Public Trust Board

Thu 21 May 2026, 10:00 - 13:00

Trust Headquarters, Nantgarw / via Microsoft Teams

Agenda

10:00 - 10:30
30 min

1. STANDARD BUSINESS

Sara Moseley, Chair

1.1. Welcome and Apologies

Sara Moseley, Chair

1.2. In Attendance

Sara Moseley, Chair

1.3. Declarations of Interest

Sara Moseley, Chair

1.4. Minutes of the Public Trust Board meeting held on 26th March 2026

Sara Moseley, Chair

1.4.0 DRAFT Public Trust Board minutes 26.03.2026 (v3SM).pdf (15 pages)

1.4.1. Minutes of the extraordinary Public Trust Board meeting held on 30th April 2026

Sara Moseley, Chair

1.4.1 DRAFT Extraordinary Public Trust Board Minutes 30.04.2026 (v3SM).pdf (3 pages)

1.5. Public Action Log

Sara Moseley, Chair

1.5.0 PUBLIC TRUST BOARD ACTION LOG - MAY 2026.pdf (1 pages)

1.6. Matters Arising

Sara Moseley, Chair

*There are no matters arising for discussion.

1.7. Patient, Donor or Staff Story: Genetic Haemochromatosis – turning treatment into donation

Elisabeth Davies, Principal Clinical Scientist (Transfusion Medicine) and Joanne Gregory, Genetic Haemochromatosis Clinic Co-ordinator, WBS

1.7.0 Grant (donor) presentation to share with VUNHST board.pdf (10 pages)

10:30 - 10:40
10 min

2. KEY REPORTS

2.1. Chair's Report

Sara Moseley, Chair

2.1.0 Chair's update Trust Board 21.05.2026.pdf (8 pages)

2.2. Chief Executive's Update

Jacinta Abraham, Deputy Chief Executive Officer

2.2.0 CEO's Update Trust Board 21.05.2026.pdf (5 pages)

10:40 - 11:30
50 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. Performance Management Framework (March 2026)

Jacinta Abraham, Deputy Chief Executive Officer, Anne Carey, Chief Operating Officer, Sarah Jenkins, Executive Director OD & Workforce (interim), Lauren Fear, Director of Place, Portfolio & Partnerships and Matthew Bunce, Executive Director of Finance

3.1.0 Trust Board PMF 21.05.26 MARCH 2026 version 001 (1).pdf (54 pages)
3.1.0a Month 12 Finance Report Cover Paper - TB 21.05.2026.pdf (14 pages)
3.1.0b Appendix 1 - M12 2025 26 VELINDRE UNHS TRUST FINANCIAL POSITION TO TB 21.05.2026.pdf (35 pages)

3.2. Trust Risk Register

Non Gwilym, Director of Corporate Governance (interim)

3.2.0 Public TRR Cover Paper - TB - May 2026 - V01.pdf (6 pages)
3.2.0a Public TRR Appendix -Trust Board- May 2026 - V02.pdf (8 pages)

3.3. Board Assurance Framework

Non Gwilym, Director of Corporate Governance (interim)

3.3.0 BAF Cover Paper - TB -May-2026 V01.pdf (6 pages)
3.3.0a 01 - CAPACITY MAY 2026.pdf (5 pages)
3.3.0b 02 - QUALITY - MAY 2026.pdf (5 pages)
3.3.0c 03 - RDI - MAY 2026.pdf (7 pages)
3.3.0d 04 - FINANCE - MAY 2026.pdf (9 pages)
3.3.0e 05 - SUSTAINABILITY - MAY 2026.pdf (3 pages)
3.3.0f 06 - POD - MAY 2026.pdf (4 pages)
3.3.0g 07 - DIGITAL - MAY 2026.pdf (4 pages)
3.3.0h 08 - GOVERNANCE MAY 2026.pdf (4 pages)

11:30 - 11:45
15 min

COMFORT BREAK

11:45 - 12:15
30 min

4. ORGANISATIONAL DEVELOPMENT

4.1. New Operating and Accountability Arrangements 2026

Victoria Oxley, Director of Strategy, Planning and Performance (interim)

4.1.0 260521 Trust Board accountability paper.pdf (7 pages)
4.1.0a 260521 Trust Board Appendix 1 accountability.pdf (10 pages)

4.2. Board Committee Structure

Non Gwilym, Director of Corporate Governance (interim)

4.2.0 Board Committee Structure Update.pdf (5 pages)

4.3. Streamlined approach for the Culture Milestone Plan

Sarah Jenkins, Executive Director of People & Organisational Development (interim)

4.3.0 Streamlined Approach for the Culture Milestone Plan.pdf (7 pages)

12:15 - 12:20
5 min

5. COMMITTEE HIGHLIGHTS FOR DISCUSSION

5.1. Public Quality, Safety & Performance Committee Highlight Report (07/05/2026) – including Quarter 4 Integrated Quality and Safety Report

Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee

- 5.1.0 Public Quality, Safety, Performance Committee Highlight Report.pdf (7 pages)
- 5.1.0a Appendix 1 - QUARTER 4 2025-26 Integrated QS Report.pdf (61 pages)

12:20 - 12:20
0 min

6. CONSENT ITEMS FOR APPROVAL

Sara Moseley, Chair

*There are no items for approval.

12:20 - 12:30
10 min

7. CONSENT FOR NOTING

Sara Moseley, Chair

7.1. Trust Seal Report

Non Gwilym, Director of Corporate Governance (Interim)

- 7.1.0 Trust Seal Report 21.03.2026-14.05.2026.pdf (4 pages)

7.2. Trust-wide policy approvals update

Non Gwilym, Interim Director of Corporate Governance

- 7.2.0 TRUST WIDE POLICIES APPROVED UPDATE MAY 2026.pdf (4 pages)
- 7.2.0b QS08 Management of Safeguarding_Allegations_Concerns_v4_May 26.pdf (21 pages)
- 7.2.0c QS12 Safeguarding and Public Protection Policy_v3_May 26.pdf (19 pages)
- 7.2.0e IG03 Email and IM Policy_v1_MAY 2026.pdf (12 pages)
- 7.2.0d IG07 VUNHST Acceptable Internet Use Policy_v1_MAY 2026.pdf (10 pages)
- 7.2.0f IG09 VUNHST Information Governance and Information Security Policy_v1_MAY 2026.pdf (14 pages)

7.3. Strategic Partnerships Update

Lauren Fear, Director of Place, Portfolio and Partnerships

- 7.3.0 Strategic Partnerships Update - Trust Board - May 26.pdf (10 pages)

7.4. Public Strategic Development Committee Highlight Report (20/01/2026 & 17/03/2026)

Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee

- 7.4.0a TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 20.01.2026 Final (2).pdf (3 pages)
- 7.4.0b v2 TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 17.03.2026.pdf (4 pages)

7.5. Shared Services Partnership Committee Assurance Report (19/03/2026)

Non Gwilym, Director of Corporate Governance (interim)

- 7.5.0 SSPC Assurance Report 19 March 2026.pdf (5 pages)

7.6. Joint Commissioning Committee Highlight Reports (17/03/2026 & 23/03/2026)

Non Gwilym, Director of Corporate Governance (interim)

- 7.6.0a JC Highlight Report - 17 March 2026 1.pdf (7 pages)
- 7.6.0b JC Highlight Report - 23 March 2026 1.pdf (4 pages)

12:30 - 12:30
0 min

8. ANY OTHER BUSINESS

Sara Moseley, Chair

*Prior approval required by Chair

12:30 - 12:30
0 min

9. DATE OF NEXT MEETING

The next meeting will be held on 30th July 2026 @ 10:00

12:30 - 12:30
0 min

10. CLOSE

The Board is asked to adopt the following resolution:

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

12:30 - 12:30
0 min

11. ITEMS FOR DISCUSSION IN PART B

- Whitchurch Land – City Hospice Land Sale
- Private Risk Register
- Board Assurance Framework – new Strategic Risk
- Lineofsight update
- NWSSP – Implementation Group update
- Committee Highlight Reports
- Chair's Urgent Actions

MINUTES PUBLIC TRUST BOARD MEETING (HELD REMOTELY)
VELINDRE UNIVERSITY NHS TRUST
26th March 2026 – 10:00am-1:00pm

PRESENT	
Sara Moseley	Chair
Lindsay Foyster	Vice Chair
Gareth Jones	Independent Member
Prof. Andrew Westwell	Independent Member
Vicky Morris	Independent Member
Hilary Jones	Independent Member
Ceri Doyle	Independent Member
John Union	Independent Member
Carl James	Chief Executive Officer (interim)
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Sciences
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director / Deputy Chief Executive (interim)
Sarah Jenkins	Executive Director of People and Organisational Development (interim)
ATTENDEES	
Anne Carey	Chief Operating Officer
Lauren Fear	Director of Place, Portfolio and Partnerships
Non Gwilym	Director of Corporate Governance (interim)
Kyle Page	Business Support Manager (Secretariat)

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	**Welcome and Apologies:** The Chair welcomed attendees to the meeting, noting the following apologies: • Carl Taylor, Chief Digital Officer • David Cogan, Chair of Patient and Carer Partnership Board • Ben Leijokari-Olosunde, Aspiring Board Members Programme Member The Chair apologised for a technical outage at Trust Headquarters, which had resulted in today's meeting being held virtually.	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Katrina Febry, Audit Lead, Audit Wales • Alison Roberts, Senior Clinic Nurse (for item 2.0.0) • Susan Myles, Director, Health Technology Wales (for item 6.1.0) • Rebecca Nelson, Director of Planning, Performance & Informatics (NWSSP) (for item 6.2.0) • Alison Ramsey, Director of Finance and Corporate Services, NWSSP, (for items 6.2.0 and 8.4.0)	

	• James Quance, Assistant Director of Corporate Services, NWSSP (for item 8.5.0) • John Murray, Managing Partner, Lineofsight Consulting LLP (observing) • Paige Jennings-Brooksby, Management Graduate (observing)	
1.3.0	**Declarations of Interest** There were no declarations of interest noted in respect of today's agenda.	
1.4.0	**Minutes of the Public Trust Board meeting held on 29th January 2026** Gareth Jones advised that page 8 of the minutes indicated that a Board Development Session would be required to provide better understanding of delivery of Phase 2 of the Digital Health and Care Record (DHCR) work. It was agreed to capture this as an action. The Trust Board was otherwise content that the minutes of the meeting held on 29th January 2026 were an accurate reflection of proceedings.	**KP**
1.5.0	**Action Log** The Board was content to close all actions marked as 'propose to close'. This closed all remaining actions on the log.	
1.6.0	**Matters Arising** Led by Sara Moseley, Chair	
1.6.1	**Fire Safety Training Compliance Improvement Plan** Led by Lauren Fear, Director of Place, Portfolio and Partnerships Lauren Fear confirmed that compliance had improved, following a period when it had been below 50%, highlighting stronger leadership and directorate ownership, particularly within the Velindre Cancer Service (VCS). Lindsay Foyster focused on Level 2 fire safety training compliance within VCS, noting its direct relevance to patient safety. While current work was acknowledged, it was queried whether the Board was beginning to see improvement and sought clarity on the expected trajectory and timescale for reaching the target compliance level. Lauren confirmed that improvements in this training were already being seen at VCS, emphasising that this was a Trust-wide effort across cancer and blood services, and agreed to return with a clear timescale for achieving the target level of compliance. The Board acknowledged the assurance level **3**, which was in line with the level of assurance approved at the Quality, Safety and Performance Committee. The Trust Board **NOTED** the Improvement Plan.	**LF**
2.0.0	**STAFF STORY**	
2.1.0	Led by Alison Roberts, Senior Clinic Nurse Wrexham The Board heard a staff story from Alison Roberts, a Senior Clinic Nurse in the Welsh Blood Service. A short video featuring Alison was played at the outset, sharing her career journey, her leadership development and how she had overcome the experience of having her leadership challenged. Following this, several Board members thanked Alison for her honesty and courage, reflecting on the importance of psychological safety and support, how organisational systems and processes	

	can affect frontline leaders, and the need to identify and nurture leadership potential within the workforce. A number of Board members offered reflections and questions, particularly in relation to how the Trust can better support future leaders. Alison suggested clear communication, encouragement and access to opportunities as key enablers for staff development.	
3.0.0	**KEY REPORTS**	
3.1.0	**Chair's Report** Sara Moseley, Chair The Chair took her report as read and added the following updates: • Positive engagement with the Welsh Blood Service, including donor awards, praising the scale and quality of work undertaken by the teams. The Chair proposed that the Board write formally to thank them for this work. • Reported on her appraisal and objective-setting with the Cabinet Secretary ahead of the pre-election period, advising that Chair objectives would be cascaded to Independent Members and the Executive Team. • Constructive engagement with community representatives to reset relationships and support future service development, thanking colleagues for continuing dialogue and engagement through workshops. The Trust Board **NOTED** the content of the Chair's update.	**Chair**
3.2.0	**Chief Executive's Report** Carl James, Chief Executive Officer (interim) Carl James highlighted the following key points: • Progress regarding implementation of the Shared Services Review, noting further engagement with Shared Services colleagues and Welsh Government, with additional feedback to follow. • A recent visit by the Cabinet Secretary to the Welsh Blood Service, emphasising the service's national and international contribution. The Cabinet Secretary had enjoyed the visit and was of the opinion that the Welsh Blood Service should be better known and better understood. • Continued developments across the Cancer Service, including work on satellite services, new models of care and preparation for the opening of the new cancer hospital next year; these developments position the Trust well for an upcoming strategic discussion on the next five years. The Trust Board **NOTED** the content of the CEO's update.	
4.0.0	**QUALITY, SAFETY & PERFORMANCE**	
4.1.0	**Performance Management Framework (PMF) (January 2026)** Carl James, Chief Executive Officer (interim), Anne Carey, Chief Operating Officer, Sarah Jenkins, Interim Executive Director of People & Organisational Development, Carl Taylor, Chief Digital Officer, Lauren Fear, Director of Place, Portfolio and Partnerships and Matthew Bunce, Executive Director of Finance	

	Carl James explained that detailed scrutiny had already taken place at Quality, Safety and Performance Committee (QSP) and that focus should be on areas of exception and assurance levels, rather than revisiting all detail. The Board noted that overall performance remained strong, with most standards being met and high levels of patient and donor satisfaction, but that there were significant performance challenges in SACT (Systemic Anti-Cancer Therapy) and Radiotherapy, which required particular attention. Anne Carey provided context on cancer performance, including the Single Cancer Pathway, shared accountability with Health Boards, and the actions underway to address capacity and pathway issues, particularly in SACT, where improvement timelines were less certain. The Chair emphasised that SACT and Radiotherapy represented the greatest current risks, and that clarity on when improvement would be seen was required, with actions captured to return with clearer trajectories. Board members queried timescales for improvement, requesting further explanation of the booking and scheduling issues, noting that the paper referenced data quality problems and non-integrated digital systems as barriers to effective scheduling. Anne Carey advised that booking and scheduling issues stem from non-integrated digital systems and confirmed that work is underway with suppliers and DHCW to optimise functionality and improve scheduling. Anne Carey explained that booking and scheduling issues stem from non-integrated digital systems and confirmed that work is underway with suppliers and DHCW (Digital Health and Care Wales) to optimise functionality and improve scheduling. Vicky Morris advised that The Quality, Safety & Performance Committee had identified the need for a workshop to deepen Board understanding of cancer pathway performance and asked that this be opened to all Board members. The Board questioned why time-to-treatment performance had fallen in January compared with earlier months and asked whether this was largely driven by patient choice or other underlying factors. Anne Carey advised that the January dip in time-to-treatment performance reflected a combination of seasonal patient choice and temporary capacity impacts from equipment upgrades, rather than a single underlying failure. The sustainability of savings schemes and reliance on non-recurrent savings was also queried. Matthew Bunce confirmed that a balanced position would be achieved but noted an underlying recurrent gap to be carried forward, with continued reliance on a mix of recurrent and non-recurrent savings, while aiming to improve the recurrent proportion. The Chair highlighted the scale of the projected NHS Wales deficit next year and suggested the Board should consider the Trust's commissioning and contracting position more strategically, beyond in-year financial performance, via a dedicated workshop or future committee discussion, to identify how the Trust could influence commissioning over the coming year. The Board queried the likelihood of progress on contract rebasing of LTAs (Long Term Agreements), noting that similar discussions had stalled previously. Matthew Bunce advised that agreement was unlikely without intervention from Welsh Government's Performance and Improvement team, given historic challenges, and noted increasing pressure from Welsh Government to resolve the issue without arbitration.	

