executive Director of Finance is the nominated accountable board member and is nominated with the NHSCFA. Audit Committee Chair is nominated with the NHSCFA. Ensure nominations of DoF, ACC and counter fraud specialists is kept up to date.	GovS 013 – Requirements 1, 2, 5 & 6	Throughout Year
Outcome Based Metrics and Dashboard – Database maintained tracking all work undertaken by the counter fraud department on behalf of the organisation. Allowing for reviews of trends, investigations, proactive work and awareness work.	GovS 013 – Requirement 5	Throughout Year
Partnerships and Campaigns – Collaborate with key stakeholders regularly including Internal Audit, Workforce and OD and counter fraud colleagues. Attendance at Counter Fraud Liaison Groups and other national panels/groups (e.g. Counter Fraud Authority Stakeholder Engagement Group). Participate in International Fraud Awareness Week. Regular fraud newsletters and bulletins to be developed, promoted and circulated.	GovS 013 – Requirements 2, 3, 10 & 11	Throughout Year

AUDIT COMMITTEE	
DECLARATIONS OF INTERESTS, GIFTS, HOSPITALITY SPONSORSHIP AND HONORARIA (21 AUGUST 2025 – 24 FEBRUARY 2026)	
DATE OF MEETING	03/03/2026
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	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This report details the Declarations of Interests, Gifts, Hospitality, Sponsorship and Honoraria received for the period 21/08/2025 – 24/02/2026. • There are 13 new entries on the Gifts, Hospitality, Sponsorship and Honoraria Register for this reporting period Appendix 1. • There have been 7 amendments/additions to the Declarations of Interest Register for this period inclusive of those received via the Trust's established Annual Review Process Appendix 2. No objections to approval were received in respect of the items of business considered.
RECOMMENDATION / ACTIONS	The Audit Committee is requested to: • NOTE the Trust Declarations of Interests, Gifts, Hospitality, Sponsorship and Honoraria

	received for the period 21/08/2025 – 24/02/2026.
GOVERNANCE ROUTE – N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1	Gifts, Hospitality, Sponsorship and Honoraria Register (Additional Entries: 21/08/2025 – 24/02/2026)
Appendix 2	Trust Declarations of Interest Register (via established Annual Review process updated entries: 21/08/2025 – 24/02/2026)

1. SITUATION / BACKGROUND

- 1.1 In line with the requirements of the Trust Standing Orders and the Trust Standards of behaviour Framework Policy, a report from the Trust register is required to be received by the Audit Committee, which detail any Gifts, Hospitality, Sponsorship and Honoraria activities that have been approved, together with any amendments/ additions to the interests that have been declared.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The form in the Standards of Behaviour Policy should be used to seek approval for receiving gifts/hospitality/sponsorship/honoraria and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is sent to the Trust Headquarters.
- 2.2 Appendices 1 and 2 include the new amendments and additional entries received for the period **21/08/2025 – 24/02/2026**.
- There have been **13** new entries on the Gifts, Hospitality, Sponsorship and Honoraria Register this period.
 - There have been **8** amendments / additions to the Declarations of Interest this period inclusive of those received via the Trust established Annual Review Process.
- 2.3 The declarations received this period have been completed in accordance with the Standards of Behaviour Policy and authorised by the appropriate Trust Officer.
- 2.4 All declaration forms are reviewed and checked by the Head of Corporate Governance and any queries addressed prior to entry on the register.
- 2.5 Please refer to the register for the Declaration of Gifts, Hospitality, Sponsorship and Honoraria included at **Appendix 1** and the Declarations of Interest Register at **Appendix 2**.
- 2.9 The Audit Committee is requested to:
- **NOTED** the Trust Declarations of Interests, Gifts, Sponsorship, Hospitality and Honoraria received for the period **21/08/2025 – 24/02/2026**.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report directly support the achievement of 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)	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust will support the delivery of quality care.
	The Register and Declaration of Interests is the method by which the Trust safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur. The Trust must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.

EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL/ntranet/SitePages/E.aspx	There are no specific equality implications related to the activity outlined in this report
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	There are no direct socio economic duty implications to the Trust identified.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream Please refer to the detail within the registers at Appendix 1 and 2.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

APPENDIX 1 – Gifts, Hospitality, Sponsorship and Honoraria Register (Additional Entries: 21/08/2025 – 24/02/2026)

Date Entry Received for Register	Name	Designation or Department	Division	Provided by/ From	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
01/09/2025	Annabel Borley	Consultant	Velindre Cancer Service	Roche	Chair and Speak at Educational Meeting 15/10/2025	HER2 Positive Breast Cancer Neo/Adjuvant Management & Multidisciplinary Meeting	Honoraria: £950 speaker fee	Trust Time	Honoraria to reflect hours worked	Kate Hannam, Director of Velindre Cancer Service	01/09/2025	Accepted
01/09/2025	Annabel Borley	Consultant	Velindre Cancer Service	Roche	ESMO 16-20 October 2025	Sponsorship to attend ESMO Congress	Sponsorship: Registration Fee £400 Hospitality: Flights £200 and Hotel £400	Study Leave	N/A	Kate Hannam, Director of Velindre Cancer Service	01/09/2025	Accepted
01/09/2025	Annabel Borley	Consultant	Velindre Cancer Service	Novartis	Local Chair and Host for National Hub and Spoke Meeting, Village Hotel, Whitchurch, Cardiff 17/09/2025	Honoraria: Breaking New Ground: Introducing KISQALI® (ribociclib) in Early Breast Cancer	Honoraria: £1113.50	Own Time	Honoraria to reflect hours worked	Kate Hannam, Director of Velindre Cancer Service	01/09/2025	Accepted
04/09/2025	Carys Morgan	Consultant in Clinical Oncology / Divisional Medical Director	Velindre Cancer Service	University of Hong Kong-ShehZen Hospital, China	Cardiff FRCR Course Inaugural Meeting with Hong Kong University - Shenzhen University Hospital, China - 15 to 18 September 2025	Sponsorship to attend	Sponsorship: Return Travel £2500 Accommodation for 4 nights £500 Visa application and train travel to London £300 Meals/Refreshments £100	Study Leave	N/A	Kate Hannam, Director of Velindre Cancer Service	04/09/2025	Accepted
15/09/2025	Bethan Tranter	Chief Pharmacist	Velindre Cancer Service	Novartis	National Hub and Spoke Meeting, Village Hotel, Whitchurch, Cardiff 17/09/2025	Study Evening: Ribociclib in Early Breast Cancer	Hospitality: Buffet Dinner	N/A	N/A	Kate Hannam, Director of Velindre Cancer Service	15/09/2025	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by/ From	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
24/09/2025	Theresa Jenkins	Project & Service Improvement Officer	Welsh Blood Service	SimplyDo Ideas Ltd	250 'I made a 5 Minute Improvement' badges to support the Service Improvement Initiative	Sponsorship for SIP badges	Sponsorship: £372 paid for badges	N/A	N/A	Alan Prosser, Director of Welsh Blood Service	24/09/2025	Accepted
24/09/2025	Laura Obradovic-Eaves	Service Improvement Manager	Welsh Blood Service	SimplyDo Ideas Ltd	Service Improvement Event 11/11/2025	Gift Card to support Service Improvement event for colleague voted poster.	Gift: £20 gift card	Trust Time	N/A	Alan Prosser, Director of Welsh Blood Service	24/09/2025	Accepted
29/09/2025	Anthony Cadogan	Deputy Chief Pharmacist	Velindre Cancer Service	Roche	Lancashire and South Cumbria SACT Pathway Innovation Workshop	Honoraria: for preparation and activity	Honoraria: £350	Trust Time	Honoraria directed into Pharmacy Budget	Emma James, Divisional Nurse	29/09/2025	Declined
29/10/2025	Luke Padwick	Service Improvement Lead	Velindre Cancer Service	Novartis	MRT Matters: System Readiness for Molecular Radiology 19/11/2025	Presenting at the Novartis Molecular Radiology Workshop	Sponsorship: Travel £154.79 Honoraria £950	Own Time	Honoraria to reflect hours worked	Kate Hannam, Director of Velindre Cancer Service	29/10/2025	Declined
10/11/2025	Anne Carey	Chief Operating Officer	Corporate	Amazon Web Services	NHS Wales Confederation Dinner on 05/11/2025	Guest of AWS	Hospitality: Three course meal with drink reception and table gift	Own Time	N/A	David Donegan, CEO	10/11/2025	Accepted
17/11/2025	Annabel Borley	Consultant	Velindre Cancer Service	Gilead	Gilead 1L mTNBC advisory board (London) - 28/11/2025	Advisory Board with National colleagues to discuss and consider data from recent trials relating to patients with advanced triple negative breast cancer	Honoraria: £1980	Own Time	Honoraria to reflect hours worked	Kate Hannam, Director of Velindre Cancer Service	17/11/2025	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by/ From	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
17/12/2025	Tej Quine	Advanced Nurse Practitioner Systemic Therapies	Velindre Cancer Service	Pfizer	Management of Service Capacity and Workforce in Oncology Clinics - 19/12/2025	Presenting Managing Capacity in Oncology Clinics to the Royal Marsden	Honoraria: £400	Own Time	Honoraria to reflect hours worked	Kate Hannam, Director of Velindre Cancer Service	03/12/2025	Accepted
21/01/2026	Shadi Farahat	Pharmacist	Velindre Cancer Service	Pharmaand GmbH Taborstrasse 2, 1020, Vienna, Austria	Embrace Possibilities in Ovarian Cancer (EPOC2) 09-10/03/2026	Attendance at Embrace Possibilities in Ovarian Cancer (EPOC2) Royal College of General Practitioners 30 Euston Square London NW1 2FB	Travel: £110 Accommodation: £200 Conference Fee: £26.50	Study Leave		Kate Hannam, Director of Velindre Cancer Service	21/01/2026	Accepted

Appendix 2 – Trust Declarations of Interest Register (via established Annual Review process updated entries: 21/08/2025 – 24/02/2026)

DESIGNATION	NAME	DATE RECEIVED	DIVISION	DETAILS
Trust Chair	Sara Moseley	14/11/2025	Corporate	- Mind Cymru, Pwyllgor Member (voluntary) - Tribunal Panel Chair, Health and Care Professions Council
Vice Chair (left 31/08/2025)	Stephen Harries	31/08/2025	Corporate	- Former Trustee of City Hospice until 5 September 2019. Remains a “member” of the Company, which is subject to the payment of a small annual subscription fee - Independent Member of the Welsh Government's Economy, Energy and Transport Group Audit and Risk Assurance Committee (ARAC). The role requires a maximum commitment of 6 days per annum. Trained as Senior Investigating Officer to undertake investigation activity for WG in this regard.
Independent Member	Ceri Doyle	19/11/2025	Corporate	Open University Council Member from August 2020
Independent Member	John Union	14/11/2025	Corporate	- Non-Executive Director, Swansea Building Society from November 2017 - Trustee, Infirm Clergy Society of the Archdiocese of Cardiff - will stand down shortly as Charity is to be merged within next few months and I will no longer be a trustee.
Chief Executive Officer (left 18/11/2025)	David Donegan	27/03/2025	Corporate	Nil interests declared
Executive Director of Organisational Development & Workforce (left 31/10/2025)	Sarah Morley	31/10/2025	Corporate	Joint Chair and Trustee of Healthcare People Management Association (01/04/2023 for three years) - No financial reward or benefit in kind. Will be in receipt of expenses.
Digital Support Officer Velindre Oncology Academy	Main Ghaleb Ali Al-Najjar	05/11/2025	Velindre Oncology Academy	Directorships: - Director and Employee at 1 Stop Training Solutions Limited (1Stop Training) - from 01 August 2025 - Salary and Dividend (not fixed, differs from period to period. Interest in Companies and Securities: - Shareholder (33%) at 1 Stop Training Solutions Limited (1Stop Training) - from 09 February 2024 - Before directorship and employment only earned a dividend. Following directorship and employment, started to earn a salary through PAYE in addition to the dividend.



AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING

3rd March 2026

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE INDICATE REASON

Not Applicable - Public Report

PREPARED BY

David Osborne, Head of Finance Business Development

PRESENTED BY

David Osborne, Head of Finance Business Development

EXECUTIVE SPONSOR APPROVED

Matthew Bunce, Executive Director of Finance

REPORT PURPOSE

FOR NOTING

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

COMMITTEE OR GROUP

DATE

OUTCOME

ACRONYMS

VCC

Velindre Cancer Centre

KPI

Key Performance Indicator

DSO

Days of Sales Outstanding

1. SITUATION/ BACKGROUND

- 1.1 A review of the Velindre Cancer Services (VCS) Private Patient Service debt management process and position was completed in January 2024 as part of an Internal Audit of the Trust's Core Financial Systems.
- 1.2 Audit Committee raised some questions relating to the increase in the aged debt position and it was agreed that regular updates would be provided.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The Private Patients team are in the process of completing and submitting invoices for February 2026, demonstrating that four week billing has been achieved and that the 6-month turnaround time for invoicing with insurers is met. The team commence the billing cycle at month end. This includes all individual treatments during that preceding reporting month.
- 2.2 The Private Patient team has been fully recruited since November 2023, establishing resilience, and addressing the historic capacity issues which resulted in delayed invoicing.

Unapplied/ Unidentified Receipts

- 2.3 As a result of the extensive work that has been undertaken to date, the process of transacting the unapplied and unallocated income against the aged debt greater than 180 days is complete.
- 2.4 A small proportion of debts, totaling £7.5k were required to be written off during the financial year 25/26, due to the conclusion of the review of individual private patient debtor accounts. This review comprised of tracking services received, invoices raised and payments received by individual patient accounts. Whilst the majority of debt owed to Velindre had been appropriately raised and received, mismatches in invoicing resulting from errors in historic administrative practices had necessitated the write off of historic imbalances of debt owed. It is deemed inappropriate to chase debt owed to patients which have subsequently sadly passed away or go back several financial years which could be distressing to patients and families or are lower than £10 as processing requirements would be in excess of any amount recovered. Debts owed by insurance companies, even where aged greater than 6 months remain liable and are being challenged alongside contract renewal discussions
- 2.5 The Key Performance Indicator (KPI) to monitor and manage the billing process will be the Days of Sales Outstanding (DSO). In order that invoices are raised in a timely manner and are followed up to collect the cash, it is suggested that the KPI for DSO is set at 90 days. The DSO performance since Aug 2025 is as follows:

Key Performance Indicator	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Days Sales Outstanding	141	82	108	73	63	88

There has been marked improvement in the KPI for DSO in comparison to the commencement of the review, the 90-day target was achieved in 4 of the 6 months and consecutively for the last quarter. The months where DSO was greater than 100 days is due to a significant level of debt raised in the month, for example the August DSO was 141 days due to the raising of £0.54m invoices in month, resultant from the aforementioned cleansing work of unapplied/unidentified receipts. In order to ensure that performance is maintained, the following process will continue to be monitored:

- (i) Self-payer and Top-Up income monitored monthly, and payment requests made prior to any planned treatments or procedures.
- (ii) Pre authorisations obtained on a weekly basis.
- (iii) Breakdown of remittance sent to debtors team with account numbers and invoice reference to reconcile.
- (iv) Aged Debt report managed by the Private Patient manager.
- (v) Private Patient team continue to use the Oracle system to match payments.

2.6 The trend of the last 6 months illustrates that approximately 95% of private patient income will be derived from insurance companies. This is demonstrated for information purposes in the following table:

Debts % by Customer and by Age	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
% Debts Payable by Insurance Companies	97.6%	95.0%	95.2%	94.3%	92.9%	94.9%
% Debts Not Payable by Insurance Companies	2.4%	5.0%	4.8%	5.7%	7.1%	5.1%
% Debts aged 90 days or less	57.3%	25.1%	44.2%	22.1%	0.5%	16.2%
% Debts aged 91 days or more	42.7%	74.9%	55.8%	77.9%	99.5%	83.8%

2.7 The table shows that the proportion of debt aged 90 days or less varies each month, demonstrating an improvement in prompt raising and payment of invoices. The debts aged 91 days or more are largely with one insurer, resolution of which is planned within the coming weeks as part of concluding the tariff negotiations.