	Carl James noted that the Trust would need to be more ambitious about income generation, including through existing services, new services and partnerships, given the wider NHS Wales financial context. The Trust Board: • **NOTED** the Performance Management Framework for assurance purposes. • Reviewed and **CONCURRED** with the levels of assurance noted in the report. The Chair suggested that the Board would benefit from a short briefing on how the levels of assurance work and how they are applied, particularly for newer Board members who were not present when the framework was originally introduced.	**NG**
4.2.0	**VUNHST Risk Register** Non Gwilym, Interim Director of Corporate Governance Non Gwilym advised that the paper provided assurance on the current position of the Trust Risk Register, focusing on risks exceeding the Board-approved reporting thresholds. Four new risks had been added since the previous cycle, mainly relating to safety, quality, performance and digital infrastructure, and that one risk had reduced, with mitigation set out in the appendix. It was noted that this resulted in 17 risks currently reported on the public register, reflecting ongoing pressures around clinical capacity, service sustainability, and reliance on ageing national digital systems and dependencies. Non Gwilym highlighted progress on replacing the risk management system and the refresh of the Risk Management Framework, which would be brought to the Executive Board for consideration in May. The report demonstrated active and systematic risk management across the organisation and confirmed that the assurance rating remained at Level **3**, while expressing an expectation that this could improve as the new framework and system mature. The Trust Board **NOTED:** • 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. • the update on the Datix risk system replacement. • the update on sub-threshold risks.	
4.3.0	**Board Assurance Framework (BAF)** Non Gwilym, Interim Director of Corporate Governance Non Gwilym confirmed the governance position of the Board Assurance Framework (BAF), noting that it had been reviewed and updated through the appropriate Executive and Committee routes before prior to Board. Non re-iterated that the BAF remains a live document, subject to ongoing review and refinement, rather than a static report. The Trust Board **NOTED** the current status of the Board Assurance Framework, which has a current assurance rating of **2**.	

5.0.0	**ORGANISATIONAL DEVELOPMENT**	
5.1.0	**Embedding the Donor & Patient Voice Across Velindre University NHS Trust Improvement** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences Nicola Williams explained that the paper followed earlier Board and Quality Safety & Performance Committee discussion and presented a development plan to strengthen how patient and donor voice is embedded across the organisation, aligned to the national People's Experience Framework. It was acknowledged that while there was good activity on capturing experience and feedback, there was more work to do to clearly connect engagement, experience and impact; the Board was asked to approve the initial actions pending further development. Non Gwilym supported the approach, emphasised the need to bring together different strands of engagement and experience into a coherent, whole-Trust framework, building on the existing Patient Engagement strategy and highlighting opportunities to build on the work of the Patient and Carer Partnership Board. Board members raised the following: • Caution regarding the use of the term *co-production*, emphasising the need for clear definitions and boundaries, particularly given clinical safety considerations. • While the paper was strong on listening and feedback, wider engagement in service change and improvement needed further development, suggesting Board development to explore this. • Confirmation that the Quality, Safety & Performance Committee had discussed the paper and would continue to monitor progress, while recognising areas requiring strengthening. The Chair summarised that the work on listening and experience was essential, but that the engagement model and language needed further clarification. She proposed that the paper be reworked outside the meeting, retaining requirements for Quality Safety & Performance Committee assurance, and brought back once the engagement and co-production approach had been more clearly defined. The Board **AGREED** this approach.	**Board** **EDoN**
5.2.0	**Organisational Culture: Milestones** Led by Sarah Jenkins, Executive Director of People & Organisational Development (interim) Sarah Jenkins introduced the organisational culture milestones, emphasising that culture should be understood through lived experience and not solely plans or metrics. The milestones brought together multiple strands of evidence, including the staff survey, WRES (Workforce Race Equality Standard) data, staff stories and qualitative feedback, to give a rounded picture of culture. Sarah highlighted that culture change would be driven through leadership behaviours, co-creation with staff and integration into everyday business, rather than a centrally imposed programme; the Board's role was to set outcomes rather than design detailed actions. A phased, multi-year approach was proposed, with initial focus on understanding, engagement and locally-owned action, supported by clear principles and success measures. Board members welcomed the approach, recognising the importance of	

	psychological safety, compassionate leadership and visible follow-through from listening. Board members commented as follows: • The Trust already had many areas of strong culture and should focus on strengthening consistency, not "starting again", noting that the organisation was attracting high-quality staff and leaders. • The importance of triangulating culture data, particularly ensuring the WRES data is considered alongside the staff survey to understand the experience of minority ethnic staff. • Culture work must connect clearly to purpose, priorities and the work staff are asked to do. • Staff rate the Trust highly as a compassionate and inclusive organisation, and that this strength should be recognised and built upon, not overshadowed by areas for improvement. The Board **APPROVED** the organisational culture milestones approach, agreed the proposed principles and measures, and emphasised the importance of site visits, visibility and engagement as part of Board assurance.	
5.3.0	**Staff Survey 2025** Led by Sarah Jenkins, Executive Director of People & Organisational Development (interim) Sarah Jenkins highlighted that the Trust performed strongly compared to the all-Wales position, with improved response rates and overall results placing the Trust in a green position nationally. It was noted that while the overall engagement score had slightly reduced compared with the previous year, it remained above the Wales average, and the Trust should remain ambitious about further improvement. Sarah emphasised that the staff survey was a snapshot in time and should be interpreted alongside other intelligence, including WRES data, staff stories and qualitative feedback, rather than in isolation. Key themes identified for ongoing focus included psychological safety, team time, healthy working environments, flexible working, and learning and improvement. Early actions were already underway, including rapid engagement and "ask anything" sessions, and that divisions would co-create local action plans with staff, ensuring ownership and demonstrable follow-through. Board members re-iterated the importance of triangulating staff survey results with WRES data, particularly to understand the experience of minority ethnic staff, and ensuring improvements are sustained over time, not treated as one-off responses. The Board recognised that the results showed the Trust to be a compassionate and inclusive organisation, and agreed this strength should be celebrated and built upon, while continuing to address areas for improvement. The Board **NOTED** the findings and agreed to maintain support for the Culture and Leadership Programme.	
5.4.0	**Board Committee Structure** Led by Non Gwilym, Director of Corporate Governance (interim)	

	Non Gwilym presented the proposal to change the Trust's Board Committee structure, setting out the case for change, the proposed principles, and the new structure and timetable for implementation. She explained that the changes were intended to strengthen governance, streamline assurance, and ensure the committee framework was fit for purpose as the organisation's priorities and scale of work continue to evolve. Non highlighted that the proposal had been informed by earlier Board discussions and feedback, and that external support (Lineofsight Consulting) would assist with implementation over the coming months. Non advised that the Board was not being asked to approve detailed terms of reference at this stage, but to note the proposal and agree the overarching principles, structure and implementation timetable. Board members supported the approach, however, it was proposed that a mapping exercise should be undertaken once Terms of Reference for the restructured Committees had been drafted, to identify any gaps. The Trust Board **NOTED** the proposal and **AGREED** the proposed principles, structure and timetable for implementation.	**NG**
5.5.0	**IMTP 2026/27 – 2028/29** Led by Carl James, CEO (interim) Carl James confirmed that the IMTP (Integrated Medium-Term Plan) had been considered by the Strategic Development Committee, providing assurance on prior scrutiny. He also confirmed that the IMTP had not yet been formally submitted to Welsh Government as further work was still underway to finalise elements of the plan. It is the intention to submit within the required national timetable, with informal feedback anticipated during April / May; the Trust would not expect formal approval until the appointment of a new Cabinet Secretary. The Trust Board **APPROVED** the final IMTP 2026-2029.	
6.0.0	**HOSTED SERVICES**	
6.1.0	**Health Technology Wales (HTW) Strategic Plan** Led by Susan Myles, Director, Health Technology Wales Susan Myles explained that the Strategic Plan (2026–2030) had been developed and consulted on over the past year, including public consultation, stakeholder engagement, committee scrutiny and consideration through the Strategic Development Committee. The plan is similar to the previous HTW Strategy (2021-25), reflecting no real change to the organisation's remit and funding. Susan confirmed that the intention was to publish the Strategic Plan following the May election, subject to Trust Board approval at today's meeting. Susan also wished to note that equality, diversity and inclusion considerations were embedded in the plan, particularly through patient and public involvement mechanisms, rather than as a standalone section. It was queried whether the plan gave sufficient weight to artificial intelligence (AI), noting that this felt light given the pace of development across different sectors. It was queried how AI techniques and standards are being appraised and how these could be embedded appropriately within HTW's work, as AI raises not only technical and operational issues, but also ethical and moral. Susan responded that AI is a growing area of work for Health Technology Wales, with increasing numbers of AI	

	topics coming forward, and assured the Board that ethical and wider system impacts are considered alongside technical evidence. Board members raised concern that the HTW Strategic Plan was ambiguous about HTW's role in social care; they asked for explicit clarification and assurance about whether, and to what extent, HTW is involved in social care, given increasing integration between health and social care systems. Susan assured the Board that Health Technology Wales is actively engaged with social care in practice, particularly where technologies span health and social care. She clarified that HTW does not issue formal guidance for social care, but undertakes evidence reviews only. It was agreed that this assurance and distinction should be clearly captured in the minutes. The Trust Board **APPROVED** the Strategic Plan.	
6.2.0	**NHS Wales Shared Services Partnership – IMTP 2026-2029** Led by Rebecca Nelson, Director of Planning, Performance & Informatics and Alison Ramsey, Director of Finance & Corporate Services (NWSSP) Rebecca Nelson introduced and talked the Board through the Shared Services Partnership IMTP, outlining the background, approach and development process, explaining that the IMTP sets out priorities and delivery plans for NWSSP, aligned to national expectations and the needs of host organisations. Rebecca confirmed that the Shared Services Partnership Committee (SSPC) had already approved the IMTP in January, and that it was now being brought to the Trust Board for awareness and assurance, rather than for further approval. Alison Ramsey focused on the financial and governance context, confirming that the IMTP was affordable and aligned with the financial framework, and that appropriate financial scrutiny and assurance had been applied through Shared Services governance routes. The Board noted ambiguity within the organisational chart in the IMTP, which appeared to show an 'Audit Committee for Shared Services' and 'The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership'. There was concern that having parallel or overlapping audit arrangements could compromise clarity of escalation and assurance to the Board. It was agreed that Shared Services colleagues would review this and clarify. The Trust Board **NOTED** the Shared Services IMTP 2026-2029.	**RN/AR**
7.0.0	**COMMITTEE HIGHLIGHTS FOR DISCUSSION**	
7.1.0	**Public Charitable Funds Committee Highlight Report (10/03/2026)** Led by Sara Moseley, Chair and Chair of the Charitable Funds Committee Sara Moseley explained that a number of services currently supported by Charitable Funds are core Trust services and that the Committee had therefore agreed to return these costs back to core Trust budgets. It was noted that while this did not pose a material risk for the current or next financial year, this approach may present a *future* financial risk, which would require active monitoring.	

	Matthew Bunce explained that, over the past three years, the Trust had been able to absorb the costs of such core services using exceptional non-recurrent income, higher than usual bank interest and other one-off income streams. This had enabled the Trust to avoid charging these costs to the charity during the period, despite business cases having been approved for those services. However, this position may not be sustainable in future years if similar non-recurrent income is unavailable. It was agreed that the Board would be kept informed throughout the year. The Trust Board **NOTED** the escalation.	
8.0.0	**CONSENT ITEMS FOR APPROVAL**	
8.1.0	**Trust Policies for Approval** Led by Sarah Jenkins, Interim Executive Director of People and Organisational Development There was one Workforce policy for Trust Board approval, which had been reviewed by NHS Wales. **(1) All Wales Reserve Forces Training and Mobilisation Policy.** The Trust Board **APPROVED** this policy.	
8.2.0	**Microsoft Enterprise Agreement – Strategic Case only** Led by Carl James, Chief Executive Officer (interim) The Trust Board **APPROVED t**he All-Wales Enterprise Agreement Business Case for Digital Health and Care Wales (DHCW) to contract for the Microsoft 365 suite of products, on behalf of all NHS Wales organisations, for the period 1st July 2026 to 30th June 2031, based on Option 2.	
8.3.0	**Chair's Urgent Actions** Led by Non Gwilym, Interim Director of Corporate Governance There was one urgent item of business for the Trust Board that was considered via Chairs Urgent Action during the period **23/01/2026 – 19/03/2026 – (1) All-Wales e-Rostering Solution – addition of Cardiff & Vale University Health Board Medical and Dental staff.** No objections to approval were received in respect of the items of business considered and the Trust Board **RATIFIED** the Chair's Urgent Action taken between the period.	
8.4.0	**NWSSP items for approval** Led by Alison Ramsey, Director of Finance and Corporate Services Three items were received from NHS Wales Shared Services for approval: **(1) All-Wales E-Rostering Solution contract –** Alison advised that this arrangement allows other organisations to join the contract in due course, highlighting its all-Wales, collaborative nature. The Trust Board **APPROVED** the additional expenditure to be incurred and recharged relating to the expansion of the **all-Wales E-Rostering Solution contract** to include Medical & Dental staff for a value of £5,183,463.27 excluding VAT and novate current local Medical and Dental contracts for Betsi Cadwaladr University Health Board (BCUHB), Cwm Taf Morgannwg University Health Board	

	(CTMUHB), Hywel Dda University Health Board (HDUHB) and Swansea Bay University Health Board (SBUHB). This increases the total contract value awarded to £21,842,446.27 excluding VAT (£26,210,935.52 including VAT). The Trust Board also **AUTHORISED** the Chief Executive to approve the purchase orders where they exceed NWSSP limits. **(2) NHS Resolution Service Level Agreement (NHSR) –** Alison advised that the Board was requested to approve the year 3 NHS Resolution SLA, noting circa £300k savings achieved and that work was currently underway to negotiate the next agreement. For clarity, Alison confirmed that 'NHS Resolution' is the working name, with NHS Litigation Authority being the organisation's legal title. The Trust Board **APPROVED** the £421,244 expenditure to comply with Year 3 of the overarching SLA which has been approved up to 31 March 2027 for the **NHS Resolution Service Level Agreement (NHSR)**. The Trust Board also **AUTHORISED** the Chief Executive to approve the purchase order. **(3) National GP Payments System -** Alison advised that this system is provided and supported by colleagues in Northern Ireland, noting that the arrangement had been originally approved by the Partnership Committee and Trust Board in 2019. Because the value sits above the Scheme of Delegation, Board approval was sought. The Trust Board **APPROVED** the 2026-27 expenditure under the current SLA for an established, secure and reliable **National GP Payments system** to enable the continuation of payments to GP Practices in Wales by NWSSP Primary Care Services. The cost for 2026-27 is £605,833 and is fully funded by Welsh Government. The Trust Board also **AUTHORISED** the Chief Executive to approve the purchase order.	
8.5.0	**Amendment to NHS Wales Shared Services Partnership Committee Standing Orders** Led by James Quance, Assistant Director of Corporate Services, NWSSP James Quance explained that while piecemeal changes to the Committee standing orders are not routine process, this had been necessary as a result of the standing down of the Committee Chair. James outlined that the purpose of the amendment was to change the composition of the panel responsible for making a recommendation to the Partnership Committee on the appointment of the Partnership Chair; specifically, ensuring that the Trust's Chair is included on the panel, reflecting Velindre's host role and responding directly to the first recommendation of the Governance Review. Non Gwilym re-iterated that this was a fast-moving piece of work, driven by the need to progress the appointment of a Partnership Chair within a tight timescale. Non also noted that a number of points within the annexe had been identified as requiring further review, and that more work remained to be undertaken on the documentation as part of the wider Governance Review implementation. The Trust Board **APPROVED** the revisions to the Annexe 5 process for the selection, appointment and termination of the Chair of the Shared Services Partnership Committee as set out in the appended version with track changes shown.	