2.8 The full report (Appendix 1) provides the breakdown of debt profile by age, value, and customer category.

2.9 In summary, the key things to note include:

- (i) Days of sales outstanding KPI is being achieved in 67% of the last 6 months.
- (ii) The months where DSO was greater than 100 days is due to a significant level of debt raised in the month, for example the August DSO was 141 days due to the raising of £0.54m invoices in month, compared to £0.16m average of the remaining 5 months. The DSO recovered to within KPI target in the subsequent month.
- (iii) There are no further unapplied/ unidentified receipts relating to private patients older than 180 days as of October 2025.
- (iv) In the last 6 months, aged debt greater than 91 days has largely stagnated, ongoing contract discussions with the largest Insurer includes discussion of recovery of the most significant aged debt (approx. £321k) which will largely address the position with a consequent reduction in the KPIs.
- (v) Work continues with Digital Services to review ways of working and suggest potential improvements to the billing process.
- (vi) Audit Committee will continue to have oversight of the Finance and Commercial actions in the improvement plan and the Quality, Safety & Performance Committee will have oversight of all the actions in the improvement plan.

3.0 IMPACT ASSESSMENT

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

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee is asked to **NOTE** the information provided in this report.

Appendix 1 – Aged Debt Report as of March 2026

Spreadsheet attached.

Totals of Debt Categories Per Aged Debt Report (input values in grey shaded cells only)

Key Performance Indicators (Targets to be agreed)

% Debts Payable by Insurance Companies

% Debts Not Payable by Insurance Companies

% Debts aged 90 days or less

% Debts aged 91 days or more

Days Sales Outstanding (private patient value divided by the amount of income raised in the last twelve months (rolling year) times 365 days)

All debts	31.05.2025	30.06.2025	31.07.2025	31.08.2025	30.09.2025	31.10.2025	30.11.2025	31.12.2025	31.01.2026	All debts	31.05.2025	30.06.2025	31.07.2025	31.08.2025	30.09.2025	31.10.2025	30.11.2025	31.12.2025	31.01.2026
Within maturity (0-30 days)	38 382	367 717	111 979	536 614	19 181	261 454	77 351	13 066	60 855	Within maturity (0-30 days)	361 517	(329 335)	255 738	(424 635)	517 433	(242 273)	184 103	64 286	(47 790)
31-60 days	85 998	20 810	63 603	39 035	126 965	19 163	2 569	(5 490)	12 814	31-60 days	(33 366)	65 188	(42 793)	24 568	(87 930)	107 802	16 594	8 059	(18 304)
61-90 days	13 961	14 599	2 773	16 940	1 618	57 393	37 629	(5 490)	3 872	61-90 days	(14 476)	(638)	11 826	(14 167)	15 322	(55 775)	19 764	43 119	(9 362)
91-180 days	27 562	18 333	24 833	4 090	17 817	4 324	2 366	29 141	9 864	91-180 days	2 061	9 229	(6 500)	20 743	(13 727)	13 493	1 958	(26 775)	19 277
181-365 days	32 719	28 584	39 025	38 890	18 554	18 885	17 687	1 488	2 241	181-365 days	1 656	4 135	(10 441)	135	20 336	(331)	1 198	16 199	(753)
1 year +	434 017	420 412	422 755	397 867	404 377	404 242	395 331	395 391	389 198	1 year +	2 728	13 605	(2 343)	24 888	(6 510)	135	8 911	(60)	6 193
Total	632 639	870 455	664 968	1 033 436	588 512	765 461	532 934	428 106	478 845	Total	320 120	(237 816)	205 487	(368 468)	444 924	(176 949)	232 527	104 828	(50 739)

Insured	40 956	366 646	108 118	532 661	10 628	254 473	70 727	6 592	59 853	Insured	355 825	(325 690)	258 528	(424 543)	522 033	(243 845)	183 746	64 136	(53 262)
Within maturity (0-30 days)	83 284	20 780	62 898	38 456	126 629	10 610	(5 985)	(5 490)	12 814	Within maturity (0-30 days)	(31 221)	62 504	(42 118)	24 442	(88 173)	116 019	16 595	(495)	(18 304)
31-60 days	13 635	12 392	5 317	16 907	1 282	57 057	37 293	(5 490)	3 872	31-60 days	(14 150)	1 243	7 075	(11 590)	15 625	(55 775)	19 764	42 783	(9 362)
61-90 days	27 452	18 150	24 466	4 060	17 754	3 925	1 967	19 882	970	61-90 days	765	9 302	(6 316)	20 406	(13 694)	13 829	1 958	(17 915)	18 912
91-180 days	32 719	28 474	39 098	38 890	18 371	18 702	17 504	1 275	1 996	91-180 days	1 616	4 245	(10 624)	208	20 519	(331)	1 198	16 229	(720)
181-365 days	413 867	400 262	402 645	377 757	384 267	384 132	381 001	381 061	374 868	181-365 days	2 768	13 605	(2 383)	24 888	(6 510)	135	3 131	(60)	6 193
1 year +	611 913	846 704	642 542	1 008 731	558 931	728 899	502 508	397 830	454 373	1 year +	315 603	(234 791)	204 162	(366 189)	449 800	(169 968)	226 391	104 678	(56 543)
Total	(2 574)	1 071	3 861	3 953	8 553	6 981	6 624	6 474	1 002	Total	5 692	(3 645)	(2 790)	(92)	(4 600)	1 572	357	150	5 472

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)

Within maturity (0-30 days)	2 714	30	705	579	336	8 553	8 554	0	0	Within maturity (0-30 days)	3 487	(2 973)	(3 462)	3 505	356	(507)	357	150	(1 002)
31-60 days	326	2 207	(2 544)	33	336	336	336	0	0	31-60 days	163	376	(3)	(210)	243	0	0	0	0
61-90 days	110	183	367	30	63	399	399	9 259	8 894	61-90 days	(326)	(81)	2 951	(2 577)	33	0	0	0	0
91-180 days	0	110	(73)	0	183	183	183	213	246	91-180 days	1 296	(73)	(184)	337	(33)	0	0	30	33
181-365 days	20 150	20 150	20 110	20 110	20 110	14 330	14 330	14 330	14 330	181-365 days	40	(110)	183	(73)	(183)	0	0	(30)	(33)
1 year +	20 150	20 150	20 110	20 110	20 110	14 330	14 330	14 330	14 330	1 year +	(40)	0	40	0	0	0	5 780	0	0
Total	20 726	23 751	22 426	24 705	29 581	36 562	30 426	30 276	24 722	Total	4 517	(3 025)	1 325	(2 279)	(4 876)	(6 981)	6 136	150	5 804

Self payer	(2 574)	399	3 861	356	0	507	150	0	1 002	Self payer	3 487	(2 973)	(3 462)	3 505	356	(507)	357	150	(1 002)
Within maturity (0-30 days)	406	30	33	243	0	0	0	0	0	Within maturity (0-30 days)	163	376	(3)	(210)	243	0	0	0	0
31-60 days	326	407	(2 544)	33	0	0	0	0	0	31-60 days	(326)	(81)	2 951	(2 577)	33	0	0	0	0
61-90 days	110	183	367	30	63	399	399	33	8 894	61-90 days	1 296	(73)	(184)	337	(33)	0	0	30	33
91-180 days	0	110	(73)	0	183	183	183	213	246	91-180 days	40	(110)	183	(73)	(183)	0	0	(30)	(33)
181-365 days	571	571	531	531	531	150	150	150	150	181-365 days	(40)	0	40	0	0	0	381	0	0
1 year +	(1 161)	1 700	2 175	1 193	777	1 284	546	396	1 398	1 year +	4 620	(2 861)	(475)	982	416	(507)	738	150	(1 002)
Total	0	672	0	3 597	8 553	6 474	6 474	6 474	0	Total	405	(672)	672	(3 597)	(4 956)	2 079	0	0	6 474

Top Up	508	0	672	336	336	8 553	8 554	0	0	Top Up	(508)	508	(672)	336	0	(8 217)	(1)	8 554	0
Within maturity (0-30 days)	0	0	0	0	336	336	336	0	0	Within maturity (0-30 days)	0	0	0	0	(336)	0	(0)	336	0
31-60 days	0	0	0	0	0	336	336	0	0	31-60 days	0	0	0	0	0	(336)	(0)	8 890	332
61-90 days	0	0	0	0	0	336	336	9 226	8 894	61-90 days	0	0	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0	14 180	91-180 days	0	0	0	0	0	0	5 399	0	0
181-365 days	19 579	19 579	19 579	19 579	19 579	14 180	14 180	14 180	14 180	181-365 days	(103)	(164)	0	(3 261)	(5 292)	(6 474)	5 398	0	6 806
1 year +	20 087	20 251	20 251	23 512	28 804	35 278	29 880	29 880	23 074	1 year +	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	Total	(103)	(164)	0	(3 261)	(5 292)	(6 474)	5 398	0	6 806

Overseas (Note Charges in Respect of Overseas Patients Only)

Within maturity (0-30 days)	1 800	0	0	0	0	0	0	0	0	Within maturity (0-30 days)	0	0	0	0	0	0	0	0	0
31-60 days	0	1 800	0	0	0	0	0	0	0	31-60 days	0	0	0	0	0	0	0	0	0
61-90 days	0	0	0	0	0	0	0	0	0	61-90 days	0	0	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0	0	91-180 days	0	0	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0	0	181-365 days	0	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0	0	1 year +	0	0	0	0	0	0	0	0	0
Total	1 800	1 800	0	0	0	0	0	0	0	Total	0	0	0	0	0	0	0	0	0

VALUE OF DEBT RAISED ON A ROLLING 12 MONTHS

ADJUSTMENT OF IDENTIFIED UNALLOCATED

TOTAL DEBT PER MONTH ADJUSTED

DAYS SALES OUTSTANDING

Key Performance Indicator	mai-25	jun-25	jul-25	aug-25	sep-25	okt-25	nov-25	des-25	jan-26
Days Sales Outstanding	90	117	103	141	82	108	73	63	88
Debts % by Customer and by Age	31.05.2025	30.06.2025	31.07.2025	31.08.2025	30.09.2025	31.10.2025	30.11.2025	31.12.2025	31.01.2026
% Debts Payable by Insurance Companies	96,7%	97,3%	96,6%	97,6%	95,0%	95,2%	94,3%	92,9%	94,9%
% Debts Not Payable by Insurance Companies	3,3%	2,7%	3,4%	2,4%	5,0%	4,8%	5,7%	7,1%	5,1%
% Debts aged 90 days or less	21,9%	46,3%	26,8%	57,3%	25,1%	44,2%	22,1%	0,5%	16,2%
% Debts aged 91 days or more	78,1%	53,7%	73,2%	42,7%	74,9%	55,8%	77,9%	99,5%	83,8%

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)

Debts recovered in month compared with total debt end of month

31.05.2025	30.06.2025	31.07.2025	31.08.2025	30.09.2025	31.10.2025	30.11.2025	31.12.2025	31.01.2026
56,7%	14,9%	47,7%	16,3%	78,9%	11,0%	58,1%	27,5%	2,1%
31.05.2025	30.06.2025	31.07.2025	31.08.2025	30.09.2025	31.10.2025	31.10.2025	31.10.2025	31.10.2025
361 517	(329 335)	255 738	(424 635)	517 433	(242 273)	184 103	64 286	(47 790)
(33 366)	65 188	(42 793)	24 568	(87 930)	107 802	16 594	8 059	(18 304)
(14 476)	(638)	11 826	(14 167)	15 322	(55 775)	19 764	43 119	(9 362)
2 061	9 229	(6 500)	20 743	(13 727)	13 493	1 958	(26 775)	19 277
1 656	4 135	(10 441)	135	20 336	(331)	1 198	16 199	(753)
2 728	13 605	(2 343)	24 888	(6 510)	135	8 911	(60)	6 193
320 120	(237 816)	205 487	(368 468)	444 924	(176 949)	232 527	104 828	(50 739)

355 825	(325 690)	258 528	(424 543)	522 033	(243 845)	183 746	64 136	(53 262)
(31 221)	62 504	(42 118)	24 442	(88 173)	116 019	16 595	(495)	(18 304)
(14 150)	1 243	7 075	(11 590)	15 625	(55 775)	19 764	42 783	(9 362)
765	9 302	(6 316)	20 406	(13 694)	13 829	1 958	(17 915)	18 912
1 616	4 245	(10 624)	208	20 519	(331)	1 198	16 229	(720)
2 768	13 605	(2 383)	24 888	(6 510)	135	3 131	(60)	6 193
315 603	(234 791)	204 162	(366 189)	449 800	(169 968)	226 391	104 678	(56 543)

5 692	(3 645)	(2 790)	(92)	(4 600)	1 572	357	150	5 472
(2 145)	2 684	(675)	126	243	(8 217)	(1)	8 554	0
(326)	(1 881)	4 751	(2 577)	(303)	0	(0)	336	0
1 296	(73)	(184)	337	(33)	(336)	0	(8 860)	365
40	(110)	183	(73)	(183)	0	0	(30)	(33)
(40)	0	40	0	0	0	5 780	0	0
4 517	(3 025)	1 325	(2 279)	(4 876)	(6 981)	6 136	150	5 804

3 487	(2 973)	(3 462)	3 505	356	(507)	357	150	(1 002)
163	376	(3)	(210)	243	0	0	0	0
(326)	(81)	2 951	(2 577)	33	0	0	0	0
1 296	(73)	(184)	337	(33)	0	0	30	33
40	(110)	183	(73)	(183)	0	0	(30)	(33)
(40)	0	40	0	0	0	381	0	0
4 620	(2 861)	(475)	982	416	(507)	738	150	(1 002)

AUDIT COMMITTEE

Private Patient Service Improvement Group Highlight Report

DATE OF MEETING	3rd March 2026	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	DAVID OSBORNE, HEAD OF FINANCE BUSINESS DEVELOPMENT	
PRESENTED BY	DAVID OSBORNE, HEAD OF FINANCE BUSINESS DEVELOPMENT	
EXECUTIVE SPONSOR APPROVED	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board

VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is for the Audit Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting, last held on 15th September 2025. Action Plan updated for latest status.
- **NOTE** the amended Private Patient Improvement Plan action completion dates.
- **NOTE** the continuance of Liaison Financial Services external expert support with a reduced scope of work to progress the areas identified for them in the improvement plan until the conclusion of planned activities.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHP and Health Science was asked to provide Executive leadership to the Group and take on the role as Senior Responsible Officer (SRO). The role was accepted on the provision that appropriate delivery support would be allocated as identified by the SRO.

It was agreed that the Audit Committee would have oversight of the Finance and Commercial actions in the improvement plan and the Quality, Safety & Performance Committee oversight of all other actions in the improvement plan.

3. PRIVATE PATIENT IMPROVEMENT PLAN

The Private Patient Improvement Plan has been continuously reviewed by the Private Patient Improvement Group with extended deadlines given to a number of outstanding actions as listed within the Highlight Report, with updates regularly provided to the Audit Committee.

The repeated extensions to deadlines reflect a period of procurement renewal for the external specialist provider (Liaison) under a revised scope of work and ongoing activities both internally in respect of establishing a Clinical Advisory Group (CAG) and external negotiations with Insurers.

4. HIGHLIGHT REPORT

The following are highlights from the meeting.

ALERT / ESCALATE	There are no items for alert / escalation
ADVISE	<u>External Specialist PP Support</u> Liaison re-commenced work on improvement plan actions mid-February '25. Improvement Plan Actions: The Commercial & Financial actions in progress are: <u>Strategic Business Management</u> ➤ PP17 In Progress: Renegotiate the contracts with insurers – • Ongoing negotiation of insurer contracts: ○ Internal review of tariffs concluded with revised price list issued to Insurers advising on rates applicable from 1st July 2025. ○ Challenges and queries for new service lines received and reviewed during the last quarter, resulting in a revised tariff scheduled being issued for effect from 1st November 2025.