9.0.0	**CONSENT FOR NOTING –** ***Several reports were removed from consent due to items for escalation.***	
9.1.0	**Trust Seal Report** Led by Non Gwilym, Director of Corporate Governance (Interim) The Trust Board **NOTED** the contents of the Trust Board Seal Register.	
9.2.0	**Public Quality, Safety & Performance Committee Highlight Report (12/03/2026) – including Q3 Integrated Quality and Safety Report** Led by Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee Vicky Morris reported that the Quality, Safety & Performance Committee was reassured by clearer risk themes and stronger divisional ownership of risk and would continue to monitor progress. The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 12th March 2026.	
9.3.0	**Public nVCC Project Scrutiny Sub-Committee Highlight Report (22/01/2026)** Led by Hilary Jones, Independent Member and Chair of the nVCC Project Sub-Committee The Trust Board **NOTED** the content of the report and actions being taken.	
9.4.0	**Public Strategic Development Committee Highlight Report (04/11/2025)** Led by Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee It was noted that this report had been drafted in November and that the digital items for escalation had progressed. Carl James indicated that there had been clear and shared recognition at a recent DDaT (Digital, Data and Technology) meeting that digital services are oversubscribed and have insufficient capacity, which is system-wide rather than a Trust issue. This is largely due to the demands of national programmes and priority projects. Carl advised that a clear view of Welsh Blood Service requirements had been established and that a similar meeting would take place to identify requirements for Velindre Cancer Service over the next 6-12 months. In terms of moving forward, a bid had been submitted to secure additional capital monies. It was agreed that an update would be brought back to the next Board. The Trust Board **NOTED** the content of the report and any actions being taken to address any issues highlighted in the meeting.	**CJ**
9.5.0	**Public Audit Committee Highlight Report (03/03/2026)** Led by Gareth Jones, Independent Member and Chair of the Audit Committee Gareth Jones highlighted the following items for escalation: • A number of management actions arising from audits had not been completed, with some persistently overdue. As a result, the Audit Committee downgraded	

	its assurance rating and indicated that Executive Directors responsible for outstanding actions may be required to attend the Audit Committee to explain lack of progress. • Digital risks were recurring across several assurance areas, including the Risk Register and Board Assurance Framework, causing concern at Committee level. • Compliance with management responses to internal audit findings was below the 85% target, at around 38%, delaying audit reports and creating assurance risks. • One internal audit received limited assurance. Although it was acknowledged that performance had improved significantly since fieldwork, the limited assurance still required formal reporting to Welsh Government. It was noted that these issues would continue to be actively managed through the Audit Committee, with further escalation to the Board if no improvement was evidenced. While members of the Executive team agreed that if timelines have been committed to and subsequently not met, notice of this should be provided in writing or attendance at the meeting should an ongoing issue require explanation. It was also pointed out that genuinely significant pressures on some Executive team members had been created by recent gaps within the team. In such instances, the relevant Executive could request an extension to delivery dates prior to the Committee. The Trust Board **NOTED** the content of the report and actions being taken.	
9.6.0	**Trust-wide policy approvals update** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **NOTED** the policies that have been approved during the period **January 2026 to March 2026.**	
9.7.0	**Shared Services Partnership Committee Assurance Report (22/01/2026)** The Trust Board **NOTED** the content of the report from the last meeting of the Shared Services Partnership Committee, which took place on 22nd January 2026.	
9.8.0	**NHS Wales Shared Services Audit Committee Highlight Report (10/02/2026)** The Trust Board **NOTED** the content of the report from the last meeting of the NWSSP Audit Committee, which took place on 10th February 2026.	
9.9.0	**Joint Commissioning Committee Highlight Report (27/01/2026)** The Trust Board **NOTED** the content of the report.	
9.10.0	**Strategic Partnership Update** Led by Lauren Fear, Director of Place, Portfolio and Partnerships The Trust Board **NOTED** the update.	
9.11.0	**Anti-Racist Wales Action Plan Progress Report** Led by Sarah Jenkins, Executive Director of People & Organisational Development (interim)	

	Lindsay Foyster explicitly highlighted that the WRES data is an important part of the overall staff experience picture and should not sit solely within the Anti-Racist Action Plan reporting, rather considered alongside the annual staff survey to enable the Board to effectively triangulate experiences and not miss key inequities. It was noted that the data had indicated that some BAME (Black, Asian and Minority Ethnic staff) were feeling less positive in certain areas compared with previously, which warranted further analysis by the Board. It was noted that the Board needs to demonstrate that this has been recognised and that action will be undertaken. This was acknowledged and Sarah Jenkins advised that the WRES data forms part of the wider evidence base used to understand staff experience, alongside staff surveys, staff stories and other qualitative data.	
10.0.0	**ANY OTHER BUSINESS** Led by Sara Moseley, Chair While no other business had been received prior to the meeting, the Chair wished to formally note that this was Nicola Williams' final Board meeting. She paid tribute to having worked closely with Nicola over the past six months, highlighting the consistent advice, support and expertise that Nicola had provided. She also emphasised Nicola's deep professional identity as a nurse and congratulated Nicola on her appointment to the Royal College of Nursing, recognising this as a role well suited to her values and national contribution. Carl James also spoke on behalf of the Executive team and the Trust, describing it as a privilege to have worked with Nicola since her arrival in 2019. Carl highlighted Nicola's visible leadership at Trust, regional and national level and the impact this had had on colleagues and patient care. In particular, Carl recognised Nicola's clinical leadership during COVID-19, describing it as steady, brave and decisive during a time of significant system pressure. Nicola thanked colleagues for their kind words, stating how it had been a privilege and pleasure to serve as Executive Director of Nursing, Allied Health Professionals and Health Sciences. She reflected on having done her best to represent these areas, noting that the primary driver throughout her role had been making a difference for patient outcomes and staff experience.	
11.0.0	**DATE OF NEXT MEETING** The next public meeting will take place on Thursday, 21st May 2026 at 10:00h.	
12.0.0	**CLOSE**	
13.0.0	**ITEMS FOR DISCUSSION AT PART B**	
	• Minutes of the previous meeting • Action log • NHS Wales Microsoft Enterprise Agreement – Full business Case • Readiness Master Plan • Private Trust Risk Register • Lineofsight Board Development Programme • NWSSP review implementation update • Scheme of Delegation – nVCC • nVCC Construction Programme • IRS Change in Machine Configuration to be installed at nVCC	

	• Chairs Urgent Actions • Commitments of Expenditure Exceeding CEO Limit • NWSSP items for approval • Private Committee Highlight Reports

MINUTES OF THE EXTRAORDINARY PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST (HYBRID)
30th April 2026 – 10:00am-10:10am

PRESENT	
Sara Moseley	Chair (remotely)
Lindsay Foyster	Vice Chair
Gareth Jones	Independent Member (remotely)
Vicky Morris	Independent Member (remotely)
Hilary Jones	Independent Member (remotely)
Carl James	Chief Executive Officer (interim) (remotely)
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director / Deputy Chief Executive (interim)
Sarah Jenkins	Executive Director of People and Organisational Development (interim)
ATTENDEES	
Anne Carey	Chief Operating Officer
Lauren Fear	Director of Place, Portfolio and Partnerships
Carl Taylor	Chief Digital Officer
Non Gwilym	Director of Corporate Governance (interim)
Kyle Page	Business Support Manager (Secretariat)

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	**Welcome and Apologies:** The Chair welcomed attendees to the meeting, noting the following apologies: • Victoria Oxley, Director of Strategy, Planning and Performance • Gillian Knight, Interim Executive Director of Nursing, Allied Health Professionals and Health Science • Andrew Westwell, Independent Member • Ceri Doyle, Independent Member • John Union, Independent Member The Chair explained that there was one item on today's agenda for approval; the Strategic Business Case for the Talbot Green Infrastructure (TGI) Programme. Lauren Fear and the team were thanked for their work on developing this.	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Alan Prosser, Director, Welsh Blood Service (remotely) • Sarah Richards, Head of Planning and Performance Services, Welsh Blood Service (remotely) • Jason Hoskins, Assistant Director of Estates, Environment and Capital Development (remotely) • Ben Leijokari-Olosunde, Aspiring Board Member Programme • Annie Evans, Deputy Director of Nursing, Quality and Patient Experience (deputising for Gillian Knight)	

	• Richard Skone, Deputy Medical Director	
1.3.0	**Declarations of Interest** There were no declarations of interest noted in respect of today's agenda.	
2.0.0	**ITEMS FOR DISCUSSION**	
2.1.0	**Talbot Green Infrastructure (TGI) Programme – Strategic Business Case** Led by Lauren Fear, Director of Place, Portfolio and Partnerships Lauren Fear introduced the Strategic Case for the Outline Business Case (OBC) for the Talbot Green Infrastructure (TGI) Programme, which set out the rationale for the need to modernise the infrastructure to support increasing and changing demand across the services. It was advised that the Strategic Business Case had been endorsed by Executive Management Board and scrutinised by the Strategic Development Committee, with issues addressed and member briefings completed prior to submission for Board approval. The Strategic Business Case set out a dual case for change, with the primary driver being resilience of critical infrastructure, alongside longer-term service delivery and sustainability considerations; it had also been developed in partnership with, and with assurance from, Welsh Government and specialist estates colleagues (via NWSSP). The next step would be submission to Welsh Government, (subject to Board approval), aligned with the current scrutiny timetable. Jason Hoskins advised that, from a risk perspective, the Welsh Blood Service building constituted critical NHS Wales infrastructure with insufficient and non-compliant existing services, creating a business-continuity risk that the programme was intended to mitigate by delivering resilient infrastructure capable of meeting required standards. Alan Prosser explained that, operationally, the programme would future-proof the Welsh Blood Service facility for the next 30 years, enabling it to keep pace with advancing transfusion, transplantation and diagnostic technologies, support automation and advanced therapies, address existing building constraints, and provide a modern environment that supports workforce recruitment and retention while expanding services such as donor care, plasma for medicines and apheresis. Lindsay Foyster, as Chair of the Strategic Development Committee, further assured the Board that members had received detailed briefing sessions in advance and that the Committee had undertaken informed and thorough scrutiny of the Strategic Business Case in the public session, supported by significant input by Committee members. The Board queried whether the Strategic Business Case sufficiently addressed digital requirements, specifically whether the Talbot Green Infrastructure building would be fit for national and planned Welsh Blood Service digital programmes or would require further adaptation to be genuinely "digitally smart", noting limited references to digital capability in the paper. Jason Hoskins explained that a "smart" building encompasses both mechanical/electrical systems and digital infrastructure, advising that the project would introduce a new Building Management System (BMS) to deliver smart, resilient infrastructure from day one, alongside the wider digital components addressed by colleagues.	

	Additionally, Carl Taylor advised that the Talbot Green Infrastructure would use the same smart network infrastructure already being deployed elsewhere across the Trust, including the new Velindre Cancer Centre, enabling digital capabilities such as asset tracking and supporting automation, and confirmed that TGI would adopt this established strategic digital approach rather than a bespoke solution. Lauren Fear acknowledged that the digital capability had not been written explicitly into the current strategic case and confirmed that the wording would be strengthened to clearly reflect the smart digital infrastructure approach described, noting that this could be explicitly added to the strategic case prior to submission. The Trust Board **APPROVED** the Strategic Case for investment in the Talbot Green Infrastructure Programme to ensure long-term resilience, sustainability, and service continuity for NHS Wales. Alan Prosser wished to formally record his thanks to Sarah Richards and Jason Hoskins for their diligence, professionalism and sustained commitment over a long and complex project, noting their exemplary coordination of stakeholders and positive engagement with staff.	**LF**
3.0.0	**ANY OTHER BUSINESS**	
3.1.0	Led by Sara Moseley, Chair The Chair had not received any items of any other business prior to the meeting and no other business was raised.	
4.0.0	**ITEMS FOR DISCUSSION AT EXTRAORDINARY PART B**	
	Led by Sara Moseley, Chair The Chair advised that the Talbot Green Infrastructure (TGI) Programme Full Business Case would be discussed at today's Extraordinary Part B session.	
5.0.0	**CLOSE**	

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	**AGENDA ITEM**	**Action number**	**ACTION**	**LEAD**	**DEADLINE DATE**	**UPDATE (including date)**	**STATUS**
26/03/2026	**1.4.0**		**Minutes of the Public Trust Board meeting held on 29th January 2026**				
		66	Page 8 of the minutes indicated that a Board Development Session would be required to provide better understanding of delivery of Phase 2 of the Digital Health and Care Record (DHCR) work and that this should be captured as an action.	All Board Members	**21/05/2026**	**March update** - Secretariat captured on Board Development Session workplan for a future date.	**PROPOSE TO CLOSE**
26/03/2026	**1.6.1**		**Fire Safety Training Compliance Improvement Plan**				
		67	Return to the Board with a clear timescale for achieving the target level of compliance with Level 2 fire safety training (trust-wide).	Director of Place, Portfolio and Partnerships	**21/05/2026**	Analysis has been undertaken and in order to reach target compliance, an additional 70 staff need to be trained by end of August (this takes into account those whose training expires over this period too). There is sufficient capacity on the seven courses scheduled for May-August. The Fire Safety lead is working with the operational mangers to ensure all required staff are booked	**PROPOSE TO CLOSE**
26/03/2026	**3.1.0**		**Chair's Report**				
		68	1) Formally write to the Welsh Blood Service teams to thank them for the scale and quality of work undertaken regarding donors. 2) Cascade Chair's objectives set by the Cabinet Secretary to Independent Members and the	Chair Chair	**21/05/2026**	**May update:** Letter sent from Chair to Director of WBS 05/05/2026. **March update:** Objectives have been cascaded.	**PROPOSE TO CLOSE**
26/03/2026	**4.1.0**		**Performance Management Framework**				
		69	Provide the Board with a short briefing regarding how levels of assurance work and how they are applied, in particular for newer Board members.	Interim Director of Corporate Governance	**21/05/2026**	Briefing documentation shared with Independent Members.	**PROPOSE TO CLOSE**
26/03/2026	**5.1.0**		**Embedding the Donor & Patient Voice across VUNHST**				
		70	Board development session to explore further development in relation to the wider engagement in service change and improvement requirements.	Interim Director of Corporate Governance	**21/05/2026**	Topic included on Board Development agenda item grid.	**PROPOSE TO CLOSE**
26/03/2026	**5.1.0**		**Embedding the Donor & Patient Voice across VUNHST**				
		71	Rework the paper that had been brought to the March Trust Board outside the meeting, retaining requirements for QSP Committee assurance, and to return to Board once the engagement and co-production approach has been more clearly defined.	Executive Director of Nursing (new EDoN not present at meeting)	~~**21/05/2026**~~ **30/07/2026**	Update proposed for July meeting. Deadline extension request.	**OPEN**
26/03/2026	**5.4.0**		**Board Committee Structure**				
		72	Mapping exercise to be undertaken once Terms of Reference for restructured Committees have been drafted, to identify any gaps.	Interim Director of Corporate Governance	**21/05/2026**	Issue included on project plan for Committee restructure.	**PROPOSE TO CLOSE**
26/03/2026	**6.2.0**		**NWSSP IMTP 2026-2029**				
		73	Clarify ambiguity in the organisational chart contained within the IMTP, which appears to include an 'Audit Committee for Shared Services' and 'the VUNHST Audit Committee for NHS Wales Shared Services Partnership'.	Alison Ramsey / Rebecca Nelson (Shared Services)	**21/05/2026**	**March update** - Clarification received from NWSSP on 26/03/2026 that this is an editing error and that the document would be amended to include 'The Velindre University NHS Trust Audit Committee for NHS Wales Shared	**PROPOSE TO CLOSE**
26/03/2026	**9.4.0**		**Public Strategic Development Highlight Report**				
		74	Update to be brought back to Board regarding Digital (resource) requirements for both divisions over the next 6-12 months, including an update on the bid submitted to secure additional capital	Chief Executive Officer	~~**21/05/2026**~~ **30/07/2026**	Update proposed for July meeting. Deadline extension request.	**OPEN**
30/04/2026 (EXTRAOI	**2.1.0**		**Talbot Green Infrastructure (TGI) Programme - Strategic Business Case**				
		75	strengthening the wording to reflect that smart digital infrastructure approach described during the meeting.	Director of Place, Portfolio and Partnerships	**21/05/2026**	Updates made and final versions submitted to Welsh Government for their scrutiny process to commence.	**PROPOSE TO CLOSE**

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Turning treatment into Donations

Elisabeth Davies, Principal Clinical Scientist,
Joanne Gregory, GH Clinical Coordinator,
Welsh Blood Service

Introductory video aimed at people with Genetic Haemochromatosis

https://www.bing.com/videos/riverview/relatedvideo?q=welsh+blood+service+youtube+Genetic&mid=27D71F1720FECF2DE25327D71F1720FECF2DE253&churl=https%3a%2f%2fwww.youtube.com%2fchannel%2fUCRGsfK6H03YNCauZhrA2Wiw&FORM=VIRE

Quality Street made for sharing

"WBS Change programme that benefits GH Patients, clinicians & our population"

Grant Evans

Donor/Patient with Genetic Haemochromatosis

Grants Story

63-years-old, retired

20 years senior leadership & service improvement manager at NHS Wales

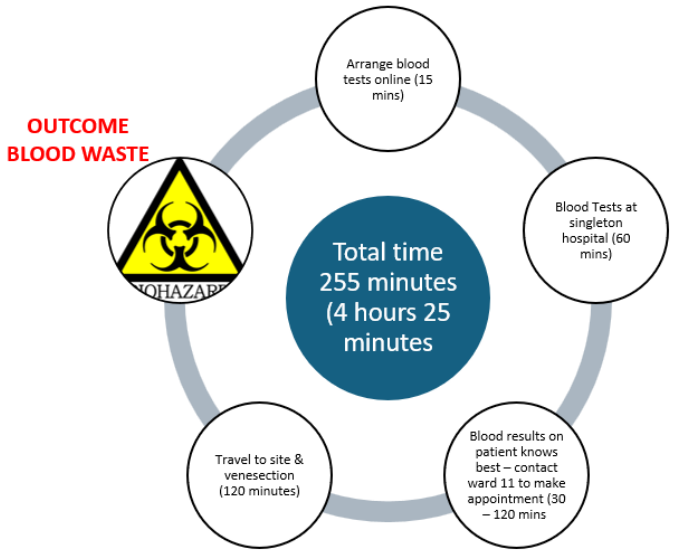
Genetic Haemochromtosis Patient since 2003 (first diagnosed)

Welsh Blood Service Donor since 2020

Change agent - influencing for positive change for people with Genetic Haemochromatosis in Wales

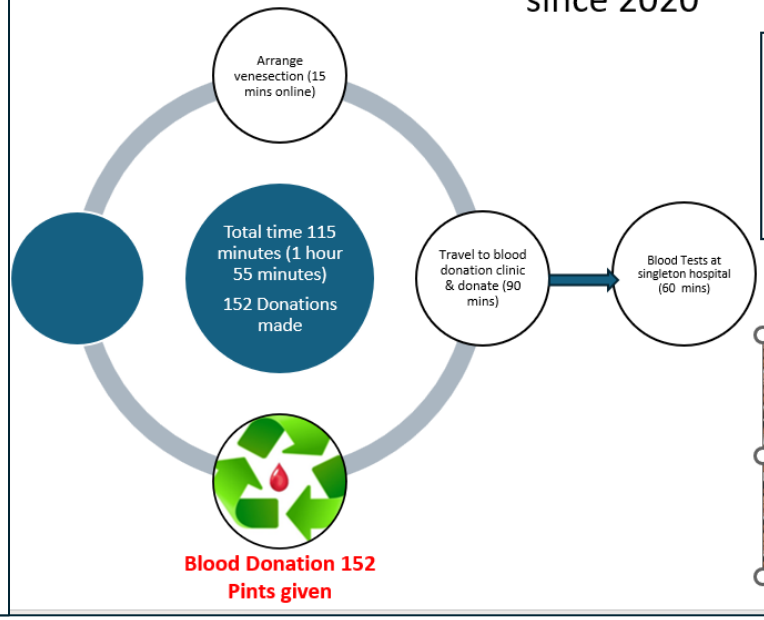
Grants experience of the two pathways

SBUHB treatment cycle 2003 - 2020

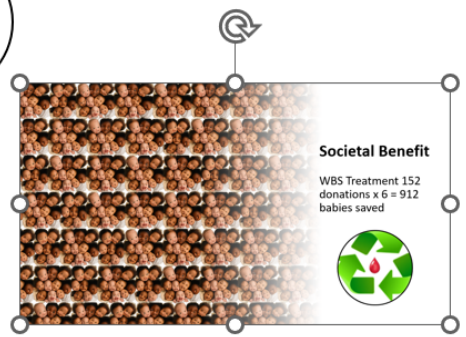


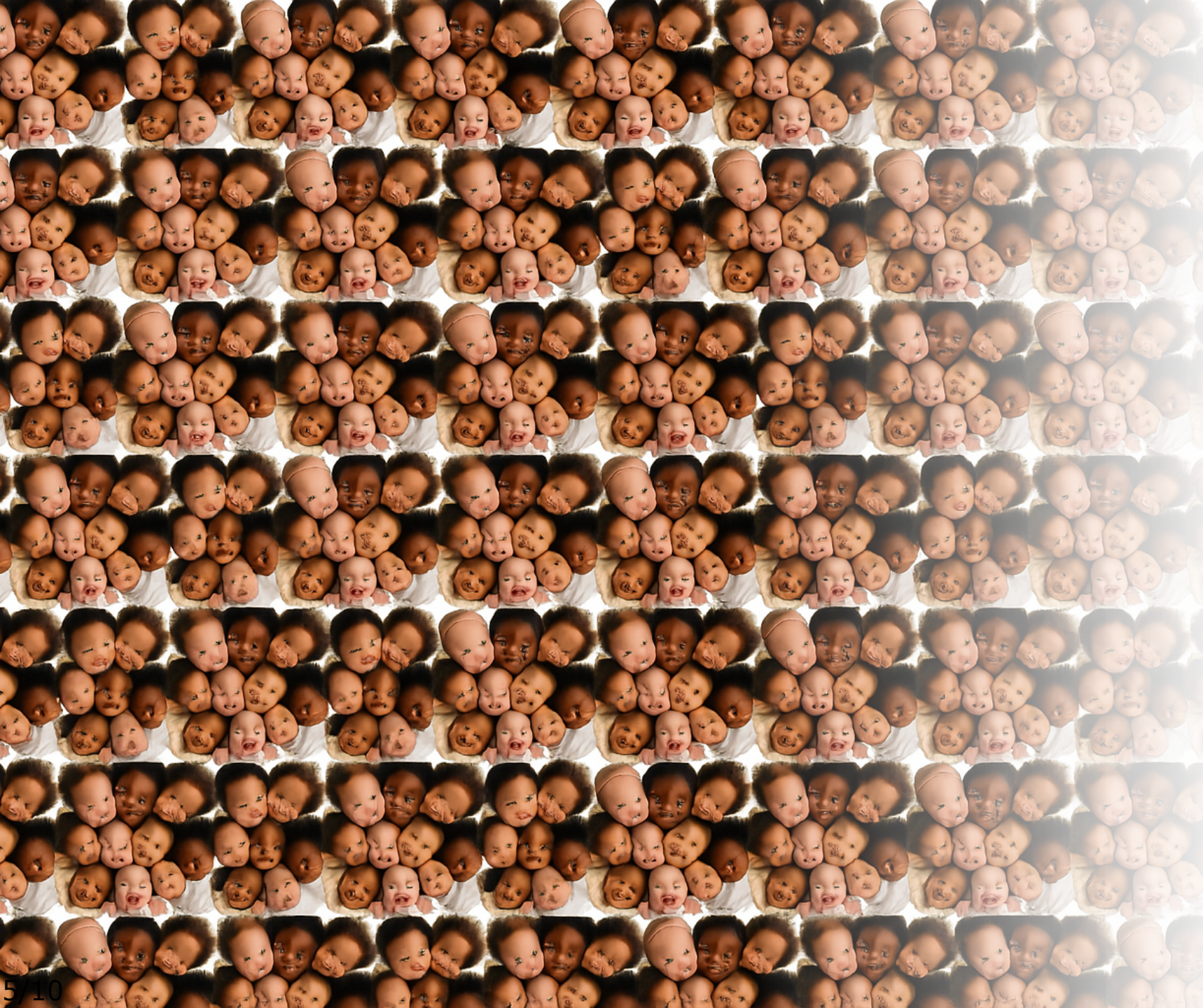
255 minutes x 4 venesections a year x 38 years = 38,760
646 hours in total
646 hours in working weeks=17.2 weeks or 4.3 months

Genetic Haemochromatosis (GH) WBS donation treatment cycle since 2020



115 minutes x 4 venesections a year x 38 years = 17,480
divided by 60 = 291 Hours
291 hours in working weeks = 7.76 weeks or 1.9 months





Societal Benefit

WBS Treatment 152 donations x 6 = 912

babies saved

Positive patient donor quotes (donor survey)

It is very easy and a lot more user friendly than any other clinic I have been to

Keep on educating people

Convenient location, great parking

I love the idea that my blood is useful

Parking is good, a more relaxed environment, blood is going to someone who needs it.

Helps others and eases pressure on over-burdened NHS services

Saves lives

It's easier to manage my WBS venesection appointment online

It's good not to waste blood

Easy process to book appointments with lots of time slots available to plan around work

I can drop in on my way home from work

My blood gets recycled

Future areas for improvement (donor survey)

More streamlined registration process, less repetition

We need more donor clinics in Aberystwyth

Now I've moved to south Wales it's a lot easier to donate than it was in Mid Wales

Clinics to be advertised more in advance

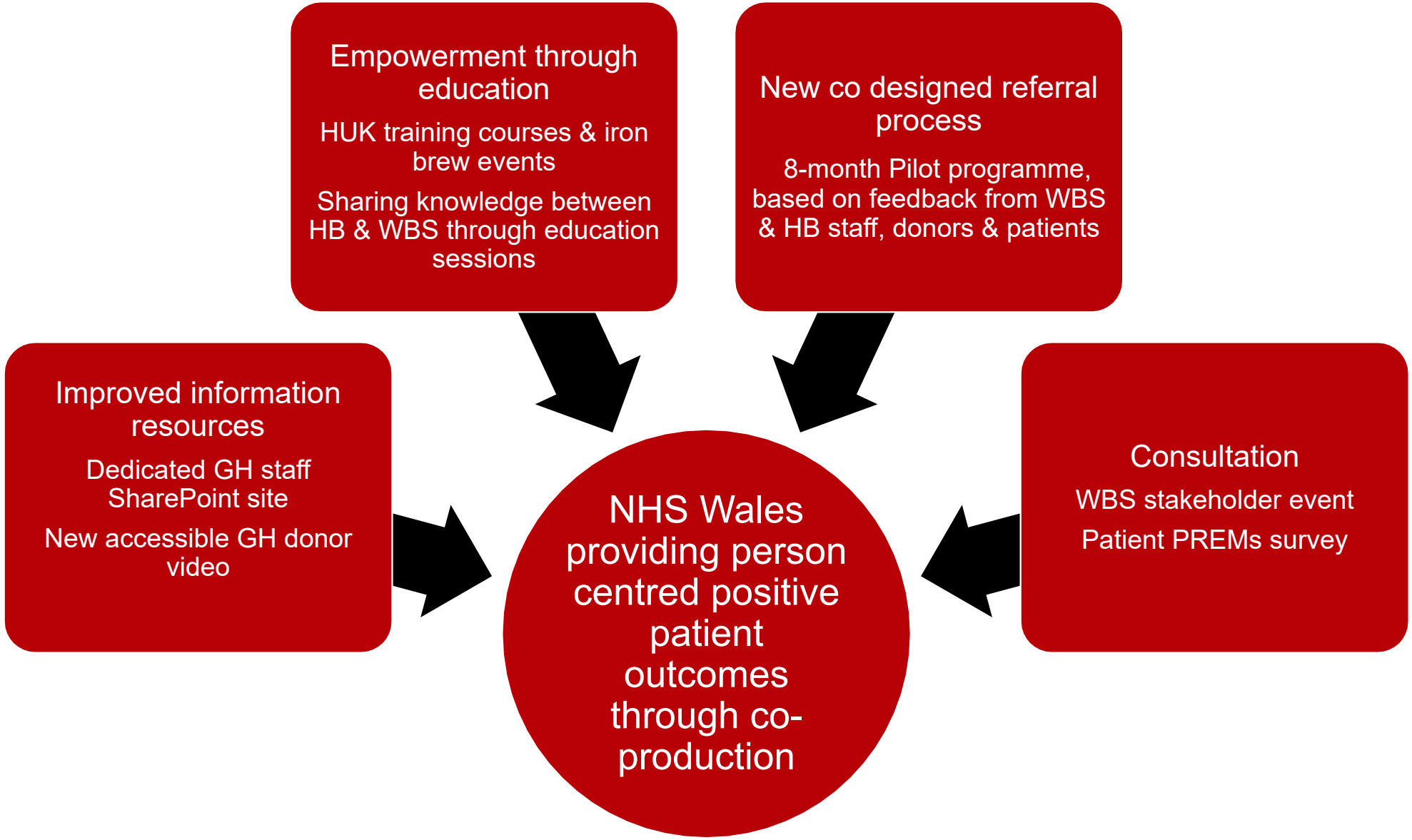
The WBS IT system needs work to standardise and simplify the process for GH donors