	○ Negotiations continue with each of the insurer contracts to reach agreement of final tariff listing. ○ Final tariff listing nearing conclusion, with 2 of 5 in agreement (with exception of 1 tariff which is ongoing). ○ Price lists may evolve contingent on continued negotiations. ○ Billing is up to date. ○ Target remains for conclusion by the end of the financial year, with the tariff to be updated for inflation each year, for the next 3 years. Target Date completion: 31/03/2026 • Recovery of outstanding debts from Insurers remains part of contract re-negotiation, with a focus on the significant liability for one insurer. • Private Patient Service Medical Professional Liability and Public Liability (MPL) Insurance procurement is in progress utilising the Insurance Brokers Framework led by Procurement– Target date for insurance commencement 31/03/26 (Previously reported date: 31/12/2025) ➤ PP18 In progress: Develop a new process to produce estimates with prescribed recharge to consultants for PP support costs which ensures the Trust complies with the Unfair Trading Practices Act • The proposed prices developed by Liaison for negotiation with Insurers have been reviewed by the finance team and finance Service Improvement & Costing Accountant. The consequent Price List is being continuously reviewed to reflect live negotiations with insurers. Date for completion: 31/03/26 ➤ PP20 In Progress: Develop new professional fee arrangements which provide consistency across disciplines • proposed new professional fee arrangements that are consistent across disciplines have been developed, requiring the CAG and associated clinical leadership to agree process of debt risk share. These terms are reflected in the Private Patient Consultant Agreement, reviewed by

CAG and awaiting formal ratification. **Revised Target Date: 31/03/2026** (Previously reported date: 31/12/2025)

Commercial

- PP22 In Progress: Develop a new charge capture process and procedure and billing methodology and implement reflecting the new pricing structure.
 - Application of the new prices commenced 1st July, with a further iteration commencing 1st November, for agreed contracts with remainder awaiting contract negotiations to be completed with Insurers.
 - Several actions to automate the billing process have been identified. There is no capacity within the digital team for these actions to be progressed. Digital Team to provide alternative options to resource the actions. **Revised Target Date: 31/03/2026** (Previously reported date: 31/10/2025)
 - New version of Healthcode to Healthcode Plus / Professional that enables automation of billing process is in operation with implementation being supported by Digital Team.

Operational

- PP10 In Progress: Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, therapies, psychology etc)
 - CNS support in place via MDTs for all PP clinics. Therapies input requirement is under service improvement review. **Revised Target Date: 31/03/2026** (Previously reported date: 31/12/2025).
- PP41 In Progress: Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk
 - The Trust view is the credit risk from non-payment should be

	shared between the Trust and clinicians. These terms are reflected in the Private Patient Consultant Agreement, reviewed by CAG and awaiting formal ratification. Revised Target Date: 31/03/2026 (Previously reported date: 31/12/2025) ➤ PP43 Paused: Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service initial review of the Sciensus contract was undertaken, but due to priority implement the two pharmacy reviews as part of the SACT service improvement work the commencement of the full review and option appraisal has been suspended and will commence in 25/26 Financial Year to align with new HCaH procurement and review of service specification of need. Target Date review start: 31/03/2026 (Previously reported date: 31/10/2025) <u>Completed Actions</u> It is important to note that whilst there are a few actions outstanding the improvement Group has completed 38 actions to date (1 further action closed since the last reporting period).
ASSURE	<u>PP8 Closed: Establishment of a Clinical Advisory Group (CAG)</u> CAG Group established and meeting monthly. The Private Patient Consultant Agreement has been reviewed at CAG and awaiting formal sign off, the Agreement outlines responsibility and governance obligations for private patient activities. This agreement will enable the following actions to be progressed and closed: - realignment of payment arrangements for consultant fees to ensure the credit risk from non-payment is shared between the Trust and clinicians [PP41] - new professional fees set at commercial levels which provide consistency across disciplines. This will continue to evolve

	influenced by commercial negotiations and CAG led consistency [PP18 & PP20]
INFORM	<u>Aged Debt at 03/03/26</u> key things to note: (i) Days of sales outstanding KPI is being achieved in 67% of the last 6 months. (ii) The months where DSO was greater than 100 days is due to a significant level of debt raised in the month, for example the August DSO was 141 days due to the raising of £0.54m invoices in month, compared to £0.16m average of the remaining 5 months. The DSO recovered to within KPI target in the subsequent month. (iii) There are no further unapplied/ unidentified receipts relating to private patients older than 180 days as of October 2025. (iv) In the last 6 months, aged debt greater than 91 days has largely stagnated, ongoing contract discussions with the largest Insurer includes discussion of recovery of the most significant aged debt (approx. £321k) which will largely address the position with a consequent reduction in the KPIs. (v) Work continues with Digital Services to review ways of working and suggest potential improvements to the billing process. (vi) Audit Committee will continue to have oversight of the Finance and Commercial actions in the improvement plan and the Quality, Safety & Performance Committee will have oversight of all the actions in the improvement plan. <u>Additional Income</u> The Trust is benefitting from additional income of c£550k p.a. comprised of £160k recovery of Pathology and Allied Health Professional service costs, with £390k in relation to improved data capture to ensure all activity is charged. The additional income through wider Insurance contract negotiations are presently being assessed, but an indicative £150k p.a. value has been planned.

Improvement Plan - Private Patient Service			
Date Updated: 02/12/2025			
Ref No.	Status	Date	Recommendation/Issue to be addressed
STRATEGIC BUSINESS MANAGEMENT			
PP17	IN PROGRESS	28.01.22	Renegotiate the contracts with large insurers.
PP18	IN PROGRESS	28.01.22	Develop a new process to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.
PP20	IN PROGRESS	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.
COMMERCIAL			
PP22	IN PROGRESS	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.
OPERATIONAL			
PP10	IN PROGRESS	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)

Improvement Plan - Private Patient Service			
Date Updated: 02/12/2025			
Ref No.	Status	Date	Recommendation/Issue to be addressed
PP41	IN PROGRESS	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.
PP43	PAUSED	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.

Action Progress	Action Owner	Target Date	Revised Target Date	RAG
12/03/25 - Meeting has taken place with Liaison to discuss the recommended tariffs compared to NHS tariffs. Liaison has recommended that self payer rates to be used for negotiations with insurers at this stage. Follow up meeting to finalise tariffs on 24.03.25 with a view that negotiations then to commence before the end of the month. Where insurers disagree with the proposed tariffs we then cost by exception which will align to principle that we cannot subsidise this activity. 27.08.2025 - Preparatory work for negotiation of insurer contracts: Review concluded on current contract prices and price list issued to Insurers advising on rates applicable from 1st July 2025 for all except 2 Insurers with whom contract negotiations are underway for 1 and meetings being scheduled for Sept 2025 with largest Insurer. Price lists may evolve contingent on continued negotiations. Ensured billing is up to date. Negotiated & renewed contracts with insurers for pathology and diagnostic testing to charge for these costs separately, which continues to yield income. Recovery of outstanding debts from Insurers to be part of the contract re-negotiation, largely focused with largest Insurer in Sept 2025. Private Patient Service Medical Professional Liability and Public Liability (MPL) Insurance procurement is in progress using the Insurance Brokers Framework. Renewed Procurement Forms have been received and are in process of completion – Target date for insurance commencement 31/10/25 Liaison has commenced Insurer contract negotiations from 31/03/2025 via renewed price listing commenced July 1st 2025, with further dialogue scheduled for largest insurer in Sept 2025. Revised Target Date completion: 31/10/2025 (Previously reported date: 31/06/2025) 02/12/25. Ongoing negotiation of insurer contracts: oInternal review of tariffs concluded with revised price list issued to Insurers advising on rates applicable from 1st July 2025. oChallenges and queries for new service lines received and reviewed during the last quarter, resulting in a revised tariff scheduled being issued for effect from 1st November 2025. oNegotiations continue with each of the insurer contracts to reach agreement of final tariff listing. oPrice lists may evolve contingent on continued negotiations. oBilling is up to date. •Recovery of outstanding debts from Insurers remains part of contract re-negotiation, with a focus on the significant liability for one insurer. •Private Patient Service Medical Professional Liability and Public Liability (MPL) Insurance procurement is in progress utilising the Insurance Brokers Framework led by Procurement– Target date for insurance commencement 31/12/25 (Previously reported date: 31/10/2025) •Negotiations with all insurers are active, with tariffs evolving and addition of new service line. Negotiations are taking longer than targeted conclusion, resulting in an extended deadline. Revised Target Date completion: 31/03/2026 (Previously reported date: 31/10/2025)	Executive Director of Finance / External Provider	30.09.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/03/2026	
05/11/2024 - AGP/ AA to review the charging basis and component elements with PP team - pathology charges, outpatient revenue capture to ensure full cost + profit recovery. Meeting with Liaison 3rd December 24 to determine the basis for their recommendations 19.12.24 As above. Contracts to be signed by both parties prior to any further engagement. Work to commence in the new year by costing team. 31.01.25 Contracts signed early January and costing team continue to progress the costing work - AA to develop action plan to engage with service leads and confirm ETA for completion of costing work. 12.03.25 - Expected that contract negotiations (including debt recovery) to commence before the end of March 2025 27.08.2025 - The proposed prices developed by Liaison for negotiation with Insurers have been reviewed by the finance team and finance Service Improvement & Costing Accountant. The consequent Price List has been issued to Insurers, with resultant negotiations underway. Revised Date for completion: 31/10/25 (Previously reported date: 12/03/2025) 02/12/25 The proposed prices developed by Liaison for negotiation with Insurers have been reviewed by the finance team and finance Service Improvement & Costing Accountant. The consequent Price List is being continuously reviewed to reflect live negotiations with insurers. Revised Date for completion: 31/03/26 (Previously reported date: 31/10/2025)	External provider/Finance	31.05.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/03/2026	
31.01.25 - Contract signed early January and costing team continue to progress the costing work - AA to develop action plan to engage with service leads and confirm ETA for completion of costing work. 12.03.25 - as per PP17 27.08.2025 - Proposed new professional fee arrangements that are consistent across disciplines have been developed, requiring the CAG and associated clinical leadership to agree process of debt risk share. Inaugural CAG held with emphasis of Terms of Reference, discussion to be scheduled for informing policy and process to be adopted. Revised Target Date: 31/10/2025 (Previously reported date: 30/06/2025) 02.12.25 Proposed new professional fee arrangements that are consistent across disciplines have been developed, requiring the CAG and associated clinical leadership to agree process of debt risk share. These terms are reflected in the Private Patient Consultant Agreement, reviewed by CAG and awaiting formal ratification. Revised Target Date: 31/12/2025 (Previously reported date: 31/10/2025) 03.03.26 - Agreement awaiting formal ratification by Divisional Director	External provider/Finance Team/Head of Planning, Performance and Operational Services.	31.07.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/12/2025 31/03/2026	
03/02/35 - DMH back and has emailed to confirm this will be picked up as a priority 12/03/25 - Question as to where this work will sit when DMH leave post. No update for the meeting. 27.08.2025 - Application of the new prices commenced 1st July for agreed contracts with remainder awaiting contract negotiations to be completed with Insurers. Several actions to automate the billing process have been identified. There is no capacity within the digital team for these actions to be progressed. Digital Team to provide alternative options to resource the actions. Revised Target Date: 31/10/2025 (Previously reported date: 30/06/2025) Order complete for new version of Healthcode to Healthcode Plus / Professional that enables automation of billing process. Digital Team to support implementation. 02.12.25 Application of the new prices commenced 1st July, with a further iteration commencing 1st November, for agreed contracts with remainder awaiting contract negotiations to be completed with Insurers. Several actions to automate the billing process have been identified. There is no capacity within the digital team for these actions to be progressed. Digital Team to provide alternative options to resource the actions. Revised Target Date: 31/03/2026 (Previously reported date: 31/10/2025 New version of Healthcode to Healthcode Plus / Professional that enables automation of billing process is in operation with implementation being supported by Digital Team.	Private Patients Service Lead/ Finance	31.07.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/03/2026	
27.08.2025 - CNS support in place via MDTs for all PP clinics. Therapies input requirement is under service improvement review. Revised Target Date: 31/10/2025 (Previously reported date: 30/06/2025). 02.12.25 CNS support in place via MDTs for all PP clinics. Therapies input requirement is under service improvement review. Revised Target Date: 31/12/2025 (Previously reported date: 31/10/2025). 03.03.226 - PP Action Plan Group has not met since that the last Audit Committee - updated sought on resolution	Private Patients Service Lead	30.06.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/12/2025 31/03/2026	

Action Progress	Action Owner	Target Date	Revised Target Date	RAG
19/12/24 - Paper to be taken to the Clinical Advisory Group in January 2025 03.02.25 - First meeting of CAG likely to be March 2025 (Date TBC). Paper to be drafted and shared with the group. Liaison asked to inform this piece of work 12.03.25 - Discussion taken place with Liaison to determine options available to manage the credit risk bourne by the Trust. Included within the scope of Liaison work is: - Negotiate with Trust consultants through Clinical Advisory Group:realignment of payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians [PP41] - new professional fees set at commercial levels which provide consistency across disciplines [PP18 & PP20] 27.08.2025 - The Trust view is the credit risk from non-payment should be shared between the Trust and clinicians. A paper setting out this mechanism is in development for discussion with CAG. Revised Target Date: 31/10/2025 (Previously reported date: 30/06/2025 02.12.25 •The Trust view is the credit risk from non-payment should be shared between the Trust and clinicians. These terms are reflected in the Private Patient Consultant Agreement, reviewed by CAG and awaiting formal ratification. Revised Target Date: 31/12/2025 (Previously reported date: 31/10/2025) ~~03.03.26 - Agreement awaiting formal ratification by Divisional Director~~ On hold until 01/04/2025 - to be brought to RH attention prior to this.	Finance	30.05.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/12/2025 31/03/2026	As per PP20
27.08.2025 - Initial review of the Sciensus contract was undertaken, but due to priority implement the two pharmacy reviews as part of the SACT service improvement work the commencement of the full review and option appraisal has been suspended and will commence in 25/26 Financial Year to align with new HCaH procurement and review of service specification of need. Target Date review start: 31/10/2025 03.03.26 - Agreement awaiting formal ratification by Divisional Director 02.12.25 Initial review of the Sciensus contract was undertaken, but due to priority implement the two pharmacy reviews as part of the SACT service improvement work the commencement of the full review and option appraisal has been suspended and will commence in 25/26 Financial Year to align with new HCaH procurement and review of service specification of need. Target Date review start: 31/03/2026 (Previously reported date: 31/10/2025)	Cancer Centre Director	31.07.2022	31/01/2024 31/06/2024 31/08/2024 31/11/2024 31/01/2025 28/02/2025 30/06/2025 31/10/2025 31/03/2026	

Outcome		Evidence for Closure	
		Private DHCR - Phase 1 Benefits Realisation v.0.8.docx Delivery Technical Element FETF Update. 2024.docx	
		Evidence needed	

Outcome	Evidence for Closure

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

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

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY
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

AUDIT COMMITTEE

LOSSES & SPECIAL PAYMENTS REPORT 2025/2026

DATE OF MEETING	03/03/2026
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	Tracy Hughes, Head of Financial Services & Accounting
PRESENTED BY	Angela Evans, Financial Accountant
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide the Audit Committee with an update in relation to losses written-off and special payments made during the period 1 st November 2025 to the 31 st January 2026, along with the 2025/2026 year to date position - in accordance with Standing Financial Instructions (SFIs), Chapter 17.2 Losses and Special Payments and the NHS Wales Manual for Accounts (MfA) Chapter 6.



RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE the information provided in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

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

APPENDICES	
Appendix 1	Bad Debt Write-offs 01/11/2025 – 31/01/2026
Appendix 2	NWSSP Losses & Special Payments 1/4/25-31/9/25 (Q1 & Q2)

1. SITUATION / BACKGROUND

- 1.1 The purpose of this report is to provide the Audit Committee with an update in relation to losses written off and special payments made during the period 1st November 2025 to the 31st January 2026, along with the 2025/2026 year to date position, in accordance with Standing Financial Instructions (SFIs) Chapter 17.2 Losses and Special Payments and the NHS Wales Manual for Accounts (MfA) Chapter 6.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Debt Write-offs

- 2.1 Write-off of the debts summarised in the following table have all been authorised in line with the Scheme of Delegation within the Trust's Standing Orders & Standing Financial Instructions. A more detailed breakdown is provided in Appendix 1.
- 2.2 During the period 1st November 2025 to 31st January 2026, debt write-offs totalled £8,681.08:

Summary	Trust £	NWSSP £	Total £
Salary Overpayments	780.93	280.74	1,061.67
Trade & Commercial	0	30.00	30.00
Private Patients	7,589.41	0	7,589.41
Total	8,370.34	310.74	8,681.08

- 2.3 Of the £1,061.67 relating to salary overpayments, 3 cases totalling £986.87 were referred to the debt collection agency after all internal recovery efforts had been exhausted. Based on the agency's advice, this amount has been written off as all pre-legal collection efforts have been exhausted, and further recovery is uneconomical. Three cases totalling £74.80 were not referred, as the amounts were too small to justify recovery costs, and have also been written off.
- 2.4 The trade & commercial write-offs of £30 relate to exchange rate differences. Exchange rate differences are not written off in the same sense as bad debts; they represent accounting adjustments for currency fluctuations and are recognised as gains or losses in the Statement of Comprehensive Income in accordance with IFRS and NHS Wales accounting policies. Where a small residual balance remains outstanding on an invoice due to exchange rate movement and cannot be recovered, it is written off as uneconomical to pursue.

- 2.5 Private Patient debts totalling £7,589.41 were written off due to the conclusion of a review of individual private patient debtor accounts. This review comprised of tracking services received, invoices raised, and payments received by individual patient accounts. Whilst the majority of debt owed to the Trust had been appropriately raised and received, mismatches in invoicing resulting from errors in historic administrative practices have necessitated the write-off of historic imbalances of debt owed. It is deemed inappropriate to chase debt owed by patients which have subsequently deceased or go back several financial years which could be distressing to patients and families or are lower than £10 as processing requirements would be in excess of any amount recovered. Debts owed by insurance companies, even where aged greater than 6 months remain liable and are being challenged alongside contract renewal discussions.
- 2.6 The total amount of debt written-off to date in this financial year is £18,923.61.
- 2.7 The debts identified in this report were included in the 2024/2025 provision for expected credit losses and therefore will not result in an additional charge to the Trust's Income & Expenditure statement for 2025/2026.
- 2.8 The age range of the debts written-off during this period is between the years 2018 – 2025.

Ex gratia payments

- 2.9 No further ex gratia payments have been made in the period 1st November 2025 to 31st January 2026.
- 2.10 As previously reported, in May 2025, one payment of £84,844.02 was made by the core Trust under the Voluntary Early Release Scheme (VERS) which was approved by both Welsh Government and the Remuneration & Terms of Service Committee.

NHS Wales Shared Services Partnership (NWSSP)

- 2.11 NWSSP report their losses written off and special payments made to the VUNHST Audit Committee for NWSSP bi-annually, so the figures for the period 1st October 2025 to 31st March 2026 (Q3 & Q4) will be reported in April 2026.

- 2.12 NWSSP losses written off and special payments made during the period 1st April 2025 to 30th September 2025 (Q1 & Q2) were reported to the December 2025 Audit Committee meeting. These amounted to £631,179 and consisted of stock write-offs £147,925 and special payments £483,254. A more detailed breakdown is provided in Appendix 2.
- 2.13 The £483,254 of special payments includes £219,315 relating to COT3 settlements for staff employed under the Single Lead Employer model. These costs have been fully recharged to the host Health Boards where the trainees worked. It has been agreed with Audit Wales, the Welsh Government Financial Control & Governance team and the relevant Health Board that these special payments should be recognised in the accounts of the host Health Boards. To ensure full transparency, the Trust will include a narrative disclosure explaining this accounting treatment.



3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
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) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

<i>For more information:</i> https://www.gov.wales/socio-economic-duty-overview	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Choose an item
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Audit Committee are informed that during the period 1st November 2025 to 31st January 2026 there have been debt write-offs totalling £8,681.08. The total losses and special payments recorded for 2025/2026 to date include: • Debt write-offs £18,923.61 • Ex gratia payment (VERS) £84,844.02 • NWSSP stock write-offs £147,925 • NWSSP Special Payments £483,254
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL/_layouts/15/Tranet/SitePages/E.aspx	Not required - please outline why this is not required
	Not required for L&SP reports
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.



4. 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?	No
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1 : BAD DEBT WRITE-OFFS: 1ST November 2025 – 31ST January 2026

Date	Account No.	Invoice date	Amount of Write off	Nature of Debt	Reason for Write off	Trust or NWSSP
20/11/2025	394565	26/09/2019	£270.84	Salary Overpayment	Debt collection agency advised uneconomical to pursue further	NWSSP
20/11/2025	429727	09/02/2022	£370.14	Salary Overpayment	Debt collection agency advised uneconomical to pursue further	Trust
20/11/2025	432169	28/03/2023	£345.89	Salary Overpayment	Debt collection agency advised uneconomical to pursue further	Trust
20/11/2025	899926	13/01/2025	£42.36	Salary Overpayment	Unable to contact individual to collect and uneconomical to send to debt collection due to value of debt	Trust
20/11/2025	1050990	27/07/2025	£15.00	Commercial	Exchange rate difference - uneconomical to pursue	NWSSP
20/11/2025	1050990	31/07/2025	£15.00	Commercial	Exchange rate difference - uneconomical to pursue	NWSSP
20/11/2025	912079	13/01/2025	£9.90	Salary Overpayment	Unable to contact individual to collect and uneconomical to send to debt collection due to value of debt	NWSSP
20/11/2025	864876	16/09/2024	£22.54	Salary Overpayment	Unable to contact individual to collect and uneconomical to send to debt collection due to value of debt	Trust
20/11/2025	410878	15/10/2022	£1,426.40	PP - self payer	Patient Top-Up - RIP	Trust
20/11/2025	410878	29/10/2022	£2,463.80	PP - self payer	Patient Top-Up - RIP	Trust
20/11/2025	727872	26/06/2024	£100.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	401758	16/06/2020	£231.27	PP - self payer	Patient RIP	Trust
20/11/2025	450611	30/08/2022	£73.00	PP - self payer	Patient RIP	Trust
20/11/2025	409038	24/08/2021	£753.97	PP - self payer	Patient Top-Up - RIP	Trust
20/11/2025	409038	14/09/2021	£753.97	PP - self payer	Patient Top-Up - RIP	Trust
20/11/2025	1077369	27/12/2018	£197.00	PP - Insured	Outside statutory limit of 6 years for debt collection	Trust
20/11/2025	340510	04/06/2019	£250.00	PP - Insured	Outside statutory limit of 6 years for debt collection	Trust
20/11/2025	509881	30/01/2024	£31.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	509881	30/01/2024	£169.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	409586	27/10/2021	£150.00	PP - self payer	Patient RIP	Trust
20/11/2025	782819	03/06/2024	£100.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	365012	09/07/2020	£120.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	365012	25/06/2020	£120.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	365012	27/08/2020	£120.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	389538	29/07/2021	£430.00	PP - Insured	Patient excess - RIP	Trust
20/11/2025	389538	29/07/2022	£100.00	PP - Insured	Patient excess - RIP	Trust
			£8,681.08			

APPENDIX 2: NWSSP Losses & Special Payments 1/4/25-31/9/25 (Q1 & Q2)

On the 7/11/2025, the VUNHST Audit Committee for NWSSP noted the following losses written off and special payments made during the period 1st April 2025 to 30th September 2025:

	Q1 £	Q2 £	Total £
(a) Stores - stock cycle count adjustments	5,500	20,282	25,782
(b) Stores - slow moving/obsolescent stock losses	55,549	64,726	120,275
(c) Stores - damaged stock	316	116	432
(d) Stores - inter stores deliveries	0	112	112
(e) Pharmacy stock waste	268	1,056	1,324
(f) Special payments	483,254	0	483,254
(g) Other	0	0	0
TOTAL	544,887	86,292	631,179

In relation to the year-to-date losses reported, key points to note are:

1. There are circa 1,350 stock lines cycle counted each quarter. The stock lines are sampled automatically and randomly by the stock management system, and the value of adjustments each quarter will differ depending on the lines sampled. There were no individual stock lines that required a cycle count adjustment in excess of £5k during the period.
2. All the £120,275 of slow moving/obsolescent stock losses were covered by existing provisions so there is no in year charge to the income & expenditure account in 2025/26. There were five stock lines with cumulative write off values during the period in excess of £5,000 (£47,664 in total for the 5 lines). The finance team have reviewed these and have not identified any issues or concerns. There were no individual stock lines with a write off value in excess of £50,000.
3. The £483,254 of special payments relate to four payments and one provision agreed under COT3 agreements which are legally binding once terms are submitted to ACAS.

The four payments made total £474,004 and relate to COT3 settlements reached in advance of employment tribunal proceedings for two cases filed for

disability discrimination, one for injury to feelings and one for unlawful deduction of wages.

Two of these cases with a combined settlement value of £219,315 relate to Single Lead Employee trainees and the losses were recharged to the host NHS Organisations.

The other two losses totalling £183,689 were the responsibility of NWSSP and both were fully provided for in the 2024/25 accounts so there is no charge to income and expenditure in the 2025/26 financial year.

As required in Chapter 6 of the Manual for Accounts, Annex 3 templates have been completed and Welsh Government have noted these payments as approval is not required given the payments are legally binding under COT3 agreements. The four payments that have been made to date in 2025/26 were reported to the Velindre University NHS Trust Remuneration Committee in July 2025.

One case for less than £10k can only be recognised as a provision for a loss as the settlement agreement noted that these costs are only payable upon the provision of evidence of the expenditure being incurred. We are in negotiations with the relevant health bodies regarding the apportionment of the liability for these costs. Losses would only normally be reported to Audit Committee when they have been incurred but given the COT3 agreement this is now formally being noted in advance of any payments being made.

4. There are no items with any value noted as 'other', however 81 boxes of out-of-date gowns were donated to Ukraine for training exercises. These had previously been written off and reported as a loss so there is no financial implication of this donation.

AUDIT COMMITTEE

TECHNICAL UPDATE

DATE OF MEETING	03/03/2026
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	Tracy Hughes, Head of Financial Services & Accounting
PRESENTED BY	Angela Evans, Financial Accountant
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide the Audit Committee with an update in relation to technical issues which may impact on the Trust's Financial Statements.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to NOTE the information provided in this report.
GOVERNANCE ROUTE	

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	

7 LEVELS OF ASSURANCE
N/A

APPENDICES
N/A

1. SITUATION / BACKGROUND

- 1.1 The purpose of this report is to provide the Audit Committee with an update in relation to technical issues which may impact on the Trust's Financial Statements.

2.0 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

IFRS 17 Insurance Contracts

- 2.1 IFRS 17 became effective on 1 April 2025, requiring full retrospective application. The standard sets out the principles for the recognition, measurement, presentation, and disclosure of insurance contracts, ensuring users of financial statements can understand their impact on the financial position, performance, and cash flows. Importantly, IFRS 17 applies to contracts, not organisations—any agreement meeting the definition of an insurance contract falls within its scope.
- 2.2 The Welsh Government Financial Control & Governance team (WG) has advised that NHS Wales bodies, including the Welsh Risk Pool, are unlikely to issue insurance contracts. However, each body is required to confirm compliance on an annual basis.
- 2.3 For the 2024/2025 accounts, all NHS Wales bodies reported that their review of income contracts confirmed that no insurance contracts were identified as falling within the scope of IFRS17.

- 2.4 For the 2025/2026 accounts, the Finance Leads across the Trust are currently undertaking the annual reassessment of any new income contracts against the IFRS 17 criteria. The Financial Services and Accounting team will consolidate the outcomes and provide updated confirmation to WG and Audit Wales. A final position will be reported to the Audit Committee, once the review is complete.

Administrative Duty - External Financial Limit (EFL)

- 2.5 The EFL is an Administrative Duty placed on NHS Wales Trusts to control net cash flows. Its purpose is to regulate how much cash a Trust can either:
- draw from external sources or use from its own cash reserves (a positive EFL), or
 - repay to external sources or increase its cash reserves (a negative EFL).
- 2.6 Since 2019/2020, the requirement to achieve the administrative EFL target has been suspended by WG. For 2025/26, WG has confirmed that the EFL reporting requirement will be removed and the NHS Wales Manual for Accounts (MFA) will be updated accordingly.

Remuneration Report – Senior Managers' Disclosures

- 2.7 In accordance with the requirements of the MFA, the Remuneration Report must include detailed disclosures on the salary and pension arrangements of the Trust's senior management team. These disclosures form part of the Accountability Report and are subject to external audit.
- 2.8 The 2025/2026 draft MFA, introduces a new requirement for the Remuneration Report to also include senior managers' disclosures for *"hosted bodies with a designated Accountable Officer, currently NHS Wales Shared Services Partnership (NWSSP) and NHS Wales Joint Commissioning Committee"*.
- 2.9 NWSSP has reviewed its senior management structure and developed a rationale for determining which individuals fall within scope. This approach aligns with the MFA definition:

"Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence

the decisions of the entity as a whole rather than the decisions of individual directorates or departments.”

- 2.10 The proposed list of NWSSP senior managers has been reviewed and agreed by the Trust's Director of Finance and subsequently endorsed by Audit Wales and the Welsh Government Financial Control & Governance team.
- 2.11 To ensure clarity and transparency, the NWSSP Senior Managers' Disclosures will be presented as a distinct section within the Remuneration Report, clearly identified as relating to the hosted body rather than the Trust, as the statutory body. This separation will ensure that both sets of disclosures meet the MFA requirements and can be audited appropriately.
- 2.12 NWSSP will take primary responsibility for producing its senior managers' disclosures and will work collaboratively with the Trust's Head of Financial Services & Accounting to ensure alignment and timely completion.

Remuneration Relationship

- 2.13 In previous years, the Trust has disclosed the relationship between the remuneration of the Chief Executive and the 25th percentile, median, and 75th percentile remuneration of the Trust's workforce, inclusive of all hosted services. This disclosure has been prepared in line with the requirements set out in the MFA.
- 2.14 At the All-Wales Technical Accounting Group (Remuneration) meeting held on 11 February 2026, WG confirmed a new requirement for the 2025/26 financial year. The Trust must now produce two separate remuneration relationship notes:
 - A note for the core Trust, setting out the relationship between the Chief Executive's remuneration and the 25th percentile, median and 75th percentile remuneration of the Trust's workforce; and
 - A separate note for NWSSP, setting out the relationship between the remuneration of NWSSP Managing Director and the equivalent 25th percentile, median and 75th percentile remuneration of the NWSSP workforce.
- 2.15 This expanded reporting requirement reflects the Trust's role as host for NWSSP and is intended to enhance transparency and comparability across NHS Wales organisations. The MFA will be updated to incorporate this amendment, and the Financial Services & Accounting team will ensure that both required notes are included within the 2025/26 Annual Accounts.

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
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	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required



TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL/_layouts/15/Default.aspx	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

2 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?	No

All risks must be evidenced and consistent with those recorded in Datix	

AUDIT COMMITTEE	
REVIEW OF THE STANDARDS OF BEHAVIOUR POLICY (GC03)	
DATE OF MEETING	03/03/2026
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	Kay Barry, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to update the Executive Management Board (EMB) following the review of GC03 The Standards of Good Behaviour Policy.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to APPROVE the revisions to GC03 The Standards of Behaviour Policy and its change of name to the Standards of Good Governance and Probity (in Public Services Roles) Policy.
GOVERNANCE ROUTE – N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1	GC03 Standards of Good Governance and Probity (in Public Services Roles) Policy
Appendix 2	Equality Integrated Impact Assessment

1. SITUATION / BACKGROUND

- 1.1 The purpose of this Policy is to set out the Velindre University NHS Trust (Trust) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all Employees and Independent Board Members are supported in delivering that requirement. The term “Employees” includes all those who have a contract of employment or honorary contract with the Trust.
- 1.2 This Policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations and Programmes, which are NWSSP, HTW and ATW.
- 1.3. A review of the existing Policy and Equality Impact Assessment has been undertaken and the key changes to the Policy are outlined in Section 2.