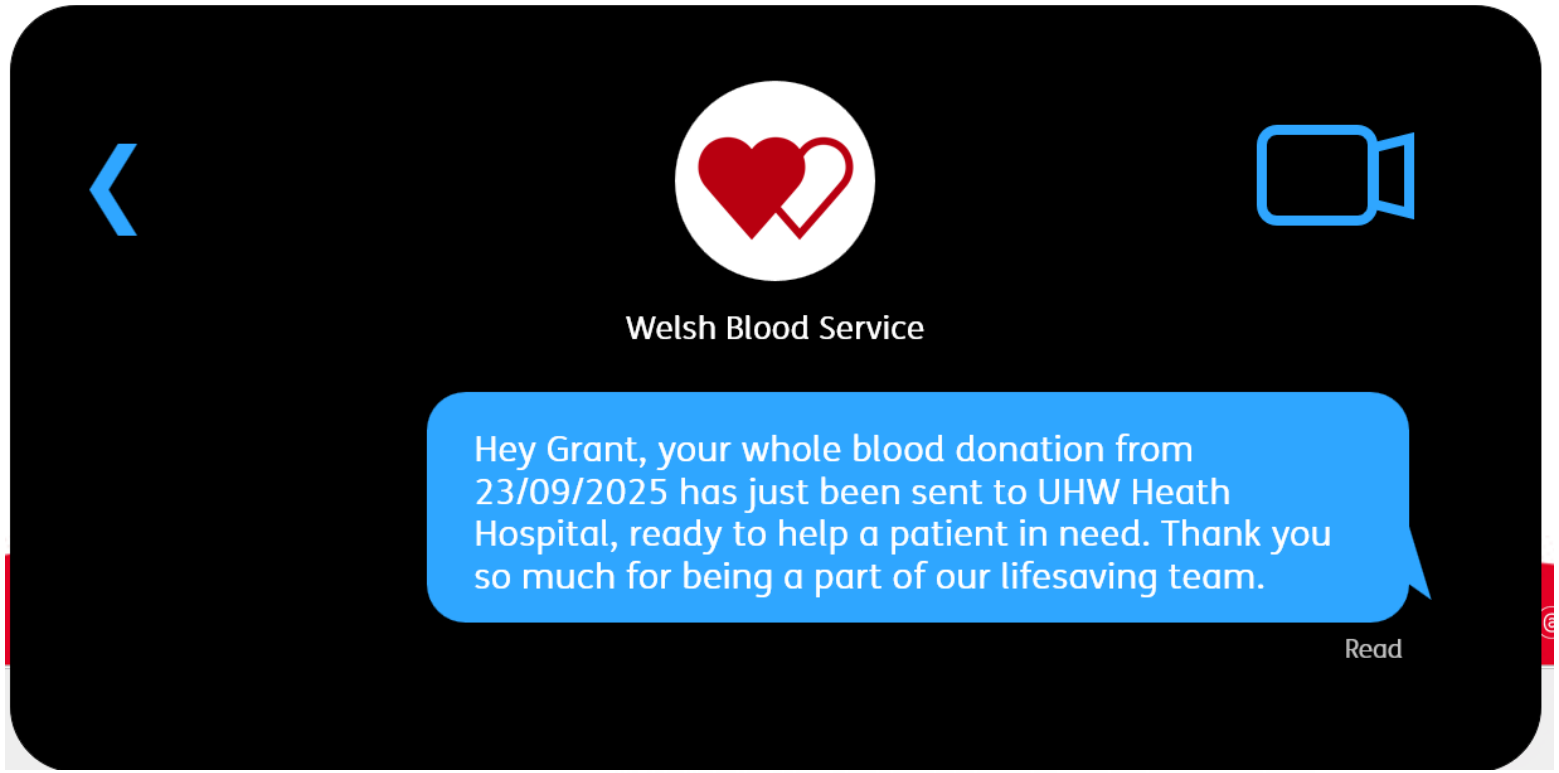
Patient becomes a donor

Blood is utilised not discarded (circular economy)

Patients in need receive blood

Turning Treatment into Donations


Empowerment through education
HUK training courses & iron brew events
Sharing knowledge between HB & WBS through education sessions
New co designed referral process
8-month Pilot programme, based on feedback from WBS & HB staff, donors & patients
Improved information resources
Dedicated GH staff SharePoint site
New accessible GH donor video
NHS Wales providing person centred positive patient outcomes through co-production
Consultation
WBS stakeholder event
Patient PREMs survey



Seeing the recent changes happening to help people like me donate blood has made me feel quite emotional at times. It has always made perfect sense to me that my blood could be used to help others. During my venesections in the hospital, I would often be sat near to someone receiving a blood transfusion. Knowing that my blood is now going to help someone who needs it is very fulfilling.

Grant Evans (Blood Donor/patient/GH advocate)

TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	21 May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sara Moseley, Chair
PRESENTED BY	Sara Moseley, Chair
APPROVED BY	Sara Moseley, Chair
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To **NOTE** the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
7 LEVELS OF ASSURANCE – N/A	

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of Chair's activity since the last meeting of the Trust Board.

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Chief Executive and Board recruitment
- Recruitment of Interim Director of Nursing, Allied Health Professionals and Health Science
- Recruitment of Consultant in Skin Cancer and Sarcoma
- Board effectiveness and governance
- Board Development Session
- Implementing the Shared Services (NWSSP) review and recruiting a new Chair of the Committee
- Welsh Blood Service – final round of donor awards and 10th anniversary as a national service
- End of Year Reviews with IM's and CEO
- Public Bodies Chairs Meeting
- Meeting with CEO of Llais
- Spotlight on the Therapies team
- Visit to University College Hospital London Cancer Centre
- Service of Remembrance – Infected Blood Inquiry

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Chief Executive and Board Recruitment

One of the most important and impactful things a Chair ever does is lead the process to select a Chief Executive of an organization. Stable, cohesive and ambitious leadership is the bedrock of a thriving organization. We have been through change at the top and I am immensely grateful to Carl James and the team for steering us through. We are now recruiting a substantive Chief Executive before moving on to fill other Executive vacancies, starting with the Directors of Governance and of Workforce and Organizational Development.

CEO recruitment opened on 6 May, and we hope to appoint in July. As well as formal interviews, we will be asking colleagues what they want to see from the next CEO and inviting stakeholders to be part of the process. The Board has a number of clear priorities over the next few months and securing our Executive team for the next few years in one of them.

3.2 Recruitment of Interim Director of Nursing, Allied Health Professionals and Health Science

We celebrated Nicola Williams' time with us as Director of Nursing, Allied Health Professionals and Health Science. A clinician through and through, Nicola is now leading the Royal College of Nursing in Wales and is an Executive Director of its work across the UK. From the very start Nicola not only made me feel welcome but took time and care to make sure that, as new Chair, I understood how the organization works and how the quality of care for patients and donors is foundational to everything we do. She was a strong advocate for health science, nursing and allied health professions and I hope the focus on this report on Therapies is a tribute to her.

Gill Knight, replaced Nic on an interim basis in April. She is a fantastic addition to out Board team – fresh from working in Government as Deputy chief Nurse and also with deep roots in nursing and in Velindre. Welcome to her first Board meeting.

3.3 Recruitment of Consultant in Skin Cancer and Sarcoma

It was an absolute pleasure to Chair a recruitment panel in April for a Consultant Medical Oncologist with a specialist focus on Sarcoma and Skin cancer. Listening to expert colleagues on the panel gave me an additional insight - particularly the opportunity to develop care for Sarcoma patients. We interviewed three excellent candidates each with so much to offer. I am delighted to say that Sadiq Shanaz has accepted the role and begins with us on August 24th from Ysbyty Glan Clwyd.

3.4 Board effectiveness and governance

Having decided to focus on simplifying and updating our governance and committee structures and on being as effective as we can as a Board, we have been working intensively with each other and with our partners, Line of Sight. The IM Chairs and Executive leads of each new committee have been working together to develop the remit and ways of working as well as how each committee links to Directorates and up to the Board. Clearly communicating what we are doing and why is really important if colleagues are to get a clear sense of how issues are considered and decisions made at the Trust and how they fit into that. It is also important in terms of our accountability to the public. In June, Board members will

have an opportunity to review the outcomes and insights gathered in total, getting us ready to launch the new committees in the summer and continue to improve and refine them over the remainder of the year.

This work is as much about culture, leadership and behaviours as it is about committee structures and business. We have a really important opportunity to hold a mirror up to ourselves and work together to be the most effective Board we can drive by our values of care, respect and accountability. The Executive are working together to make the most of these links with our Workforce and OD Director, in particular, drawing on what we are learning about our culture and how to continue to strengthen it.

3.5 Implementing the Shared Services (NWSSP) review and recruiting a new Chair of the Committee

We continue to meet regularly to implement the recommendations of the Welsh Government's review. One of the recommendations is that the Chair of Velindre should be involved in the recruitment of the Chair of NWSSP Committee and that there should be consideration of how that Chair reports on hosted matters. Both these points are being progressed, and I will be involved in the recruitment of the new Chair in June.

3.6 Board Development Session

The Board met for yet another successful development session. Topics included a pre-election briefing from the Welsh Confederation, Duty of Candour training, a presentation from Carl James and Richard Skone on improving cancer services, performance and improvement session by Chris Clayton from the NHS Wales performance and improvement team and a workshop led by Jacinta Abraham and Lauren Fear alongside Rachel Savoury and Zoe Hilton from Cardiff Health Partners.

3.7 Welsh Blood Service – final round of donor awards and 10th anniversary as a national service

May 2026 marks the tenth anniversary of the Welsh Blood Service becoming a fully integrated all-Wales Service, following the inclusion of North Wales in 2016. This milestone reflects a decade of progress in building a single, coordinated national service supporting patients across the country. Over this period, donors

in North Wales have provided around 160,000 donations from nearly 40,000 individuals, contributing over 20% of the Welsh total, while the Service now collects approximately 350 units of blood daily to support 19 hospitals across Wales and the Wales Air Ambulance.

The anniversary recognises the vital generosity of donors and the dedication and collaboration of staff across North and South Wales, whose collective efforts have been integral to delivering a resilient, unified service.

3.7 End of Year Reviews with IM's and CEO

The new NHS accountability arrangements reiterate the importance of setting and reviewing objectives and performance. As Chair, my objectives come from the Cabinet Secretary and are then cascaded by me to Independent Members and to the Chief Executives. We develop these with our context and priorities and are ultimately responsible and accountable for them. I have now met with all IM's and with the CEO to review 25/6 and discuss 26/7. Whilst I have objectives set by the previous Cabinet Secretary, we may also have additional areas for focus from the incoming Government. As we strengthen our governance, we will also consider how we bring more visibility to individual and Board objectives and performance, including through our Remuneration Committee.

3.8 Public Bodies Chairs Meeting

The main items covered at the 28th April Chair Peer Group meeting were a very helpful update from Chris Clayton, Managing Director NHS Wales Performance and Improvement (P&I) on the new Accountability Framework and role of P&I together with an update from Nesta Lloyd-Jones on the pre-election position regarding the Senedd Elections. Both items were presented directly to the Trust Board at the Board Development Day a couple of days later on 30th April.

3.9 Meeting with CEO of Llais

I met with Alyson Thomas, CEO of Llais, to discuss how we can work together more closely with the citizens voice body for Wales. Set up as an independent statutory body to give people in Wales more say in the planning and delivery of health and social care services some three years ago, Llais are keen to have a more direct relationship with us. Our Interim Director of Nursing, Allied Health Professionals and Health Science is now in touch with Alison to explore further how we work together

to make us as aware of and responsive to patients and donors as we can be to get things right and make care better.

3.10 Spotlight on the Therapies team

I attended the Cancer centre to meet Kate Baker and her team who provide some fantastic therapies to our patients. I was fascinated and proud of the team that deliver these invaluable sessions.

The role of AHP's at Velindre Allied Health Professionals (AHP's) at Velindre Cancer Centre include Psychology, Nutrition & Dietetics, Occupational Therapy, Physiotherapy and Speech & Language Therapy. All are registered autonomous professionals within the multidisciplinary team who support patients from diagnosis through treatment, recovery and palliative care.

Rehabilitation is recognised as an essential component of care, supporting individuals to maintain and maximise their quality of life before, during and after oncology treatment. The range of interventions provided, help patients to:

- maintain independence and functional ability
- Improve tolerance from treatment
- reduce treatment-related complications
- Improve clinical outcomes
- Improve nutrition, communication, and symptom management
- Improve quality of life and psychological wellbeing
- Improve patient experience
- Remain at home safely for longer/admissions prevention

I am especially proud of the unique contribution AHPs make to holistic, person-centred cancer care, ensuring patients remain active participants in goal setting and decision-making throughout their cancer journey. This, along with the biopsychosocial approach to care, directly contributes to better patient experience and improved clinical outcomes. Over the last few years, the team have developed highly specialist roles across Therapies to ensure the right people, with the right skill set, at the right place, to deliver excellence in care.

The team are looking forward to the transition to nVCC, although recognising there is still significant work to do. A key priority will be strengthening the digital approach to support more efficient and effective service delivery, alongside continuing to build and strengthening working with local health board colleagues, to ensure effective

communication, coordinated care and continuity of rehabilitation support across organisational boundaries throughout the cancer pathways.
The voice of AHPs is essential in shaping holistic care as they deliver medical treatment, but patients will live with the physical, emotional, and functional consequences beyond treatment, and that is where AHP's, are an essential component to the patient pathway. Enabling patients to live as well as they can, for as long as they can.

Attached is some information on the various therapies that the Cancer Centre deliver:

Dietetics at VCS	**Physiotherapy at VCS**
HoN Service Outline	**SLT Service Outline**

3.11 National Service of Remembrance – Infected Blood Inquiry

The Infected Blood Inquiry was established in 2018 to examine the circumstances in which men, women and children treated by national Health Services were given infected blood and infected blood products, since 1970 to the mid-1990s.

The Trust was a Core Participant in this Inquiry and provided thousands of documents to it to help understand what happened. A number of statements were also issued to the Inquiry from the Trust answering a number of key questions.

The Trust has hosted the Welsh Blood Infected Support Scheme (WBISS) since October 2017, and has provided both a streamlined financial payment service, a Welfare Advice Service and a Psychology and Well-being service for Welsh beneficiaries and their families

The Inquiry's final report was published on 20 May 2024 and the Inquiry officially closed on 31st March 2026. A national service of remembrance at St Paul's Cathedral for the infected blood community was held on Tuesday 19 May 2026 – nearly 2 years on from the publication of the report. The Trust was represented at this event by the WBS Director – Alan Prosser.

The Trust is also playing a key role in implementing the Recommendations from the IBI via the Welsh Government IBI Next Steps Group and is leading on several key areas including the implementation of a system that can trace the

journey of the blood donation from donor to recipient and the education of future medical staff.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
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
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

TRUST BOARD	
CHIEF EXECUTIVE'S UPDATE REPORT	
DATE OF MEETING	21 May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Carl James, VUNHST Chief Executive (interim)
APPROVED BY	Carl James, VUNHST Chief Executive (interim)
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chief Executive's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the content of the Chief Executive's report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

This paper provides the Trust Board with an overview of the Chief Executive's activity since the March Board meeting:

Visits

Visits to nVCC site with Cwm Taf Morgannwg CEO and Chair – 2nd April, and Cardiff and Vale CEO and Chair – 9th April

The Chair and I were delighted to accompany senior colleagues from Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to the new Velindre Cancer Centre site, to share updates on building progress. They were delighted to see the new building and took the opportunity to identify potential opportunities for collaborative working once the centre is complete.

30th Birthday celebration at Maggie's – 12th May

This event marked 30 years since Maggie's opened its first centre in Edinburgh in 1996. Over the last three decades, Maggie's has grown significantly, with around four million visits to centres to date. Maggie's provides our unique support across 27 centres in the UK; growing numbers of people are receiving a cancer diagnosis and therefore the need for Maggie's is growing too. Maggies' overall ambition is to be at all 60 major cancer hospitals in the UK, to be here for everyone impacted by cancer. The event was also to thank the Maggie's community of supporters who have helped ensure that our centre in Cardiff has been here for the last seven years for people with cancer and their loved ones and will continue to be here in the future.

Meetings of note

NHS Wales Leadership Board meetings – 24th March and 21st April

I attended the March and April meetings of the NHS Wales Leadership Board with fellow CEOs and Welsh Government colleagues, which focused on the following areas:

- Performance, Improvement and Finance
- Development of the National Patient Safety plan
- Development of a National Clinical Plan
- Emergency Care
- Value and Sustainability
- Covid-19 Inquiry Report Response

- Workforce and Waiting Times

Medical Leadership Forum Awayday – 25th March

I and a number of clinical colleagues attended the Awayday at Llanerch Vineyard, which focused on system leadership and clinical model, cultural milestones, and financial sustainability and value. Discussions also centred on nVCC 'readiness' and the Trust's priorities over the coming months.

NHS Wales Shared Services Review Implementation Group Meeting – 27th March

Following the inaugural meeting of the NWSSP Review Implementation Group on the 19th February, the meeting, which was also attended by the Trust's Chair, senior Shared Services Colleagues and Welsh Government Colleagues discussed progress to date, the development of a prioritised work programme and revised Terms of Reference, governance arrangements for support to clinical services and the panel for the appointment of a new Chair of NWSSP Committee.

Federation of Specialist Hospitals Member Meeting – 27th March

I attended the March Federation of Specialist Hospitals Member meeting, which provided an opportunity to hear from the Health Data Research Service (HDRS) on national priorities for data and the evolution of the service, to explore emerging opportunities for AI for specialist hospitals and to consider the programme of work for the coming year.

The meeting was also attended by Lt Col Dr Kevin Eardley, (Clinical Director of 202 (Midlands) Multi-role Medical Regiment (Army Reserve), Consultant Physician, and Veteran Aware Lead Champion of Shrewsbury and Telford Hospital NHS Trust), to encourage healthcare professionals to join the army reserves.

Chief Executive Management Team (CEMT) meeting – 7th April

I attended the April meeting of the Chief Executive Management Team. Discussions included Maternity / Neonats, Diabetes self-management, and draft items for the 2026 Digital Conference, to be hosted by Digital Health and Care Wales in collaboration with the NHS Wales Confederation.

Acorn Liaison Committee Meeting – 28th April

The April Acorn Liaison Committee meeting attended by the nVCC Project Director, Senior Responsible Officer, Acorn Colleagues and myself reviewed the construction programme status, final commissioning programme, completion of stage 4 design and quality compliance.

nVCC Project Readiness Board – 29th April

Following the previous two meetings of the newly established nVCC Readiness Board this meeting, chaired by myself, focused on the following areas:

- Progress updates against scope and deliverables
- Health Board Partners' involvement in transition planning
- Accommodation – desk space
- Apheresis stem cell collection rooms
- Integrated Radiotherapy Solution (IRS) Risks
- Review of Terms of Reference

Development Day for Chief Executives of Statutory Bodies – 5th May

A Chief Executive Awayday was held in place of the May Chief Executives Management Team (CEMT) meeting on the 5th May at the Park Plaza in Cardiff, the purpose of which was to provide an environment in which Chief Executives could reflect and look ahead, forming a shared understanding and agreement of our collective purpose, function and role.

It provided an opportunity to consider how our impact could be maximised by the way we work together, in addition to the quality of our relationships with Welsh Government and other Stakeholders.

Discussions were consolidated to form a clear picture of our future intentions and agreed next steps.

4 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)	**Choose an item** N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
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
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

Trust Board	
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR March 2026	
DATE OF MEETING	21/05/2026
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	Caitlin Davies, General Management Graduate Trainee Kathy Ikin, Deputy Director of Transformation, Planning and Performance
PRESENTED BY	1. Victoria Oxley, Director of Strategy, Planning and Performance (Interim) 2. Anne Carey, Chief Operating Officer 3. Sarah Jenkins, Executive Director OD & Workforce 4. Carl Taylor, Chief Digital Officer, 5. Lauren Fear, Director of Place, Portfolio & Partnerships 6. Matthew Bunce, Executive Director of Finance
APPROVED BY	VICTORIA OXLEY, DIRECTOR OF STRATEGY, PLANNING AND PERFORMANCE (INTERIM)
EXECUTIVE SUMMARY	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW** The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in Section 1 which focus on the key issues to be raised and discussed for March 2026.
RECOMMENDATION / ACTIONS	**The Trust Board is asked to take ASSURANCE from the Performance Management Framework for the month of March 2026.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	(08/04/2026)
VCS OMB / Performance Review	(21/04/2026)
Executive Management Board	(27/04/2026)
Quality Safety and Performance Committee	(07/05/2026)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The report has been considered and endorsed at the VCS and WBS Performance Review meetings, Executive Management Board and the QSP Committee and is presented to the Quality Safety and Performance Committee for assurance on the Trust's performance for the month of March 2026.

The following matters of note were discussed at QSP and are recorded here to aid the Trust Board in receiving this report with that context laid out.

- **The Performance Management Framework will be updated during 2026-2027 to reflect the new Welsh Government Accountability Framework and support monitoring and compliance of the IMTP.**

7 LEVELS OF ASSURANCE	
Velindre Cancer Service	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Welsh Blood Service	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Workforce & Wellbeing	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Digital Services	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Estates, Infrastructure and Sustainability	**Level 4 - Increased extent of impact from actions**
Health and Safety	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**

Financial Performance	**Level 4 - Increased extent of impact from actions**
APPENDICES	
	N/A

ACRONYMS AND INITIALISM	
EMB	**Executive Management Board**
KPI	**Key Performance Indicator**
LINAC	**Linear Accelerator**
MHRA	**Medicines Healthcare (products) Regulation Agency**
OMB	**Operational Management Board**
PADR	**Performance appraisal and Development Review**
PMF	**Performance Management Framework**
PPM	**Planned Preventative Maintenance**
QSF	**Quality Safety Framework**
QSP	**Quality Safety and Performance Committee**
RD&I	**Research Development and Innovation**
RIDDOR	**Reporting Injuries Diseases Dangerous Occurrences Reporting**
RT	**Radiotherapy**
SABRE	**Serious Adverse Blood Reactions and Events**
SACT	**Systemic Anti-Cancer Therapy**
SLA	**Service Level Agreement**
WBS SLT	**Welsh Blood Service Senior Leadership Team**
VCS Tri	**Velindre Cancer Service Triumvirate**
SMART	**Relating to goal setting "Specific, Measurable, Achievable, Relevant, Timely"**
SPC	**Statistical Process Control Charts**
VAI	**Velindre Acquired Infections**
VUNHST	**Velindre University NHS Trust**
WHC	**Welsh Health Circular**
WHO	**World Health Organisation**

1. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR March 2026

1.1 Overall High-Level Quality Performance Summary

A selection of the most critical Quality Performance Management Framework (PMF) Key Performance Indicators (KPIs), taken from the full PMF Scorecards in Section 3, will now be reported each month (presented below), followed by a number of PowerPoint slides highlighting certain issues 'by exception'.

1.2 Work has commenced to propose the full range of quality and safety metrics that need to be in place at Board level. 35 KPIs have been included, and this work will be concluded by January after going through governance cycle for approval e.g. RT 30-day mortality data collection and Inpatient mortality benchmarking target

Quality Domain	Trust-wide Safety Scorecard			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safe	Total Number of Velindre Acquired Infections (VAIs) across all bacteraemia types **(WHC 2024 (38) target)** Cumulative 25/26 versus 24/25	National	Monthly	23/24 Base 13	<13 24/25	3 25/26	✓	➔	
	SACT 30 Day Mortality Benchmark	Curative	Monthly	2.00%	2.00%	0.172% Nov	✓	➔	
	Inpatient Mortality Target under development/to be agreed	Inpatient	Monthly	N/A	N/A	4 Nov	✓	➔	
	Number of National Reportable Incidents	National	Monthly	0	0	0	✓	✓	
	WBS Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority	Local	Monthly	0	-	3	✗	🡻	Page 38
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	Local	Monthly	New	<5%	8.6%	✗	🡻	
	Number of incidents triggering Duty of Candour	National	Monthly	0	0	0	✓	➔	
Symbols Key: In Month = Compliant □ Non-compliant □				**Cumulative data trend (15 months) = Improving □ stable □ fluctuating □ deteriorating □**					

Quality Domain	Trust-wide Timeliness Scorecard			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timely	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	90% 82%	✗	🡻	Pages 21-32
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	N/A 69%	✗	➔	Pages 21-32
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 100%	✓	🡹	Pages 21-32
	% Patients Beginning Non-Emergency (Routine) SACT within 21 days	National	Monthly	98%	98%	71%	✗	🡹🡻	Pages 12-19
	% Patients Beginning Emergency SACT within 2 days	National	Monthly	100%	98%	25%	✗	🡹	Pages 12-19
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	92.1%	✓	🡻	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	97%	✓	🡻	Page 37
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%	100%	✓	➔	
Symbols Key: In Month = Compliant □ Non-compliant □				Cumulative data trend (15 months) = Improving □ stable □ fluctuating □ deteriorating □					

Quality Domain	Trust-wide Effectiveness Scorecard			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effective	Number of Cancer Pathway of Care Delays	National	Monthly	1	0	3	✗	➔	
	Clinical demand for red cells met (% manufactured to issued)	Best practice	Monthly	104%	100%	97%	✗	➔	Page 37
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	112%	✓	🡻	
	New stem cell volunteers	National	Monthly	3341	333	770	✓	🡹	Page 34

	New Apheresis Donors	Local	Quarterly	21	14	14	✓	🡻	
Symbols Key: In Month = Compliant □ Non-compliant □				Cumulative data trend (15 months) = Improving □ stable □ fluctuating □ deteriorating □					

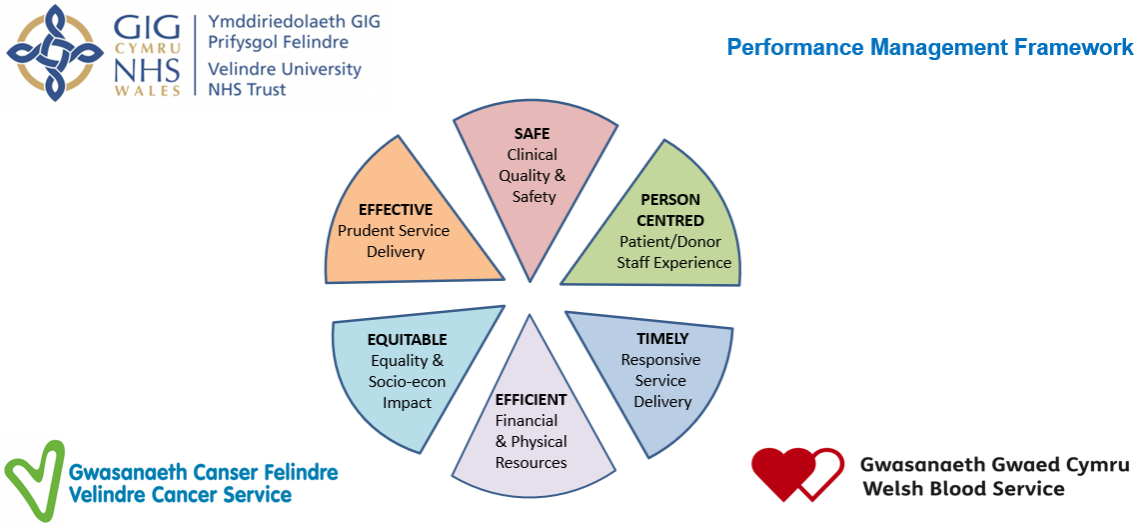
Quality Domain	Trust-wide Efficient Scorecard			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	N/A	99%	N/A	✓	🡹🡻	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£0	£0	£33k	✓	🡹🡻	Page 49
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£180k	£180k	£337k	✗	🡹	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻					

Quality Domain	Trust-wide Equitable Scorecard – Trust-wide position			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	7.81%	✓	🡹	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	7.56%	✗	🡹	
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	96.72%	✗	🡹	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻					

Quality Domain	Trust-wide Experience Scorecard			Performance as at March 2026			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Person Centred	% of Patients Who Rate Experience at VCS as good or very good	Prof. Std.	Monthly	95	85%	98%	✓	→	
	% of 'formal' VCS concerns responded to within 30 working days	Local	Monthly	100	85%	75%	✗	→	
	Whole blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	91%	✓	↑	
	Resolution of WBS formal concerns within 'Putting Things Right' regulations timescale	National	Monthly	100%	100%	100%	✓	→	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	84%	✗	↑↓	Page 43
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.54%	✗	↑	Page 43
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	Local	Monthly	N/A	27 25/26	5 Oct 30 cum	✗	↓	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✗				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓					

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR March 2026

2.1 The Performance Management Framework (PMF) Scorecards, in this Section, are now based on 'domains' in the Quality Dashboard, namely Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP).



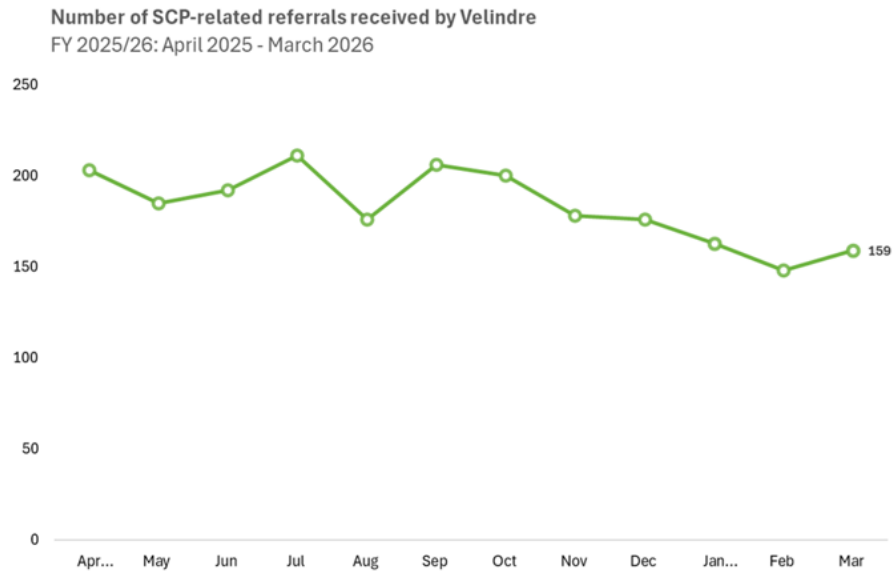
2.2 The following PMF PowerPoint slides highlight the key issues for the attention of the Trust Board, identified and discussed by the previous Executive Management Board and Quality Safety and Performance Committee meetings.

3. KEY ISSUES HIGHLIGHTED BY EXCEPTION

3.1 Velindre Cancer Service

SCP Referrals by Health Board

March 2026



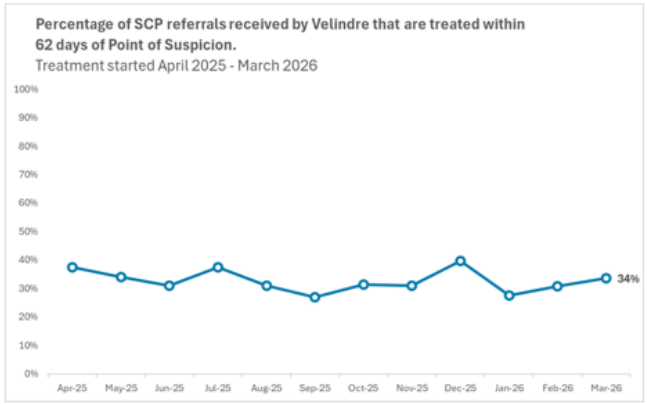
Referrals – a mean of 188 referrals per month that are linked to SCP are received by Velindre.

This accounts for 53% of new referrals received, other new referrals will be related to subsequent treatment (e.g. post surgical-treatments) and therefore, not related to the SCP.

From the HB referrals, AB have referred the most patients to VCS during this period.