2. ASSESSMENT

- 2.1 A summary of the key changes following an NHS Wales Benchmarking Exercise are outlined below:

In response to the review the following amendments have been made and highlighted in the revised Policy (**Appendix 1**):

- The policy has been retitled from ‘Standards of Behaviour Policy’ to ‘Standards of Good Governance and Probity (in Public Service Roles) Policy’, so it more clearly describes the nature of the policy.
- References to the policy title updated throughout the document.
- Updated and corrected any defective hyperlinks throughout the document.
- Section 2.1 Public Service Values – first sentence of the second paragraph – addition of the words ‘and personal’.
- Updated Trust Organisational Values.
- Section 3 Scope – inclusion of Hosted Organisations and Programmes in the scope of the Policy, which are NWSSP, HTW and ATW.
- Section 6.1: The word ‘Chairman’ amended to ‘Chair’ and the addition of three bullet points setting out the key responsibilities.
- Section 6.3: Director of Corporate Governance: Second main bullet point – Arrangements to prompt for completion of Declarations of Interest Forms clarified with four additional sub-bullets.
- Section 6.6: Employees, Independent Members and Volunteers:
 - Fourth main bullet point, second sub-bullet point – the nominal amount in the second sentence reduced from £50,000 to £5,000 to align with other NHS Wales organisations.
 - Seventh main bullet point – the addition of obtaining permission from Line Manager approval as well as Director **prior to** accepting.
 - Additional bullet as a reminder to refer to appropriate Professional Codes of Conduct and relevant documents issued by Welsh Government.
 - Emphasis on where there is any doubt.

- Section 6.7 Procurement Department: Paragraph 8 updated to signpost to email NWSSP Procurement Services.
- Section 7 Register of Interests: Replacement of hyperlink with the addition of contact email for any enquiries.
- Section 9 Gifts, Hospitality, Honoraria and Sponsorship: Bribery Act 2010 emphasised as a separate sub-heading.
- Addition of Section 9.6 Gifts by Way of Inducement or Reward to specifically emphasis the Prevention of Corruption Acts, 1906 and 1916.
- Section 30 and 31 merged and title changed from 'Sources' and 'References' to Legislative and NHS Requirements'.
- Section 32 Acknowledgements renumbered to Section 31.
- New Section 32 'Further Information'.

3. SUMMARY OF MATTERS FOR CONSIDERATION

- 3.1 The Audit Committee is asked to **APPROVE** the revisions to GC03 The Standards of Behaviour Policy and its change of name to the Standards of Good Governance and Probity (in Public Services Roles) Policy.

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)	10 - Governance
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 ☒

QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	There are no specific implications related to the activity outlined in this report
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Yes - please outline what, if any, actions were taken as a result GC03 Standards of Good Governance and Probity (in Public Services Roles) Policy has an associated EQIA attached as Appendix 2.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Ref: GC 03

STANDARDS OF GOOD GOVERNANCE AND PROBITY (IN PUBLIC SERVICE ROLES) POLICY

Executive Sponsor & Function	Director of Corporate Governance Governance
Document Author:	Head of Corporate Governance
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	October 2025
Equality Impact Assessment Outcome:	Approved
Review Date:	October 2028
Version:	4

CONTENTS

1.	Policy Statement	3
2.	Introduction	3
3.	Scope	5
4.	Aim	5
5.	Objectives	6
6.	Responsibilities	6
7.	Register of Interests	11
8.	Declaration of Interests at Meetings	11
9.	Gifts, Hospitality, Honoraria and Sponsorship	12
10.	Hospitality	16
11.	Sponsorship	19
12.	Honoraria	23
13.	Use of the Trust Branding	25
14.	Research & Development	25
15.	Charitable Funds	25
16.	Secondary Employment & Private Practice	25
17.	Rewards for Initiatives	27
18.	Social Networking Sites	28
19.	Time Keeping	30
20.	Electoral Campaigns	30
21.	Failure to adhere to the Standards of Good Governance and Probity Policy	31
22.	Equality	32
23.	Resources	32
24.	Training	33
25.	Implementation	33
26.	Publication of Registers	33
27.	Audit and Monitoring	34
28.	Distribution	34
29.	Confidentiality	34
30.	Legislative and NHS Requirements	35
31.	Acknowledgements	35
32.	Further Information	35
	Appendix 1 – Standards of Good Governance and Probity Summary	36
	Appendix 2 – Gifts, Hospitality, Honoraria & Sponsorship Form	39
	Appendix 3 – Declarations of Interest Form	42
	Appendix 4 – Tax and NICs Declaration Statement	46

1. POLICY STATEMENT

The Trust is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering that requirement/aim.

2. INTRODUCTION

2.1 Public Service Values

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

“Public service values and associated behaviours are and must be at the heart of the NHS in Wales”

The Board is strongly committed to the Trust being value-driven, rooted in “Nolan” principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Trust is committed to ensuring that all employees and Independent Members practice the highest standards of corporate **and personal** conduct and behaviour, based on the recognition that the needs of service users must come first. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering that requirement.

The “Seven Principles of Public Life” (the “Nolan Principles”), form the basis of the Trust’s Standards of Behaviour requirements for its employees and Independent Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;

- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
- **Leadership** – Individuals should promote and support these principles by leadership and example.

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 reinforce the seven principles of public life and focus on the crucial public service values which must underpin the work of the health service; these are available via the following link: <https://www.gov.wales/codes-conduct-and-accountability-nhs-boards-and-code-conduct-nhs-managers-directions-2006-2006-no>

In support of these principles, employees and Independent Members must be impartial and honest in the way that they go about their day to day functions. They must remain beyond suspicion at all times. They can achieve the seven principles of public life by:

- Ensuring that the interests of service users remain paramount;
- Being impartial and honest in the conduct of their official business;
- Using public funds to the best advantage of the service and the service users, always seeking to ensure value for money;
- Not abusing their official position for personal gain or to benefit family or friends;
- Not seeking advantage or to further private business or other interests in the course of their official duties; and
- Not seeking or knowingly accepting preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Trust.

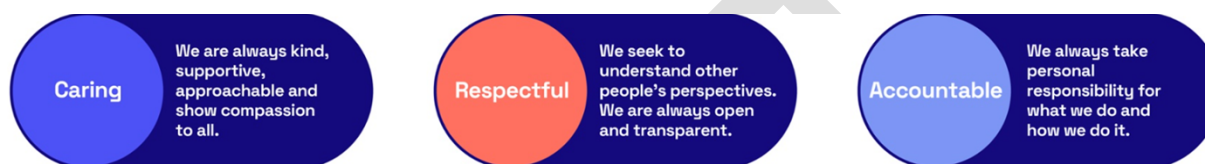
This policy re-states and builds on the provisions of Section 8 Values and Standards of Behaviour of the Trust Standing Orders. It re-emphasises the commitment of the Trust to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Trust, and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made. The policy is supported by a short guide on the Standards of Good Governance and Probity Framework (see Appendix 1) that provides a summary of expected conduct.

There are also a number of Professional Codes of Conduct which complement this policy. These are as follows:

- Nursing and Midwifery Council: <https://www.nmc.org.uk/standards/code/>
- Health and Care Professions Council: <http://www.hcpc-uk.co.uk/>
- NHS Consultants and General Practitioners: <https://www.gmc-uk.org/about/how-we-work/governance/council/code-of-conduct>

Trust Organisational Values

The Trust has also developed its own values and behaviour framework:



These values were updated and approved in March 2024 and were developed through a process of wide-ranging consultations with staff and members of the public. Our values are a mix of continuity and change, reflecting our commitment to delivering and developing our services.

3. SCOPE

This policy is applicable across the whole of the Trust in all locations. It applies to all employees and Independent Board Members. The term “employees” includes all those who have a contract of employment or honorary contract with the Trust.

Any reference in this Policy to the Trust should also be applied to any organisations or programmes that the Trust hosts such as the NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and Advanced Therapies Wales (ATW).

The policy also applies to Trustees of Velindre University NHS Trust Charity and any activities arising from fundraising activity.

4. AIM

The Trust is committed to ensuring that all employees and Independent Members practice the highest standards of corporate and personal conduct and behaviour, based on the recognition that the needs of service users must come first.

The aim of this policy is to ensure that arrangements are in place to support employees and Independent Members to act in a manner that upholds the Good Governance and Probity Framework, as well as setting out the arrangements in place to manage declarations of interests, gifts, hospitality, honoraria and sponsorship, through the

standard forms in place; these are accessible via the Governance and Communications policy intranet page via the following link:

https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx

The policy also aims to capture public acceptability of behaviours of those working in the public sector in order that the Trust can be seen to have exemplary practice in this regard.

5. OBJECTIVES

The objective of this policy is to clarify the relative responsibilities of employees and Independent Members in the discharging of this policy and adhering to the Standards of Good Governance and Probity Framework.

The policy is designed to assist the Trust and its employees and Independent Members in maintaining ethical standards in the conduct of NHS business. It sets out the principles the Trust expects all employees to uphold, and the steps which the Trust as an employer will take to safeguard the organisation where conflicts of interest arise.

A conflict of interest can be defined as 'A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.'

A conflict of interest may be:

- **actual** - a material conflict between one or more interests
- **potential/perceived** – the possibility of a material conflict between one or more interests in the future

All employees are expected to be familiar with the content of this policy, and line managers have a responsibility for bringing the policy to the attention of their staff.

6. RESPONSIBILITIES

6.1 Chair

The Chair has the responsibility for performance managing the Independent Members of the Trust through the annual individual performance review process on behalf of the Cabinet Secretary for Health and Social Services, and also has the responsibility for holding the Chief Executive to account.

The Chair should;

- Ensure that Independent Members are aware of the requirements contained within this policy.

- Lead by example and ensure they personally declare any relevant interest or the offer of gifts, hospitality, honoraria or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality, honoraria or sponsorship that have been offered to Independent Members **PRIOR** to the event.

6.2 Chief Executive

The Chief Executive is the 'Accountable Officer' with overall responsibility for ensuring that the Trust operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

6.3 Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that the Trust is provided with competent advice and support regarding the contents and application of this policy and the Standards of Good Governance and Probity Framework.

The Director of Corporate Governance will ensure that:

- A Register of Interests is established and maintained as a formal record of interests declared by employees and Independent Members. The Register will include details of directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS, and membership of professional committees and third sector bodies. Where relevant, it will also include details of interests of close family members (spouse, partner, civil partner, children, etc.).
- Arrangements are in place to prompt specific groups of employees and Independent Members to complete a Declaration of Interest Form on initial employment with the Trust, and at periodic intervals thereafter as follows:
 - **Board Members and Board Level Directors** – Annually on 31st March.
 - **Directors, Deputy Directors, Associate Directors and Assistant Directors** – Annually in the first quarter of the financial year for the forthcoming financial period.
 - **Hosted Organisations Directors and Programme Managers** – Annually on 31st March.
 - **Budget Holders** – Annually in the first quarter of the financial year for the forthcoming financial period.

Note: It is the individual employee's or Independent Member's responsibility to make a declaration should their circumstances change within these timescales.

- Scrutiny is applied to the declaration forms received to ensure appropriate declarations and acceptances have been made in compliance with the Standards of Good Governance and Probity Policy.

- A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained.
- The Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship are published on the Trust's internet site in accordance with the requirements of the organisation's Freedom of Information Act Publication Scheme.
- Reports detailing the content of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship, and the effectiveness and adequacy of the arrangements in place, are provided as a regular agenda item to the Audit Committee.
- The forms that employees and Independent Members should complete when making a declaration of interest or when advising of gifts, hospitality, honoraria or sponsorship accepted or declined, are available on the Trust's intranet site and attached at Appendices 2 and 3.

6.4 Executive / Divisional Directors

Executive / Divisional Directors have overall responsibility for their areas and must ensure that:

- Employees are aware of the requirements contained within this policy and the Standards of Good Governance and Probity Framework.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality, honoraria or sponsorship.
- Approve, or decline the acceptance of gifts, hospitality, honoraria and sponsorship that have been offered within their functions / Divisions **prior** to the event (and during periods of annual leave and prolonged absence, ensure that their responsibilities are delegated to their nominated deputy).
- They review the contents of the Registers of Interests and Gifts, Hospitality, Honoraria and Sponsorship to assist with the verification of the accuracy of the information contained within it when alerted to do so by the Director of Corporate Governance.
- They ensure any acceptances of gifts, hospitality, honoraria or sponsorship complies with the standards outlined within this policy.

6.5 Departmental / Line Managers

Departmental / Line Managers will:

- Ensure that this policy and the Standards of Good Governance and Probity Framework is brought to the attention of employees for whom they are responsible, and that they are aware of its implications for their work.
- Ensure that employees are aware of the requirement to follow and comply with the policy and Standards of Good Governance and Probity Framework, through discussions at Performance Appraisal Development Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews, as appropriate.

- Support their employees in the application of the policy and the Standards of Good Governance and Probity Framework, seeking advice from the Director of Corporate Governance, where necessary.

6.6 Employees, Independent Members and Volunteers

All employees, including those on Honorary Contracts, and Independent Members must ensure that they:

- Understand this policy and the Standards of Good Governance and Probity Framework, consulting their line manager if they require clarification.
- Are not in a position where their private interests and NHS duties may conflict. Employees and Independent Members must declare all private interests which could potentially result in personal gain as a consequence of their position within the Trust.
- Declare to the Trust for recording in the Register of Interests any relevant interests
 - At the commencement and conclusion of employment;
 - Whenever a new interest arises;
 - If asked to do so at periodic intervals by the Trust.
- Relevant interests (including those of close family members or associates) may include:
 - Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs), with the exception of dormant companies;
 - Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less;
 - A personal or departmental interest in any part of the pharmaceutical/ healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team;
 - Sponsorship or funding from a known NHS supplier or associated company/ subsidiary;
 - A position of authority in a charity or voluntary body in the field of health and social care;
 - Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests;
 - Self-employment or employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of agency working and private practice.
 - Research funding/grants that may be received by an individual or their department.

- Inform service users and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a service user. The fact that the service user has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and Committee meetings, during procurement processes, and at other Divisional / Departmental meetings, as appropriate.
- Obtain permission from **their Line Manager and** Executive / Divisional Director **prior to** accepting a gift, hospitality, honoraria or sponsorship which requires declaring and recording in the Register of Gifts, Hospitality, Honoraria and Sponsorship.
- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Trust.
- Where employees or Independent Members wish to engage in any outside employment which may affect their contractual obligation to the Trust, they must first discuss it with their Departmental / Line Manager. This will ensure that their position in the Trust is not compromised. Agreement to such outside employment will not be unreasonably refused.
- **NOTE: Employees should also refer to appropriate Professional Codes of Conduct and relevant documents issued by the Welsh Government which will complement this Policy and the Standards of Good Governance and Probity Framework.**

It is the responsibility of all employees and Independent Members to ensure they are not placed in a position that risks, or appears to risk conflict between their private interest and the NHS. This responsibility applies to all Trust staff, including those who commit resources directly by ordering goods or services, and those who do so indirectly.

The onus regarding declaration will reside with the individual employee or Independent Member. It is recognised that a judgement may be required in individual circumstances regarding the appropriateness for a declaration to be made when, for example, there is a specific contractual situation, a set of circumstances, or series of specific circumstances or a close connection. Advice should be sought from the Director of Corporate Governance in this regard as such an interest may be deemed to be a potential conflict to the business of the Trust.

Where there is doubt, a declaration of interest should be made.