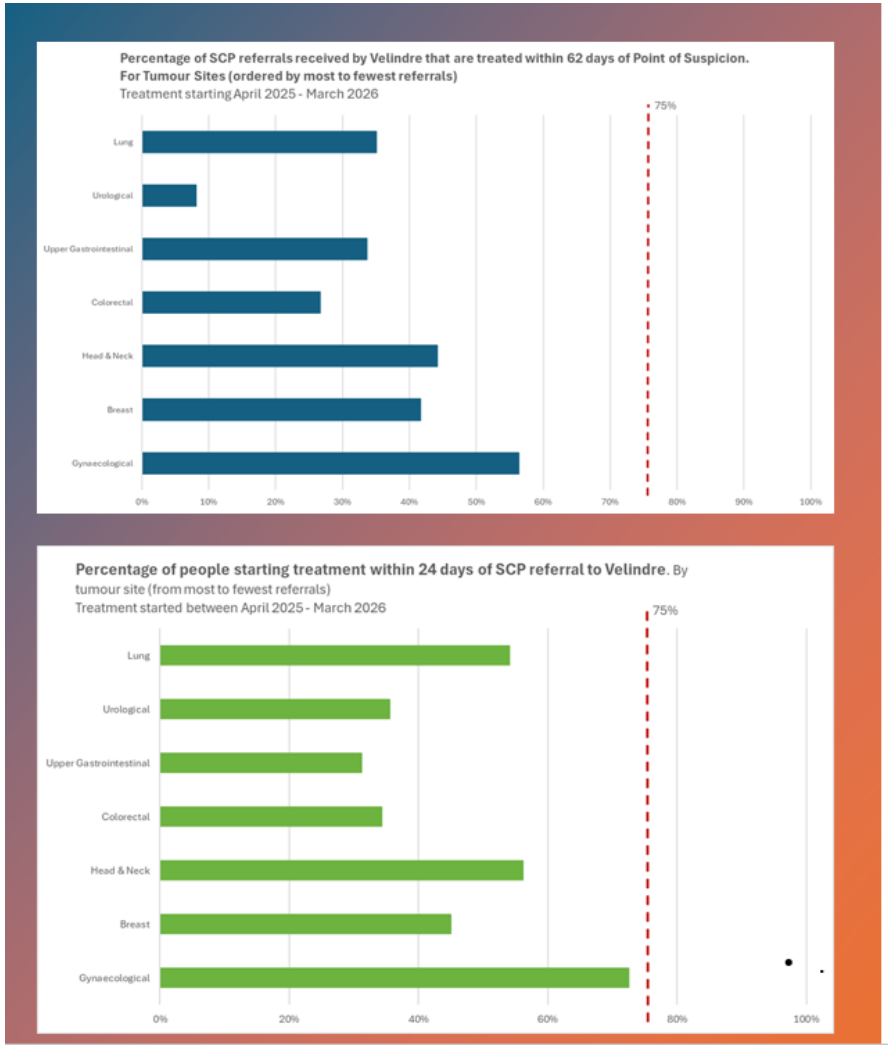
SCP Performance Overview

March 2026



For those patients treated in March at VCS, 34% had their FDT (first definitive treatment) within the 62-day cancer pathway (target 75%). Year to date position (33%).

For those patients treated in March at VCS, 50% of the patients were treated within 24 days from receipt of referral into VCS to FDT – this is a locally agreed target for which VCS would contribute to the whole patient pathway. Year to date position is 46%.



March 2026

SCP Pathway Analysis

- The first chart shows the percentage of patients who are treated within 62 days of point of suspicion by tumour site irrespective of the referring HB.
- The second charts shows the percentage of patients who are treated within 24 days from the referral received into VCS to FDT by tumour site (SST), irrespective of referring HB.
- The agreed shared breach target VCS should be aiming for is 75% of patients meet the 24 day target from referred received date by March 2027.
- Next steps: A trajectory and improvement plan is being developed within VCS, in collaboration with data and insights, to identify the key bottlenecks across the VCS pathway and to develop an associated improvement plan – three SST have been identified as the main area of focus – Breast, Gynae, Head and Neck and Lung.
- A deep dive is required to understand the key drivers to delays both across the whole pathway (62 days) and against the 24 -day internal standard at VCS. An action plan by SST will be developed in support of the wider action plan, with particular focus on lung, GI and breast - this is due for completion end May 26.

March 2026

SACT Definitions and Timings

	Type	Timings	definition
Priority 1	**Emergency**	Emergency (within 48 hours)	Patients with cancer types that tend to rapidly clinically decompensate and respond well to SACT including small cell lung cancer, germ cell tumours, lymphoma and small subsets of ovarian and breast cancer
Priority 2	**Urgent**	Within 14 days (for Curative, Palliative/Disease Control, Haematology remission and Neoadjuvant intent)	**Curative** – patients receiving SACT as first definitive treatment and so include primary chemotherapy patients and chemo-RT patients with radical intent **Priority 2: Neo-adjuvant** – those receiving SACT prior to definitive treatment **Priority 2: Palliative** - those receiving treatments that are not curative but can prolong life and reduce symptoms
Priority 3	**Routine**	Within 21 days (for adjuvant intent)	**Adjuvant** - all patients receiving systemic chemotherapy post definitive treatment.

March 2026

SACT Performance Reporting

Systemic Anti Cancer Therapy Clinical Quality Performance Indicators

The number of calendar days from when the **decision to treat** patients with systemic anti-cancer therapy (SACT) is made to when the patient receives their **first SACT treatment**.

No clear guidelines issued alongside QPIs in 2022 on how SACT performance should be reported.

SACT Performance Reporting VCS

It was identified that there were several data quality issues with the SACT data set. All cycle 1 regimens in a treatment programme were being included in the SACT performance report at the point of treatment, falsely increasing the breach numbers. A deep dive confirmed that for January 2026 this appeared as 50 patient breaches. **The data has now been corrected post a manual validation with clinical oversight and to include treatment start for cycle 1 from DTT.**

National SACT Data Group

Discussion at National SACT group on 19th January 2026 that Performance reporting for SACT should be at Treatment Programme Level i.e. Neoadjuvant, Palliative etc not regimen level.

Next steps

Subgroup established through the National SACT Data Group to agree process/definitions for treatment programme level performance reporting for SACT.

SACT Performance (all treatment intents) by SST

March 2026

SST	Total	Breach	No Breach	% Compliance
Urological	69	23	46	66.7%
GI - Lower	61	34	27	44.3%
Breast	50	26	24	48.0%
Lung	39	28	11	28.2%
GI Upper	29	16	13	44.8%
Gynae	27	11	16	59.3%
Skin	22	7	15	68.2%
Head and Neck cancers	9	5	4	44.4%
Brain	7		7	100%
Sarcoma	3	1	2	66.7%
Liver Tumours	3	3		0.0%
Endocrine	3	1	2	66.7%
Neuroendocrine Carcinomas	2	2		0.0%
Unknown Primary or Unspecified site	1	1		0.0%
CNS	1		1	100%
Germ Cell	1		1	100%
Grand Total	327	158	169	

Row Labels	Urological	GI - Lower	Breast	Lung	GI Upper	Gynae	Skin	and Neck	Brain	Sarcoma	Tumours	endocrine	Endocrine	wn Primar	CNS	Germ Cell	Grand Total
Breach	23	33	25	27	16	11	7	5		1	3	2		1			154
Scheduling delay	9	14	13	19	9	5	1	1		1		1					73
Daycase Capacity	1	2	1		2												6
Awaiting CT/MRI							1										1
concurrent RT	3	5	1	1	1	1		3									15
Booked in line with clinic	1	2	1			1		1			1						7
Diagnostics		1															1
IV access		1															1
Medical	1	5	2	3		2	1				1						15
requested start date	2			1								1					4
Social		2	3				1										6
Change of SACT						1											1
Chemocare Regimen/Programme constrain	1		1		1												3
After RT	1			1													2
Treatment swap - further line of SACT	1			1			1										3
Incorrect DTT not a breach	1					1	1										3
Blank	2	1	3	1	3		1				1			1			13

Each SST are describing their required weekly/fortnightly rhythm to map onto pathway milestones
Deep dives focused for May on lung; GI , breast and gynae for SACT clinical standards

SACT Performance (by treatment intent)

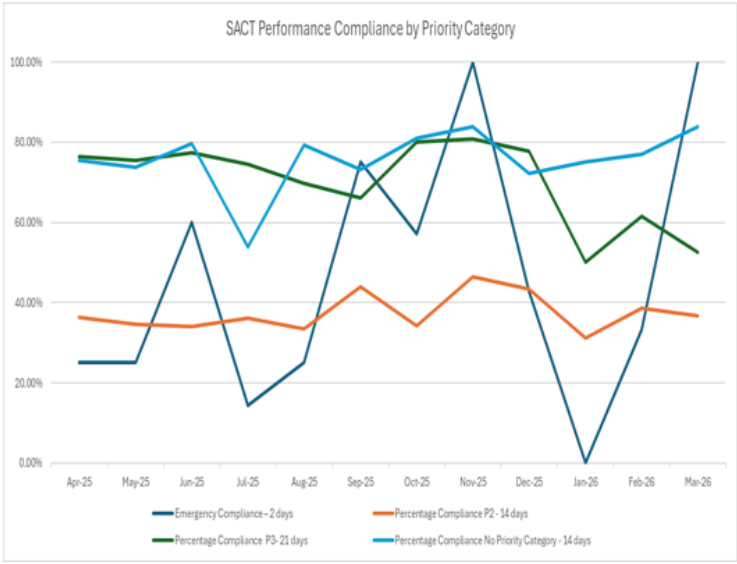
March 2026

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Emergency referrals	4	7	4	7	1	3	0
Total Number of breaches	1	3	0	4	1	2	0
Emergency Compliance - 2 days	75.00%	57.14%	100%	42.86%	0.00%	33.33%	100%

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
P2 - First definitive, Neo-adjuvant and Palliative referrals	168	207	159	168	164	163	177
Total Number of breaches	94	136	85	95	113	100	112
Percentage Compliance P2 - 14 days	44%	34%	47%	43%	31%	39%	37%

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
P3 - Adjuvant referrals	53	45	47	54	64	39	59
Total Number of breaches	18	9	9	12	32	15	28
Percentage Compliance P3 - 21 days	66%	80%	81%	78%	50%	62%	53%

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
No priority assigned (all Oral SACT)	71	74	74	90	112	74	87
Total Number of breaches	19	14	12	25	28	17	14
Percentage Compliance No Priority Category - 14 days	73%	81%	84%	72%	75%	77%	84%



Further work is required to enable SST level reporting by treatment intent and ensure targeted improvement actions to manage the risk of breaches.
In March, work has continued to embed the PTL and enable the management of waiting list activities, some patients benefited from this oversight already where the use of the PTL did support patients being brought forward to meet their targeted date.

SACT Performance (all treatment intents)

March 2026

SACT Performance Overview

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total referrals	285	268	332	273	296	333	284	319	341	279	323
Total Number of breaches	138	128	182	142	132	162	106	136	174	134	154
Percentage Compliance - All	51.58%	52.24%	45.18%	47.99%	55.41%	51.35%	62.68%	57.37%	48.97%	51.97%	52%

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
IV first treatment	218	209	254	220	223	258	210	226	228	205	233
Total IV breaches	119	115	147	129	113	148	94	111	146	117	139
Percentage compliance IV	45.41%	44.98%	42.13%	41.36%	49.33%	42.64%	55.24%	50.88%	35.96%	42.93%	40%

Oral first treatment	67	59	78	53	73	75	74	93	113	74	90
Total Oral Breaches	19	13	35	13	19	14	12	25	28	17	15
Percentage compliance Oral SACT	71.64%	77.97%	55.13%	75.47%	73.97%	81.33%	83.78%	73.12%	75.22%	77.03%	83%

Total Breaches: 154

- Hospital related reasons – 68% (104)
- Patient/Medical reasons – 16% (25)
- Other- 16% (25)

Top three hospital related breach reasons in March were as follows:

- Scheduling delays 73 compared to 33 in February
- Concurrent RT 15 compared to 16 in February
- Booked in line with clinic of 7 compared to 6 in February

An Improvement action plan is in place to drive remedial actions and target hospital related breaches – this is heavily dependent on the Data & Insights Team to inform trajectory improvements associated with these actions.

- Scheduling delays is the primary breach reason driven by vacancies and sickness across the scheduling team.
- Capacity constraints continue, but these are a secondary driver.
- Discussions are in place with the National team with regards to tracking chemo/rad pathways and opportunities for improvement
- Productivity and efficiency actions are in place to increase utilisation of existing resources, based on the existing limited activity data. A more detailed demand & capacity analysis and modelling is urgently required to ensure capacity at tumour site level in place to meet access and quality treatment standards. Data & Insight team have expect to be complete for end of May 26.

SACT Updates/Actions

March 2026

Update from last month

- Scheduling – review of non SACT activities to transfer to other administrative support members across VCS complete and associated activities also transferred
- Recruitment – recruitment to vacant posts within the booking team complete and awaiting start date. Bookings Team Leader to start 1 April.
- External review of use of chemocare – arrangements finalised with chemocare to undertake observation and benchmarking use of chemocare to maximise the productivity of the admin system and processes at VCS

Actions for next period

- SACT PTL to be updated in line with new monthly SACT performance report.
- Ongoing work for switch to pembro sub-cut – completion due end Q1
- Workforce planning to support reducing restrictions on chair usage based on patient acuity
- Capacity and demand requirements for IV SACT day-case being quantified for 2026-27 and 2027-28 by SACT Improvement Group – this will inform SACT business case.
- Timed pathways being developed for all medical consultants to assess alignment of new patient pre- SACT clinics

Key risks/issues

- Workforce Shortages: Insufficient bookers, trackers and ACPs risk bottlenecks and reduced oversight
- Capacity Constraints: Limited treatment, Pre-assessment, and booking capacity delaying patient access.
- Data & Digital Gaps: issues with data quality and digital systems hinder effective scheduling and tracking and management information to inform deep dives.

Mitigation

- New staff members to start in April 2026.
- Overtime working in place
- Workshop with Chemocare due 28th April 2026
- Data and insights – demand & capacity prioritised based on request from Exec team
- Workforce gaps identified and suggested solutions will be included in SACT business case to be developed during quarter 1 2026-27.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

SACT Clinical Standards – Improvement plan

March 2026

Key Issue	Action to resolve	Impact	Owner	Timescale	Progress to date
Capacity and Demand modelling	• Capacity and demand modelling to understand capacity required to meet SACT clinical standards and demand	Improved unitisation	• Data and insights		• Meeting held start of April to clarify modelling requirements with data and insights team
Grip and control of SACT waiting list	• Development of SACT PTL • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern	Enable management of agreed pathway milestones	CWJ	TBC In place	SCP PTL in final testing – utilised through VCS access meetings – opportunities to pull patients forward reviewed (2 patients in March) SACT PTL – data quality and validation in place – used currently for breaches and daily validation in place - need to develop to utilise for SACT waiting list management
Booking and scheduling	• Review of current process for booking and scheduling to understand opportunities for improvement • Review of DTT allocation • Development of workforce plan for resilient booking and scheduling team • Recruit to current vacancies within the team • Overtime to minimise gaps- sickness/leave etc • Chemocare – review of current process • Development of share point to replace excel documents and risk to transcription	Improved utilisation Improve performance – impact to be confirmed Approx 30 patients	Systemic Tri CD systemic GM GM Digital	Complete End April 26 Complete Complete Ongoing 28th April TBC	Process map of processes complete with identified opportunities for improvement in process Review of DTT allocation in line with National discussion – impact on performance to be assessed Recruitment in line with revised proposal – business case for additional investment to be included in overall SACT case Team leader now in place (March 26). 2 Booking team members recruited – start end May with anticipated impact end June post training Overtime at weekends has been in place and does reduce risk – sickness and leave in March though did impact on this and also willingness to pick up extra shifts Request has been made and is on the digital worklist - need to clarity the link to SACT PTL
Capacity – Consent, SACT pre-assessment clinics	• Task and finish group in place to support the development and implementation of the nurse led model		Task and finish group	Pilot to start April 26	Pilot to start– April 26 (lung/breast) Case developed by end May for full roll out – requires finance and additional workforce

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Velindre University NHS Trust