Appointing officers, for example, must declare any known relationship with potential applicants, and where a relationship is declared, the appointing officer must not be involved in any decisions relating to financial aspects of the individual's offer of

employment. On an ongoing basis, there should not be any involvement in any other financial decisions relating to the individual to whom the manager has declared any relationship. This shall include salaries, re-grading, authorisation of travelling expenses, overtime payments, etc.

It is also important that all volunteers adhere to Trust policies and procedures, and this Standards of Good Governance and Probity Policy is consistent with the Wales Council for Voluntary Action Code of Practice for organisations involving volunteers.

6.7 Procurement Department

Where an employee is requested to participate in the Trust's procurement process and has not previously completed a Declaration of Interest Form, they will be asked to do so prior to participating, or asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared.

The Procurement Lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest.

The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise the Trust, through the Director of Corporate Governance, of any such interests impacting on Trust services.

Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of the Trust, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff, for example, NHS staff benefits schemes.

All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of the Trust.

Senior managers should ensure that no special favour is shown to current or former staff or their close relatives or associates in awarding contracts to private or other businesses operated by them or employing them in a senior or relevant managerial capacity.

Contracts may be awarded to such businesses where they are won in fair competition against other tenderers, but care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

For further information in respect of procurement related declarations of interest and the relevant forms to complete please contact NHS Wales Shared Services Partnership – Procurement Services by emailing: ProcurementServicesenquiries@wales.nhs.uk

7. REGISTER OF INTERESTS

The Head of Corporate Governance, on behalf of the Director of Corporate Governance, will maintain the Registers of Board Members and Staffs Interests. Appropriate information from these Registers will be made available on the Trust's website.

A copy of the registers, together with the forms which are used to inform their content, will be retained by the Corporate Governance Department.

Any enquiries should be made to VUNHST.CorporateGovernance@wales.nhs.uk

8. DECLARATIONS OF INTEREST AT MEETINGS

It is a requirement that at the beginning of every Trust Board, Committee or decision making meeting, members and those in attendance are invited to declare their interests in relation to any items on the agenda.

Where a potential conflict is material or the individual has a financial/pecuniary interest in the matter under discussion, the individual shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action taken to avoid it will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict, the individual must declare their interest immediately.

Under certain circumstances, the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance should always be sought prior to such a decision being made.

From time to time, employees and Independent Members may need to declare interests at other NHS organisations or partnership meetings. Such declarations will be recorded as if it were a Trust Board or Committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

The Register of Interests for Independent Members and Executive Directors will be made available at every Board Meeting.

9. GIFTS, HOSPITALITY, HONORARIA AND SPONSORSHIP

Employees and Independent Members have a personal responsibility to volunteer

information regarding offers of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined.

Employees should seek approval from their Line Manager and relevant Executive/ Divisional Director, prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) and submitted to the Director of Corporate Governance for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality, honoraria or sponsorship should be accepted, the following principles should be considered:

- **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it;
- **Legitimate interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust i.e. further the aims of the organisation;
- **Relationship:** Consideration should be given as to whether the Trust is likely to enter into a contractual relationship with the organisation/individual making the offer;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation;
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct;
- **Reputation:** If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such it should always be declined.

Bribery Act 2010

Employees must be impartial and honest in the conduct of business and remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to accept a bribe in his or her official capacity, or to corruptly show favour or disfavour in the handling of contracts or other business. Employees need to be aware that a breach of the provisions of this Bribery Act may render them liable to prosecution and disciplinary action.

The Bribery Act introduced a new criminal offence in 2011 where an individual or organisation offers or receives a bribe to bring about or reward the improper performance of a function or activity. Broadly, the Act defines bribery as 'Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.'

Bribery has the potential to impact upon an employees' or Independent Members' standard of behaviour, particularly in regard to the acceptance of gifts, hospitality, honoraria or sponsorship, although guidance on the Act indicates that only 'lavish' hospitality, or hospitality that is otherwise 'inappropriate' would normally fall under the bribery definition.

The Bribery Act also introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. This is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

However, an organisation can avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The provisions within this Standards of Good Governance and Probity Policy in terms of prohibiting the giving or acceptance of inappropriate gifts, hospitality, honoraria and sponsorship complies with the requirements of the Bribery Act and subsequent guidance.

Employees and Independent Members are therefore expected to:

- Report any issues relating to fraud, bribery or corruption to the Local Counter Fraud Specialist within the Trust;
- Declare any external interest which may result in the employee or persons known to the employee gaining direct or indirect financial advantage as a consequence of their work, which could influence any decisions made by the employee, or which could interfere with contractual obligations to the organisation;
- Ensure the interests of patients are paramount and that use, or management of any public funds ensures value for money;
- Check each payslip as soon as possible following receipt to ensure that the amount paid is correct, with any queries raised with the line manager. If the employee believes that they have been overpaid, they must declare it without delay. Where employees do not understand their payslip, they should contact the Payroll Department.

The risks of breaching the Bribery Act include the following:

- Criminal justice sanctions against Board Members, Directors and other senior staff;
- Damage to the organisation's reputation;
- Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts;
- Potential diversion and/or loss of resources;
- Unforeseen and unbudgeted costs of investigations and/or defence of any legal action; and
- Negative impact on patient/stakeholder perceptions.

Guidance regarding the types of gifts, hospitality, honoraria and sponsorship which may or may not be acceptable is provided below:

9.1 Gifts

A gift is an item of personal value, given by a third party e.g. a patient, donor or a supplier. The definition includes prizes in draws and raffles at sponsored events/conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Trust. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted.

The appropriate Executive / Divisional Director and the Director of Corporate Governance should be advised immediately.

Any acceptance of a gift needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of a gift will not be misconstrued.

This Standards of Good Governance and Probity Policy excludes gifts between members of staff, for example birthday presents or leaving gifts.

9.2 Gifts from Service Users or their relatives

Gifts up to the value of £25 may be accepted from service users and relatives as a mark of their appreciation e.g. for the care that has been provided. This can include gift vouchers/ cards, chocolate, flowers, cards. A common sense approach should be applied to the valuing of gifts using an actual amount if known, or an estimate that any reasonable person would make as to its value.

There is no requirement to declare such gifts up to this value, other than where several small gifts are received to the value of £25 from the same or closely related source in a 12 month period. Where gifts are provided to a group of staff, it is the responsibility of the Line Manager to declare the gift if over the value of £25.

Where a gift is offered that is likely to be over £25 in value it should be politely declined. In some cases the gift may have already been made and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) declaring that the gift has been received must be completed.

Personal gifts of cash from service users or their relatives is **not** acceptable. These may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

The Trust's Charity Director / Head of Fundraising can provide advice regarding the mechanism for appropriately receipting such items in accordance with the Institute of Fundraising Code.

9.3 Gifts from Suppliers, Contractors and Commercial Organisations

Low cost branded or promotional gifts may be accepted where they are under the value of the common industry standard of **£6 in total** (selected with reference to existing industry guidance issued by the ABPI) and need not be declared. Any gifts outside this definition from suppliers, contractors and other commercial organisations doing business or likely to do business with the Trust above this value, should be politely but firmly declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined, a Gifts, Hospitality, Honoraria and Sponsorship Form (Appendix 2) should be completed to allow the Trust to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances, suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas or chocolates at Easter. Whilst such practices should be discouraged and whilst it is not acceptable for staff to personally accept these gifts, following discussion with the supplier/contractor/commercial organisation and the appropriate Executive / Divisional Director, it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds. The Trust's Charity Director and/or Head of Fundraising can provide advice regarding the mechanism for appropriately receipting such items.

Employees in contact with contractors should be on their guard against offers of gifts which might later be misconstrued as hampering their strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Director of Corporate Governance, where appropriate.

9.4 Gifts from Dignitaries/Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it 'culturally custom and practice' to exchange gifts. In such cases, employees should seek guidance from the Director of Corporate Governance and declare these gifts on a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2). A decision will then jointly be made as to the most appropriate way to manage the gift. This will depend on the nature of the 'gift culture' and may include decisions to 'keep and display in public', 'donate to an internal user group', 'auction for charity', etc.

9.5 Bequests / Legacies / Wills

Employees are not permitted to accept bequests left to them by a deceased patient who became known to them through providing care or treatment as part of their Trust employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an employee is made aware that they may be a beneficiary in a patient's will, they must declare this, with any complex cases escalated to the Director of Corporate Governance.

9.6 Gifts by way of Inducement or Reward

The Prevention of Corruption Acts, 1906 and 1916, prohibit staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

- Doing or refraining from doing anything in their official capacity; or
- Showing favour or disfavour to any person in their official capacity.

A breach of the provisions of these Acts renders staff liable not only to dismissal but to prosecution under the Acts, and it is expected that the Trust would deal severely with any such breaches.

Staff should be aware that the Trust is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Director of Corporate Governance.

10. HOSPITALITY

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours e.g. attendance at an awards ceremony, cheque presentations in respect of fundraising events.

Employees and Independent Members should refuse hospitality which may compromise or may be seen to compromise their professional judgement or integrity, or which seeks to exert influence to obtain a preferential consideration.

Employees in contact with contractors should be particularly mindful of accepting any offer of hospitality that might later be misconstrued as impacting on strict independence and impartiality. Where pressed to accept an offer, the employee to whom the offer has been made should seek further advice from their manager who may contact the Director of Corporate Governance, where appropriate.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality will not be misconstrued.

Hospitality must be authorised by their Line Manager and Executive / Divisional Director **prior to** their acceptance and a Gifts, Hospitality, Sponsorship and Honoraria form (Appendix 2) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of members of staff to achieve the purpose of representing the organisation should attend.

Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need authorisation from their Line Manager and Executive / Divisional Director, and should only be accepted in exceptional circumstances, and must be declared.

For example, employees may receive an offer of payment for their travel and accommodation, when invited to speak at an event or attend a meeting. Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared on a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 4). However, where business class or first class travel and accommodation (including domestic travel) or offers of foreign travel and accommodation are offered, a clear reason should be recorded on the declaration form as to why it is deemed permissible to accept travel and accommodation of this type.

10.1 Acceptable Hospitality

Employees and Independent Members may accept the occasional offer of hospitality, provided that it is 'modest and proportionate' and similar in scale to that offered by the

NHS. For example, acceptance of food and non-alcoholic refreshments during the working day will generally be deemed acceptable and need not be declared.

Hospitality must be secondary to the purpose of a meeting. The level of hospitality offered must be appropriate and not out of proportion to the occasion; and the costs involved must not exceed the level which the recipients would normally adopt when paying for themselves, or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting.

Other hospitality may be accepted where it furthers the aims of the Trust, provided it is normal and reasonable in the circumstances, for example lunches in the course of working visits. Where the value is estimated to be over £25, a declaration should be made.

Other hospitality that may be accepted but will need to be declared includes instances where:

- There is a genuine need to impart information, or represent the organisation at stakeholder community events e.g. Local Authority or charitable organisations which have an association with the Trust;
- An employee has been invited to receive an award or prize in connection with the work of the organisation, or their role within it;
- An employee is invited to a Society or Institute dinner or function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Trust.
- An event is clearly part of the life of the stakeholder community or where the organisation should be seen to be represented;
- A function or event is hosted for both staff and non-staff, which adds benefit and value to the Trust or the wider NHS;
- A function or event is hosted externally for staff only for the purposes of training or organisational development.

These types of hospitality **must be authorised** by their Line Manager and Executive / Divisional Director **prior to** their acceptance and a Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of employees to achieve the purpose of representing the Trust should attend.

10.2 Unacceptable Hospitality

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend/overnight break;
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below);
- Use of a company flat or hotel suite;
- Attendance at a function or event restricted to employees which is not for the purposes of training or organisational development;

- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event;
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories, advice should be sought from their line manager or the Director of Corporate Governance.

Employees should report any case where they have felt pressurised into accepting an offer of hospitality which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

11. SPONSORSHIP

Sponsorship is an offer of funding to an individual, team or to the Trust from an external source, whether in cash, goods, services or benefits.

Sponsorship is sometimes provided by organisations to allow employees to attend conferences. It may also include sponsorship of posts and research and development.

Employees may be offered sponsorship in the form of sponsored research, including publishing, an operational post, training, and costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

No sponsorship should be accepted **without the prior agreement** of the Line Manager and Executive / Divisional Director. A Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 2) should be completed **prior to** the acceptance of any sponsorship. If sponsorship is inappropriately offered and/or declined, this should also be declared. In cases of doubt, advice from the Director of Corporate Governance or the Director of Corporate Governance should be sought.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.

Some health related companies provide commercial sponsorship to the NHS, including sponsoring equipment, employees and training events. In accordance with the All Wales Code of Conduct (Business) for NHS staff, all employees must consider fully the implications of a proposed sponsorship deal before entering into any arrangement. Only very senior managers with the necessary authority can sign up to, or enter into, any advertising contract or agreement with a company or its representatives. Employees must not allow unauthorised advertising on Trust premises or documentation.

More detail is provided below regarding the many forms that sponsorship may take. This list is not exhaustive and offers of other sponsorship will need to be considered on a case by case basis.

11.1 Commercial Sponsorship for Attendance at Courses/Conferences

Employees may accept sponsorship for attendance at relevant conferences and courses, but only where attendance would further the aims of the Trust and where the employee has obtained permission in advance from their Line Manager and Executive / Divisional Director and in line with the Trust's Study Leave Policy. The sponsorship should only be extended to the number of employees who would have normally attended if funded by the Trust. The employee, Line Manager and the Executive / Divisional Director must be satisfied that acceptance will not compromise purchasing or any future decision-making in any way.

11.2 Commercial Sponsorship to attend Demonstrations/Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the Trust will normally meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

Arrangements whereby the company meets all or part of the cost of such a visit must be approved by their Line Manager and Executive / Divisional Director following consideration of the implications for the integrity of subsequent purchasing decisions.

11.3 Commercial Sponsorship – 'Linked Deals'

Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for the Trust. The Trust will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Trust.

Linked deals must be approved and managed within an agreed process in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may 'linked deals' be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

11.4 Sponsored Posts

Sponsored posts are posts that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the

deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive/ Divisional Director.
- Rolling sponsorship of posts should be avoided unless appropriate checks are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Executive / Divisional Director should declare any posts sponsored by external organisations on a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 2) and submit it to the Director of Corporate Governance for recording on the register.

11.5 Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings, conferences or an activity in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link: <https://www.abpi.org.uk/reputation/abpi-2024-code-of-practice/>

An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

Where the Trust receives or invites offers of sponsorship for events which are hosted wholly or partly by the Trust, the relevant Executive / Divisional Director must consider whether it is appropriate to accept the offer. For all offers, whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form (see Appendix 2) must be completed and sent to the Director of Corporate Governance.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for the Trust and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and consistent manner with opportunities being offered as widely as possible;
- Benefits should be for the Trust (not an individual) and should be proportionate;
- Arrangements must not compromise the reputation of the Trust;
- Sponsorship should be for a specific activity or event and not a general endorsement of the Trust;
- The sponsorship must not imply the Trust endorses particular products, services or companies and organisations;
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices;
- Any arrangements which could bring adverse publicity to the event or the Trust.

Particular care should be taken when considering sponsorship from companies or organisation for which the Trust has, or could have, contractual business arrangements.

The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit which may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile;
- To improve public/community relations;
- To generate public exposure and media coverage;
- To differentiate the company from its competitors;
- To increase profit/market share.

Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in-keeping with the principles listed above.

Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party. Caution should be exercised in these circumstances as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement.

The Trust may also receive unsolicited proposals for sponsorship which is not in response to any action that the Trust has taken. The Trust should carefully consider such offers and ensure that the proposal meets the Trust's requirements, standards and principals. The Trust will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest.

All sponsorship arrangements should be approved by the appropriate Executive / Divisional Director as appropriate.

12. HONORARIA

An honorarium is an ex gratia payment i.e. one which would not usually be expected to be provided.

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one off payment or honoraria is offered.

If this activity is to be undertaken during hours when the employee is contracted to work for the Trust, the payment should be made to the Trust. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Honoraria and

Sponsorship Form (see Appendix 2) and it should be authorised by the appropriate Executive / Divisional Director.

NOTE: There are tax and national insurance contribution implications relating to honoraria that should be borne in mind as set out below:

- **Honoraria received for work undertaken during Trust hours** - when appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Trust hours, any honoraria paid must be received back to the Trust's revenue budget to reimburse the Trust for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is **not** managed by the employee who has provided their services during Health Board time.

To avoid personal tax implications, the employee is strongly advised to request the honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of employee time, and not honoraria. This money will then be transferred into the Trust's revenue budget. The employee who has undertaken the work must **not** be the budget holder for the budget receiving the funds in lieu of the honorarium to avoid any conflict of interest.

Where the employee receives the honoraria directly and then reimburses the Trust, the employee remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the final destination of the honoraria.

- **Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)** - individuals are personally liable for the payment of both tax and NICs on any honoraria payments received for work undertaken in their own time. Following their first receipt of honoraria in this instance employees will be asked to sign the declaration statement that will be held on file by the Director of Corporate Governance which confirms they understand their responsibilities regarding Tax and NICs. (See Appendix 4).

Where an employee wishes, a donation may be made to the Trust's Charitable Funds in lieu of an honoraria. This must be received into the Charity's general fund and it is then for the Charity's Trustees to determine how the donated funds should be used, with the principle being that the employee giving their own time should have no influence over how the donation is then used in order to lessen the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, employees should seek advice from the Director of Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection.

Instances where honoraria has been offered and declined should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form (see Appendix 2).

13. USE OF THE TRUST BRANDING

Permission needs to be obtained from the Assistant Director of Communications & Engagement on all occasions where approaches are made by an outside organisation seeking to use the Trust's branding in connection with an event or function. Permission should also be sought by any member of staff wishing to use the logo in connection with any non-Trust related matter/event.

14. RESEARCH, DEVELOPMENT AND INNOVATION

All research, development and innovation activity sponsored by commercial companies, including those sponsored by the pharmaceutical industry, must be approved by the appropriate mechanism, and governed by the specific policies and procedures.

The Research, Development and Innovation leads, along with Corporate Governance should be contacted in these circumstances to offer advice and support in this area.

15. CHARITABLE FUNDS

There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way of funding attendances at courses or conferences. Monies paid into charitable funds from commercial companies must only be accepted as donations or for sponsorship. Where sponsorship is received, it should only be used to fund expenditure which is in line with the terms of the charitable fund's use. Such sponsorship should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form (see Appendix 4).

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy, however there may be a close association. Further guidance is available from the Trust's Charity Director.

16. SECONDARY EMPLOYMENT & PRIVATE PRACTICE

16.1 Secondary Employment (Paid, Unpaid or Self-Employed)

Employees should inform their line manager of any secondary employment and ensure that this does not affect their Trust employment. Declarations should be made using the Staff Declaration of Interests Form (see Appendix 3). There should be no conflict with their normal contractual employment obligations to the Trust, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with the Trust.

Where employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Trust. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the Trust fulfils its statutory requirement of the Working Time Directive; this is available via the following link.

<http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm>

An employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department.

16.2 Private Practice

There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicates that no employee of the Trust should work in a way detrimental to their health and performance.

Failure to notify their line manager of secondary employment and/or private practice may invoke the Trust's Disciplinary Policy.

For medical staff, the amendment to the consultant contract in Wales clarifies the relationship between NHS work, private work and fee-paying work, in that it sets out that an NHS consultant's first responsibility is to the NHS. Participation in private medical services or fee-paying services should not result in detriment to NHS patients or services or diminish the public resources available for the NHS.

Employees should:

- Seek prior approval before taking up private practice.

- Declare what they practice (name of private facility); what they practice (specialty, major procedures); when they practice (identified sessions/time commitment).
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.

17. REWARDS FOR INITIATIVE

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the Trust receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into or before work is commissioned or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain reward for their efforts, and the Trust should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the Trust should obtain a fair reward for the input its employees provide. If such an exercise involves additional work for an employee outside that paid for by the Trust under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with Trust is the property of the Trust and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights, is involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the Trust is aware of this in order to manage it appropriately.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from Trust before entering into any agreement with bodies regarding product development, research, work on pathways, etc., where this impacts on the organisations own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.

Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

Advice on Intellectual Property and copyright is available from the Trust Research & Development Manager and Trust Intellectual Property Policy.

18. SOCIAL NETWORKING SITES

All employees must uphold the reputation of the Trust, and their professional body where appropriate, at all times. This means that conduct online and conduct outside of work should be judged in the same way, and should be of a similar high standard.

The All Wales Social Media Policy (GC19), accessible via the Governance and Communications policy intranet page via the following link:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx sets out employee's responsibilities when using social media, and the implications involved. The term social media is used in reference to all Internet social networking and media sharing sites, such as Facebook, Twitter, YouTube, Snapchat, Instagram, Flickr etc., and to all 'blogs', 'chat', on-line commentaries, diaries, discussion forums, 'wikis' and sites allowing the posting of user generated content for mass consumption.

The policy is not intended to stop the use of social media, indeed the Trust itself uses social networks to engage with patients, service users, staff and other stakeholders to deliver key messages, but rather to outline areas of best practice and illustrate where problems can arise for individuals and NHS Wales. It applies to the use of social media for business and personal purposes, both at work and outside of the work environment.

The Trust acknowledges that everyone has a right to express themselves using social media but also recognises its role in offering advice on the safe use of social media and

highlighting the responsibility of employees to be aware of the potential consequences of posting content on to publicly accessible platforms. The blurring of boundaries between an individual's private and professional life on social media is recognised and it is important that employees understand and are mindful that inappropriate use could damage both their and NHS Wales' reputation.

In terms of the business use of social media, local restrictions are in place to ensure that only those employees having a genuine business need are given access to organisational social media pages and can issue corporate or organisational statements and update content. Anyone wishing to develop a social media site or application on behalf of the organisation should speak to the Assistant Director of Communications & Engagement in order for them to provide advice and guidance on the local approval process.

In terms of the personal use of social media, it is important for employees to understand their role as ambassadors for the Trust and to be conscious of the impact of their actions and words online which may negatively impact on the reputation and trust of the public.

The relationship with social media changes as soon as employees identify themselves or are identified as employees of NHS Wales or Trust. In these circumstances, they must make it clear that any views and opinions are personal and not necessarily those of the Trust. As an NHS Wales employee, it is important to remember that expressing views or commenting on content on the internet in relation to the NHS cannot be divorced from one's working life, and any unguarded comments could bring the organisation into disrepute, and may also invite legal action against both the employee and the Trust.

Where the Trust uses public Wi-Fi (wireless fidelity network), employees are encouraged to use their own personal devices to utilise any social media channels they wish to access.

However, personal use of social media should not be allowed to interfere with the performance of an employee's duties and any such access should occur during breaks or outside of normal working hours.

The Trust reserves the right to monitor and log comments and references on social media sites, including those made by its employees, relating to itself, its employees, its services and the patients in its care.

Failure to adhere to the All Wales Social Media Policy may lead to disciplinary action up to and including dismissal, depending on the individual circumstances of the case.

19. TIME KEEPING

The time of employees is a Trust resource in the same way as the buildings and equipment. The Trust spends a significant amount of its funding on salaries and wages therefore it is essential that it receives the full value for this expenditure. Where an employee is occasionally late for work or may have to leave early, this does not necessarily present an issue provided it is discussed with the line manager concerned.

What is not acceptable is where the employee falsifies time records to disguise absence or to claim attendance. This may be fraud or may amount to obtaining a monetary advantage by deception

Employees must ensure that all time keeping records are accurately completed and if an inadvertent error is noticed, their line manager notified immediately. The types of records where care should be taken are:

- on-call registers
- additional duty hours claims
- annual leave records
- shift registers
- sickness records, including "self-certification"
- expense claims
- bank claim forms
- domiciliary visit claims
- clock cards
- flexi/time-in-lieu sheets

20. ELECTION CAMPAIGNS

Welsh Government has produced guidance to NHS employees on their role and conduct during election campaigns.

The general principles that should be observed during the period of elections are that, as at other times, NHS staff should not engage in activities which could give rise to the criticism that individuals paid from public funds are being used for party political purposes, or which distract attention unduly to election campaigns.

The principles set out in this guidance apply to the NHS at all times, but particular note should be taken in the period between the start of formal campaigns and polling day.

All employees and Independent Members are requested to follow these guidelines:

- The NHS and its constituent bodies have no party political affiliation. Nothing should be said or done by any employee or Independent Member in their official capacity that suggests otherwise.
- NHS employees or Independent Members should not engage in activities which could give rise to the criticism that people paid from public funds are being used for party political purposes.
- No visits to Trust premises will be permitted by party political candidates and/or spokespeople for the purposes of personal canvassing. Party political meetings should not be held on NHS premises during the pre-election period.
- Political posters should not be displayed in public areas on NHS premises. Other

posters and advertising material purporting to be apolitical and published by other groups should be carefully scrutinised to ensure that they cannot be regarded as favouring or opposing a particular candidate or party.

- Existing health promotion campaigns can continue, but new campaigns and all high profile publicity (large scale mail drops, posters and advertising) should be deferred until after the elections.
- Social and electronic media has become more important to political parties and organisations during the pre-election period and staff should comply with existing guidance around its use both professionally and personally.
- All enquiries from political parties and candidates should be directed to the Chief Executive's Office and treated consistently.
- All media enquiries should be directed through the Assistant Director of Communications & Engagement via Velindre.Communications@wales.nhs.uk
- Routine Trust Board meetings which would normally be held in public may be held in the pre-election periods. Any public lectures given for educational purposes by the Trust employees on health matters need not be cancelled or postponed, but should avoid debate or speculation on the outcome of the election and any impact that might have on government health policy.
- NHS employees are free, in their private capacity, to engage in public debate or comment during the election period. However, they should not use NHS premises or equipment and should not make comments based on information not generally available to the public. It must be clearly stated that the views expressed are those of the individual and not of the Trust.

21. FAILURE TO ADHERE TO STANDARDS OF GOOD GOVERNANCE AND PROBITY POLICY

If any employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy, and then:

- participates in a decision making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the Trust's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS). This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches this policy or the Standards of Good Governance and Probity Framework, this could in certain circumstances result in notification/reporting to the appropriate professional codes of conducts/registration/memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and employees no longer continuing to be employed in their current position within the Trust.

Failure to declare a relevant interest by an Independent Member of the Trust will be reported by the Chair to the Cabinet Secretary for Health, Well-being and Sport, Welsh Government.

22. EQUALITY

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment to establish whether there are any possible or actual impacts that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was **no impact** to the equality groups mentioned above. Where appropriate, the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

23. RESOURCES

The implementation and management of the arrangements associated with this policy and the Standards of Good Governance and Probity Framework do not present any significant resource implications to the Trust.

24. TRAINING

All staff are required to comply with this policy. Whilst there are no particular training requirements or formal training programmes in place to ensure implementation of the policy, each Executive / Divisional Director and Departmental / Line Manager must ensure that all employees are made aware of the policy provisions and that they are adhered to at all times.

Awareness of the importance of compliance with the policy will require reference to it in induction programmes, during Performance Appraisal Development Reviews, Consultant Appraisals, and Consultant Job Plan Reviews and at times when employees and Independent Members are invited to make declarations.

25. IMPLEMENTATION

The Registers of Interests, and Gifts, Hospitality, Honoraria and Sponsorship will be maintained by the Corporate Governance Department. The Department will also be responsible for issuing periodic invitations to employees and Independent Members to declare interests, gifts, hospitality, honoraria and sponsorship.

In order to ensure that all employees and Independent Members are aware of their responsibilities in regard to declaring interests, and gifts, hospitality, honoraria and sponsorship, a number of communication methods will be utilised to raise awareness, including the use of the staff intranet, and e-mails to remind employees and Independent Members of this policy, and their responsibility to comply with it.

Targeting of specific groups and forums will also be undertaken to raise awareness of the policy such as corporate and local induction, the Local Partnership Forum, Medical Leadership Forum, Senior Management Team Meetings, and other key meetings, 1:1's, etc.

Executive / Divisional Directors and Departmental / Line Managers will need to be aware of their responsibilities for advising employees accountable to them of their responsibilities in connection with the policy.

26. PUBLICATION OF REGISTERS

The Registers of Interests and the Registers of Gifts, Hospitality, Honoraria and Sponsorship will be published on the Trust's internet site. An updated version will be added to the website quarterly. When making a declaration, employees and Independent Members are able to make representations that information on their interests or offers of gifts, hospitality, honoraria and sponsorship received, should not be published. This will allow for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

An interest will remain on the public register for a minimum of 6 months and no more than 12 months after the Director of Corporate Governance has been informed that the interest has expired. A record of historic interests will be retained by the Trust for a minimum of 6 years after the date on which it expired.

27. AUDIT AND MONITORING

The Director of Corporate Governance is responsible for the monitoring of this policy and its formal review every three years.

The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities

within Trust to be presented to the Audit Committee and Executive Management Board meetings.

The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

Audit Wales and the Trust's Internal Audit Service may also review the arrangements in place from time to time and their findings are also reported to the Audit Committee.

Staff should note that following the implementation of the Freedom of Information Act 2000, the information contained within the Trust's Register will be subject to disclosure to any member of the public on request.

28. DISTRIBUTION

The policy will be made available via the Trust internet and intranet sites. Where employees do not have access to these sites, their line manager must ensure that they have access to a copy of this policy.

Managers also have a responsibility to bring this policy to the attention of their staff. New members of staff will be made aware of this policy as part of the corporate induction process

29. CONFIDENTIALITY

As set out in employee's job descriptions, all employees may have access to confidential information about patients, staff or health service business. On no account must such information be divulged to anyone who is not authorised to receive it. Confidentiality of information must be preserved at all times whether at or away from work. Any breach of such confidentiality is considered a serious disciplinary offence, which may be liable to dismissal and/or prosecution under current statutory legislation (The Data Protection Act/ General Data Protection Regulations (2016) or any subsequent legislation to the same effect) and the Trust's Disciplinary Policy. Any breach of confidentiality may lead to disciplinary action and may be regarded as gross misconduct justifying summary dismissal.

Where employees are unsure about the use or sharing of patient identifiable information, advice should be sought from the Trusts Information Governance Manager.

30. LEGISLATIVE AND NHS REQUIREMENTS

This Policy aims to ensure the Trust complies with the requirements set out in:

- DGM (93)84: Standards of Business Conduct for NHS Staff;

- Director General. Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship-Ethical Standards for the NHS, Department of Health (November 2000);
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011);
- WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry;
- The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 (2006 No.95);
- Trust Standing Orders & Standing Financial Instructions (GC02);
- Trust Intellectual Property Policy (RD01);
- Bribery Act 2010
- General Medical Council Good Medical Practice guidance – financial and commercial arrangements and conflicts of interest, 2013
- Nursing & Midwifery Council gifts and gratuities guidance , September 2013 and The Code: Standards of conduct, performance & ethics for nurses & midwives
- Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016
- All Wales Procedure for the Recovery of Overpayments – Salary & Expenses (WF11)
- Counter Fraud, Bribery and Corruption Policy and Response Plan (FP02)
- Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011);
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010).

31. ACKNOWLEDGEMENTS

This Policy has been reviewed and developed against the following NHS Wales policies:

- Aneurin Bevan University Health Board – Standards of Business Conduct (September 2024);
- Cardiff and vale university health board – Standards of Behaviour Policy (November 2022);
- Cwm Taf Morgannwg University Health Board – Standards of Good Governance and Probity Policy (May 2025).

32. FURTHER INFORMATION

Further information and support on the policy or completion of the forms can be obtained from the Corporate Governance Team VUNHST.CorporateGovernance@wales.nhs.uk

APPENDIX 1

STANDARDS OF GOOD GOVERNANCE AND PROBITY FRAMEWORK - SUMMARY

The Board has described those values that underpin the way that services are provided within the Trust. To support this, all employees and Independent Members must ensure that they carry out their roles with dedication and commitment to the Trust and its core values.

All employees and Independent Members must have the highest standards of corporate and personal conduct and behave in an exemplary manner based on the following seven principles:

1. Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
2. Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
3. Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
4. Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
5. Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it;
6. Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;
7. Leadership – Individuals should promote and support these principles by leadership and example.

To uphold these principles you must:-

- Ensure that the interests of patients and the public remain paramount;
- Be impartial and honest in the conduct of your official business;
- Use NHS resources to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abuse your official position for personal gain or to benefit your family or friends;
- Not seek advantage or to further private business or other interests in the course of your official duties, and;
- Not seek or knowingly accept preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Trust.

The Standards of Good Governance and Probity Policy outlines the arrangements within the Trust to ensure that staff comply with these requirements, including recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

It is your responsibility to ensure that you are familiar with the requirements of the policy and supporting guidance. The relevance of this information will vary depending on your role within the Trust and your interests outside of your employment.

In summary:

Do:

- Make sure that you are not in a position where your private interests and NHS duties may conflict.
- Declare any relevant interests. These include:
 - a) Directorships, including Non-Executive Directorships held in private companies or PLCs.;
 - b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Trust.
 - c) A position of authority in a charity or voluntary body in the field of health and social care;
 - d) A personal or departmental interest in any part of the pharmaceutical or healthcare associated industries that could be perceived as an influence on decision making or on the provision of advice to members of the team;
 - e) Sponsorship or funding from a known NHS supplier or associated company/subsidiary;
 - f) Employment where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice;
 - g) Anything else that could cause a potential for conflict.

If in doubt declare it!

- Remember that the need to declare an interest also includes those of your close family and possibly friends.
- Seek your manager's permission before taking any outside work, in accordance with employment terms and conditions.
- Obtain your Line Manager and relevant Executive / Divisional Directors permission before accepting any commercial sponsorship or hospitality;
- Declare offers of gifts, hospitality or sponsorship using the appropriate form where required.

Do not:

- Accept any gifts from suppliers or commercial organisations unless they are of low value e.g. pens, diaries;

- Accept any gifts over the value of £25 from patients or their relatives, these should be politely declined;
- Accept any inappropriate hospitality or sponsorship from suppliers or commercial organisations;
- Abuse your position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favoritism in your dealings with commercial organisations;
- Use NHS resources for your own private use.

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 2 – Gifts, Hospitality, Honoraria and Sponsorship Form

GIFTS, HOSPITALITY, HONORARIA AND SPONSORSHIP DECLARATION FORM

It is a requirement that staff advise the Trust if they accept or are offered any gifts, hospitality, honoraria or sponsorship in accordance with Trust Standards of Good Governance and Probity Framework Incorporating Declarations of Interest Gifts, Hospitality & Sponsorship Policy.

Once agreement has been provided by your line manager and approval received by the Divisional Director or Executive Director, the completed and signed form should be forwarded by email to VUNHST.CorporateGovernance@wales.nhs.uk for inclusion in the Register of Gifts, Hospitality, Honoraria and Sponsorship.

Please Note: This form should be used to seek the approval to accept any gifts, hospitality, honoraria or sponsorship **PRIOR** to acceptance.

Please Note: Tax Implications of Honoraria:

i) Honoraria received for work undertaken during Trust hours

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Trust hours, any honoraria paid must be received back to the Trust revenue budget to reimburse the Trust for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is not managed by the employee who has provided their services during Trust time.

To avoid personal tax implications, the Trust employee is urged to request the Honoraria is paid directly to the Trust. This is then seen as reimbursement to the Trust to cover the loss of employee time, and not honoraria. This money will then be transferred into the Trust revenue budget. The Trust employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

*If the employee receives the honoraria directly and then reimburses the Trust, the employee **remains liable for the payment of both tax and NIC**, regardless of the final destination of the honoraria.*

ii) Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)

*Individuals are **personally liable for the payment of both tax and NICs** on any honoraria payments received.*

If such an employee wishes to suggest a donation may be made to the Trust Charity in lieu of an honoraria, this must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

Full Name:		Position:	Department:
Gift: ☐ Hospitality: ☐ Sponsorship: ☐ Honorarium ☐		Accepted: ☐ Declined: ☐	
		IF ACCEPTED, Please specify the reason why this gift/hospitality/sponsorship/honorarium has been accepted in the box below:	
Event Details including location (if applicable):			
Start Date of Event: (If Applicable)		End Date of Event: (If Applicable)	
Description: (Including course title, fees, travel, accommodation etc)			
Sponsor/Donor: (Name & address of organisation/company/individual)			
Are you aware of any current or future commercial relationship with the provider of the gift/ hospitality/ sponsorship/ honorarium?			
Exact/Approximate Value: Travel £ Accommodation £ Meals/Refreshments £ Conference/Registration £ Fees £ Other (please specify)			
Study Leave Required? Yes ☐ No ☐		Has a Study Form Been Completed? Yes ☐ No ☐	
Annual Leave Required? Yes ☐ No ☐			
Signature of Applicant:		Date:	
.....			

Approved by (Line Manager): Print Name : Signature:	Date:
Approved by (Divisional Director/Executive Director): Print Name : Signature:	Date:
Recorded on Register of Gifts, Hospitality & Sponsorship: (Executive Offices) Print Name : Signature:	Date:

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 3 – Declaration of Interest Form

 GIG CYMRU NHS WALES Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust	Declarations of Interest Form – Trust (& Charity If Applicable)		
Full Name: (Please Print)			
Contact Address:			
Tel No:			
Position Held in Trust			
In accordance with the Code of Conduct and Accountability, Standing Orders and Standing Financial Instructions. I list below my relevant interests and those of my family for inclusion in the Register of Members' Interests. If in doubt, declare! Proceed to Section h) after noting section f) if you have nothing to declare.			
Declaration	Nature of Relationship	Period of Involvement	Financial Transactions or Benefits in Kind
a) DIRECTORSHIPS Public or private appointments, employment or consultancies. Company directorship's in private or limited companies	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
b) INTEREST IN COMPANIES AND SECURITIES Substantial interest is ownership or part ownership, more than 1/100 th (i.e. share) of private companies, businesses or consultancies	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		

c) OTHER POSITIONS OF AUTHORITY (Not included in a.) A position of authority (i.e. Director, Chairman. Trustee etc.) in a charity or voluntary body in the field of health and social care	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
d) PERSONAL OR DEPARTMENTAL SPONSORSHIP a personal or departmental interest in any part of the pharmaceutical industry or Sponsorship or funding from a known NHS supplier or associated company/subsidiary, e.g. Baxter funding research, staff or equipment	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
e) ANY OTHER INTEREST Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Personal:		
	Spouse/Partner or other Relationship Specific to a Contract or Series of Contracts		
f) I undertake to notify the Trust of any changes which may occur within four weeks from the date of the change via email to: VUNHST.CorporateGovernance@wales.nhs.uk			

g) I confirm that the list accurately reflects my interests and those of my close family and understand that these declarations will be included in the register available <i>public inspection</i>				
Signed:		Date:		
h) I confirm a <i>nil declaration</i>				
Signed:		Date:		
i) Authorisation Section				
Having considered the activity declared on this form is there any action required to manage any potential conflicts of Interest? Please indicate with a (X) in the relevant box.	Yes <i>If yes, please outline in the 'Management Action' box below the steps and action that will be taken to manage any potential conflict</i>		No	
If a conflict has been identified have you sought advice from the Director of Corporate Governance for advice on how to manage and report the conflict? Please indicate with a (X) in the relevant box. <i>Director of Corporate Governance Contact Details:</i> VUNHST.CorporateGovernance@wales.nhs.uk	Yes		N/A	

Management Action Agreed: <i>(if not applicable please indicate this by writing N/A in the box below)</i>	
By signing below you are confirming that you have: • Considered the activity Declared on this form. • Identified if there are any potential conflict of interest • If a declaration of interest is perceived, considered the management action required to manage the conflict, sought advice from the Director of Corporate Governance and; • Communicated the action required to the individual declaring the interest	
Print Name:	
Designation:	
Signature:	
Date:	

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

Appendix 4

Declaration Statement

Tax and National Insurance Contributions in respect of Honoraria

I confirm that I shall fulfil the Tax and National Insurance contributions responsibilities associated with receiving honoraria payments, as outlined in the Trust Standards of Good Governance and Probity Policy.

I understand that where honoraria is received for events undertaken in my own time (out of normal working hours or on authorised annual leave) I am **personally liable** for the payment of both Tax and National Insurance Contributions on any honoraria payments received and it is my responsibility to personally declare this income to the Inland Revenue.

Where an honorarium is received for events undertaken in work time and/or whilst on study leave I will advise the sponsor that the payments should be paid **direct** to the Trust. These funds will then be reimbursed to the appropriate Trust revenue budget.

Print Name:	
Position:	
Signature:	
Date:	

For any queries or to return the fully completed approved declaration, please email:
VUNHST.Corporate.Governance@wales.nhs.uk

EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	GC 03 Standards of Good Governance and Probity (In Public Service Roles) Policy (previously Standards of Behaviour Policy)		
Manager	Head of Corporate Governance		
Date of meeting with OD Manager – ED&I			
Date of submission	October 2025		
Date of next review	October 2028		
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	Standards of Good Governance and Probity (In Public Service Roles) Policy
1.2	Who owns it?	Director of Corporate Governance
1.3	What is the aim of the change(s)?	To review and update the current policy
1.4	Who is affected most by the change?	Trust and Hosted Services Staff and others such as volunteers working on behalf of the Trust will be affected by the Policy
1.5	How does this topic fit into the wider context of the organisation?	The Policy sets out expectations and provides supporting guidance to ensure all Trust employees and Independent Members practice the highest standards of conduct and behaviour. To achieve this aim, the policy: • Sets out the procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship. • Provides guidance on good conduct through the use of social media, during election campaigns and in relation to timekeeping.
1.6	Who is undertaking the EQIA	Freedom of Information and Compliance Officer

1.7	When will you start and end the EQIA?	
2.1	What data is available to help inform the EQIA?	This policy applies to all staff employed by the Trust and Hosted Services who are involved with the policy development and review process. Trust Organisational Values
2.2	What information is still needed?	N/A
2.3	How will missing data be collected?	N/A
2.4	What is considered relevant information and data?	This policy applies to all staff employed by the Trust and Hosted Services who are involved with the policy development and review process. - DGM (93)84: Standards of Business Conduct for NHS Staff; - Director General. Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011) - Commercial Sponsorship-Ethical Standards for the NHS, Department of Health (November 2000); - Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011); - WHC (2005) 016 The NHS & Sponsorship by the Pharmaceutical Industry; - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 (2006 No.95); - Trust Standing Orders & Standing Financial Instructions (GC02); - Trust Intellectual Property Policy (RD01); - Bribery Act 2010 - General Medical Council Good Medical Practice guidance – financial and commercial arrangements and conflicts of interest, 2013

		• Nursing & Midwifery Council gifts and gratuities guidance , September 2013 and The Code: Standards of conduct, performance & ethics for nurses & midwives • Association of British Pharmaceutical Industry (ABPI) Code of Practice for the Pharmaceutical Industry 2016 • All Wales Procedure for the Recovery of Overpayments – Salary & Expenses (WF11) • Counter Fraud, Bribery and Corruption Policy and Response Plan (FP02) • Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011); • The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010).

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age <i>Younger people</i> <i>Middle-aged people</i> <i>Older people</i> <i>Other...</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with a protected characteristic in a different way to those without.	NA
Disability <i>Physical</i> <i>Learning needs</i> <i>Neurodiversity</i> <i>Sensory Loss</i> <i>Mental Health issue</i> <i>Other...</i>			x	Justification of impact identified: Copies of the policy can be made available in alternative formats (e.g. large print) on request.	NA
Gender re-assignment <i>Would this affect those in/post-transition differently?</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with	NA



				a protected characteristic in a different way to those without.	
Marriage or civil partnership <i>Are single people affected differently?</i> <i>Are married people or civil partners treated differently?</i>			x	Justification of impact identified: This policy applies irrespective of whether individuals are married, in a civil partnership or not.	NA
Pregnancy or Maternity <i>Whilst pregnant</i> <i>On maternity leave</i> <i>Returning to work</i> <i>Other...</i>			x	Justification of impact identified: The implementation of this policy applies irrespective of whether individuals are a new or expectant mother.	NA
Race <i>Colour</i> <i>Nationality</i> <i>Ethnic group</i> <i>National origins</i> <i>Other...</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with a protected characteristic in a different way to those without.	NA
Religion <i>Affects one religious group more?</i> <i>Clashes with religious holidays?</i> <i>What about groups with no religion?</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with a protected characteristic in a different way to those without.	NA

Sex/Gender <i>Does it only apply to men / women?</i> <i>Could this affect one group more than the other?</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with a protected characteristic in a different way to those without.	NA
Sexual Orientation <i>Would this affect any group from LGBTQ+ communities differently?</i>			x	Justification of impact identified: This policy sets out standards of good behaviour for staff and independent members and also sets out procedures for declarations of interests, gifts, hospitality, honoraria and sponsorship it does not have an impact on anyone with a protected characteristic in a different way to those without.	NA
Socio Economic Duty <i>Low income / no income groups?</i> <i>Rural locations affected differently?</i> <i>Those with caring responsibilities?</i>			x	Justification of impact identified: This policy applies irrespective of the individual socio economic status	NA
Welsh Language <i>Will everything be available bilingually?</i>				Justification of impact identified: Staff are welcomed to submit papers in either English or Welsh. The Trust's Welsh Language Team can support with the translation of any papers. This is in line with the Trust's Welsh Language Policy	NA

<i>How many staff might need to know Welsh?</i> <i>1. Does the subject treat the Welsh language less favourably than the English language?</i> <i>2. Have you considered the Cultural opportunities / Promotion of the project? E.g. literature / Visual art representing Welsh artists</i> <i>3. Are you assured that all aspects of this project / policy etc has considered the needs of Welsh speakers?</i> <i>If yes, identify the specifics If no, state what should be included.</i>				on using Welsh internally and externally also in ensuring that the Trust strives to comply with the Welsh Language Standards.	



4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	3. Continue the Policy Overall, there is no impact, policy reviewed and no major changes.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	No negative impact
4.3	Could the policy be implemented in a different way to avoid negative impact?	No negative impact
4.4	How will this change promote equality of access and equality of opportunity?	No negative impact
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	No negative impact
5.1	What do you have so far?	Draft Policy and EQIA
5.2	Have any themes emerged?	No themes emerged



5.3	What do people have to say about our work?	Feedback is positive with suggestions where there are perceived gaps.
5.4	How will you consult widely on your topic?	
5.5	Who will you consult with?	
5.6	How long will the consultation stage last?	
6.1	The action plan must appropriately evidence the decision for one of the following policy options:1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	No action required
6.2	What will you do with the comments or information you have gathered from your consultations?	Make appropriate changes to the policy if required
6.3	How did the consultation help guide new policy?	N/A review of existing policy
6.4	Will you make any changes to the draft report you produced?	Comments have been taken into account in the revised draft.
7.1	Confirm actions	Implement

8.1	Establish timetable for reviewing actions and refreshing the assessment	Assessment will be refreshed as part of the policy review process on a 3 year rolling cycle



Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1	Make policy available via the Trust intranet page and Trust website.	Following approval	To be decided by individual departments / services	Make policy available via the Trust intranet page and Trust website.
2				
3				

Strategic Alignment

Future Generations Act Wellbeing Objectives		Links to Objective
1	A prosperous Wales	☒
2	A resilient Wales	☒
3	A healthier Wales	☒
4	A more equal Wales	☒
5	A Wales of more cohesive communities	☒
6	A Wales of vibrant culture and thriving Welsh language	☒
7	A globally responsible Wales	☒

Double-click to add your signature below:

X

Lead Officer

Double-click to add signature below:

X

Equality & Diversity Manager



Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:

VUNHST.Equality&Diversity@wales.nhs.uk