SACT Clinical Standards – Improvement plan

March 2026

Key Issue	Action to resolve	Impact	Owner	Timescale	Progress to date
Capacity - Chair (current)	• Ad hoc additional capacity – flex use of clinical trials chairs		• Systemic Tri	• Ongoing	• Flexible use of clinical trials space during peaks in demand
	• Clinical validation – review of patients waiting treatment – prioritisation		• SACT clinical lead	• Ongoing	In place
	• Review of NH – expand chair capacity by 1 for the 2 days at NH	Additional 6 patients per week	• Systemic Tri	• End May 26	
	• Maximise use of mobile unit	TBC	• Systemic Tri & pharmacy	• End May 26	• Review utilisation of mobile unit and strategies to improve this
	• Reduce restrictions on booking rules for high-risk patients post 4pm • Implement booking strategies to improve utilisation of late afternoon capacity	TBC – utilisation post 4pm 40% booking constraints	• Directorate HoN	• End May 26	• Review of workforce to support acuity throughout the day and support more flexible booking for this cohort of patients
	• Introduce extended arrangements for transport beyond 5:00pm		• Systemic Tri	• End May 26	
	• Regular review of chair utilisation position– note performance will be impacted in coming weeks from the scheduling delays experienced				
Capacity – Chair (nVCC)	• Demand and capacity model required to inform chair requirements for VCS – hub and scope requirements and links to clinical trials with associated workforce		• GM systemic	• Quarter 1	• Demand and capacity modelling commenced by Data & Insights • Workforce development commenced
Capacity - Pharmacy	• Demand and capacity model required to inform chair requirements for VCS – hub and scope requirements and links to clinical trials		• Data and insights	• End May 26	• Demand and capacity modelling commenced by data and insights Team • Workforce development commenced

Radiotherapy Waiting Times activity

March 2026

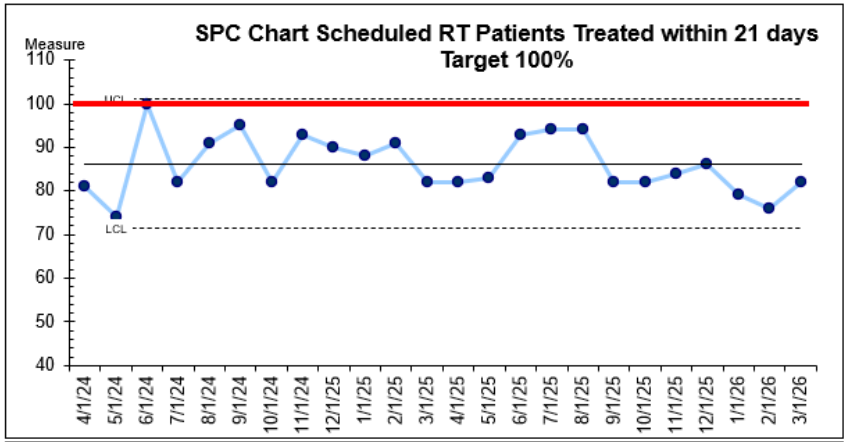
	Definition	WG 80% optimal	WG 100% mandatory
Emergency	patients with Spinal Cord Compression, Superior Vena Cava Obstruction, severe haemorrhage/haemoptysis and stridor	24hours	48hours
Urgent symptom control	patients with pain and bleeding delivered with simple treatment fields.	48 hours	7 days
Scheduled	will include all non-urgent palliative patients and all patients treated with radical intent without an elective delay.	14 days	21 days
Elective delay	reported separately from 'Scheduled' patients have an Earliest Clinically Appropriate Date (ECAD) to start Radiotherapy. The QPI will apply from the ECAD not the DTT date.	7 days	14 days

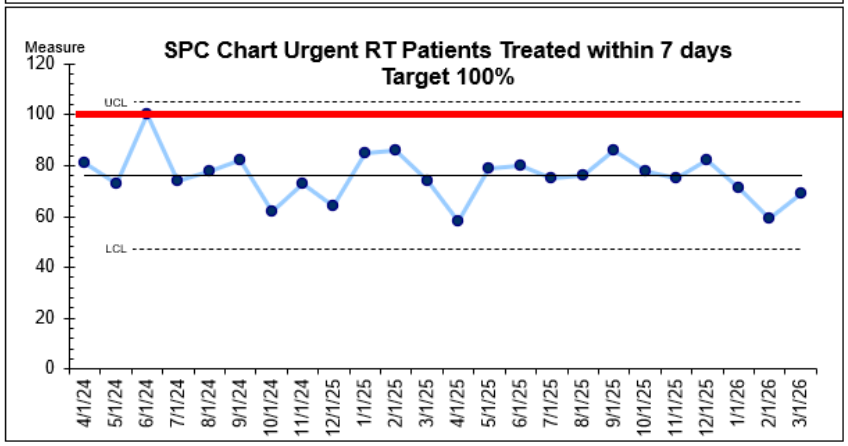
Radiotherapy Waiting Times activity

March 2026

Performance update: March

- **Emergency** (2 days) – **100%**
- **Scheduled** (21 days) - **82%,** with longest waiting patient 64-days (patient choice).
- **Urgent symptom control** (7days) - **69%**
- **Elective delay** (14 days) - **90%**





Radiation Services

March 2026

Quality Indicator	Target	February	March	Movement in Month
Scheduled radiotherapy patients to begin treatment within 21-days of decision to treat	100%	76%	82%	↑
Urgent symptom control radiotherapy patients to begin treatment within 7-days of decision to treat	100%	59%	69%	↑
Emergency radiotherapy patients to begin treatment within 2-days of decision to treat	100%	100%	100%	→
Elective delay radiotherapy patients to begin treatment within 14-days of decision to treat	100%	95%	90%	↓
Stretch Standards				
Scheduled radiotherapy patients to begin treatment within 14-days of decision to treat*	80%	n/a	n/a	n/a
Urgent symptom control radiotherapy patients to begin treatment within 2-days of decision to treat*	80%	5%	n/a	n/a
Emergency radiotherapy patients to begin treatment within 1-day of decision to treat*	80%	80%	100%	↑
Elective delay radiotherapy patients to begin treatment within 7-days of decision to treat*	80%	95%	84%	↓

Shadow Reporting - Radiotherapy

March 2026

	Target	March (With Pauses added)		March	
Scheduled	Number of referrals	256		256	
	% within 14 days (80%)	Unavailable	Unavailable	Unavailable	Unavailable
	% within 21 days (100%)	232	91%	209	82%
	Longest wait (days)	64		64 days (patient choice)	
Urgent SC	Number of referrals	45		45	
	% within 2 days (80%)	Unavailable	Unavailable	Unavailable	Unavailable
	% within 7 days (100%)	35	78%	31	69%
Emergency	Number of referrals	20		20 days (patient choice)	
	% within 1 day (80%)	20	100%	20	100%
	% within 2 days (100%)	20	100%	20	100%
Elective Delay	Number of referrals	72		72	
	% within 7 days (80%)	68	94%	64	89%
	% within 14 days (100%)	70	97%	65	90%
	Longest wait (days)			152 days (patient too ill to attend)	
Benign		1		1	
Total number of referrals		394		394	

The table highlights the difference in performance when previous pauses applied are added back in - these pauses relate primarily to patient choice and has been included for comparative purposes only.

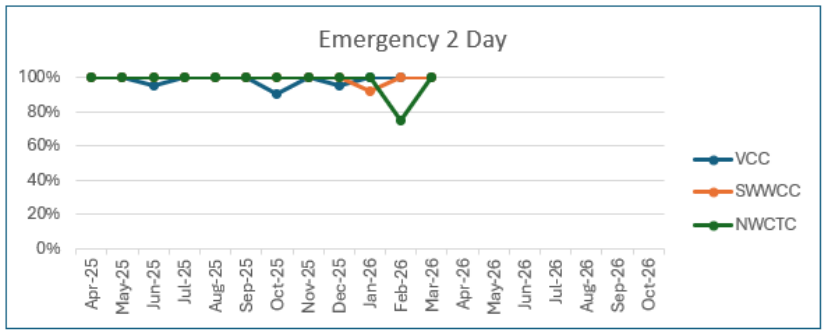
The longest waits for patients in these cohorts has also been highlighted – with the exception of the elective delay which was due to patient being unwell, the reason for the extended waits was for patient choice

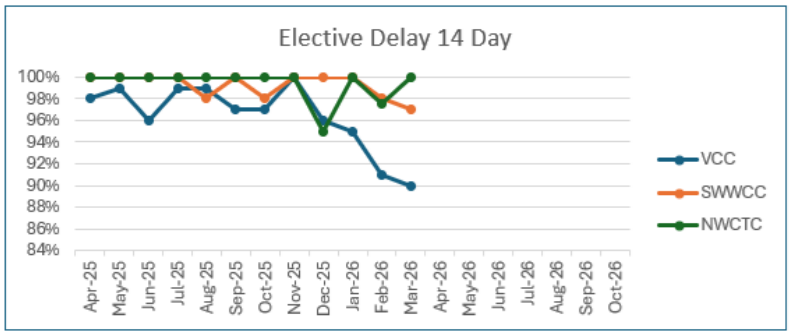
Radiotherapy

March 2026

Performance Target: Emergency
- 80% radiotherapy patients to begin treatment within 1 days of decision to treat (stretch)
- 100% patients to begin treatment within 2 days of decision to treat (mandatory)

Performance Target: Elective delay
- 100% radiotherapy patients to begin treatment within 14 days of decision to treat (mandatory)
- 80% patients to begin treatment within 7 days of decision to treat (stretch)





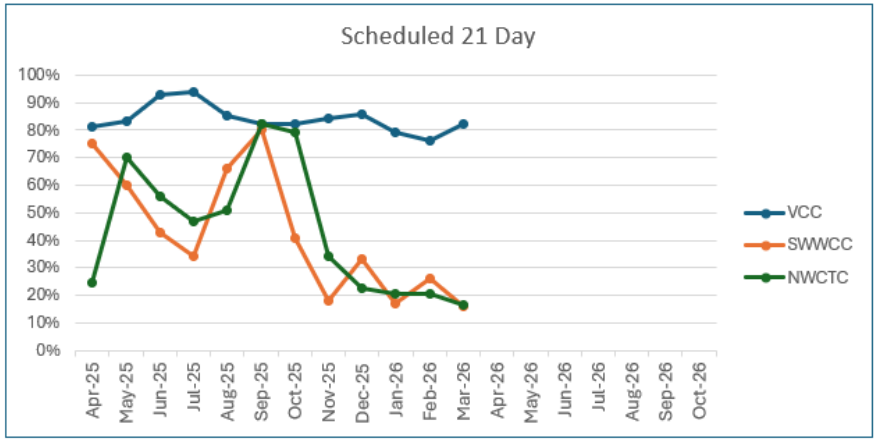
100% of patients prescribed emergency radiotherapy in March commenced treatment within the mandatory (2-days from decision to treat) and stretch (1-day from decision to treat).

Compliance against the elective delay target declined marginally in March (90% compared to 91% in February). Compliance against the stretch target at improved in March (89% compared to 84% in February). Average, all-Wales compliance against the mandatory target in March was reported as 96%.

Radiotherapy

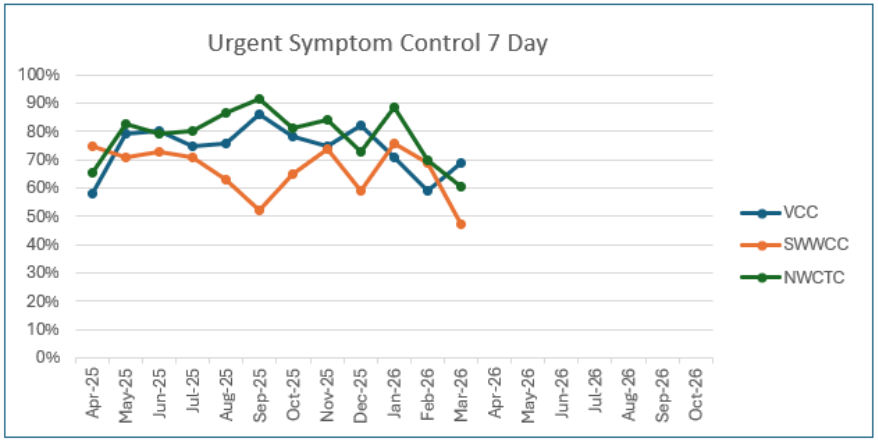
March 2026

Performance Target: Scheduled radiotherapy
- 100% patients to begin treatment within 21 Days of decision to treat (mandatory)
- 80% patients to begin treatment within 14 days of decision to treat (stretch)



Radiation services observed an improvement in compliance against to the 21-day mandatory target (82% compared to 76% in February). This exceeded the average, all-Wales reported position for March of 38%. The longest wait to commence treatment was 64-days (attributed to patient choice). In total, 45 breaches were reported in March. The most common reason to which breaches were attributed in March was patient choice.

Performance Target: Urgent Symptom Control
- 100% radiotherapy patients to begin treatment within 1 days of decision to treat (stretch)
- 80% patients to begin treatment within days of decision to treat (mandatory)



There was an improvement in compliance with the urgent symptom control target (69% compared to 59% in February). This exceeded the average, all-Wales reported position for March of 59%.
An improvement action plan is being finalised by the Directorate targeting the main drivers of the breaches and will be finalised by the end of May 26

Radiotherapy – Performance

March 2026

The main breach reasons for March were as follows:

Scheduled (47 breaches) – the main breach reasons within this category related to patient choice; re-scan; re-plan; other treatment interventions and capacity (medics)

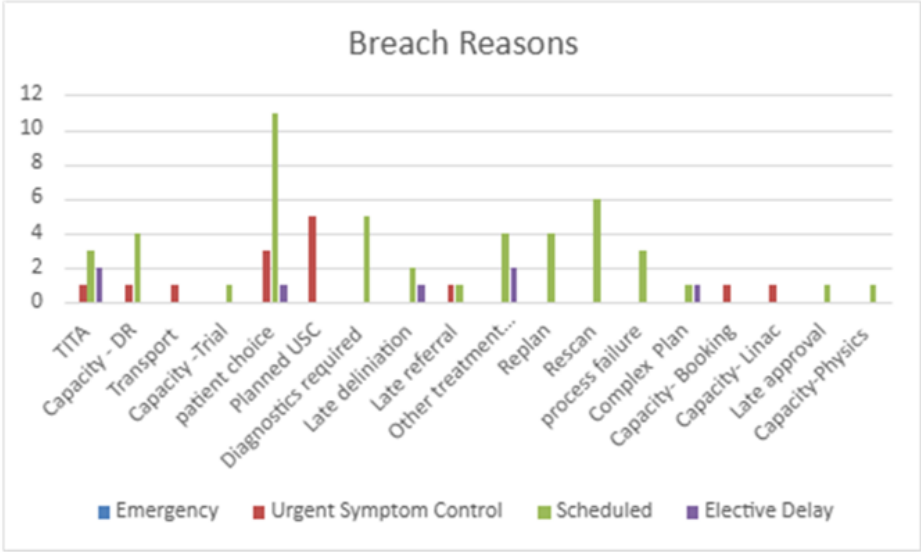
USC (14 breaches) – the main breach reasons were due to complex 3D non conformal treatment plans. Minimum production time exceeds 14 days.

Elective (7 breaches) – the main breach reasons was too ill to attend; other treatment intervention

"Other treatment" breaches reflect delays caused by medical interventions needed before radiotherapy, such as PEG insertions or dental extractions. These delay the start of treatment.

In March, performance was impacted by unplanned LINAC breakdowns linked to the fragility of the ageing fleet. This impacted on performance across all treatment categories, excluding emergencies.

Rescans are required for patients who may require additional support in regard to their preparation prior to Radiotherapy to ensure an optimal plan can be prescribed by the clinician.



Radiotherapy Breaches: definitions

March 2026

Breach reason	Rationale
Other treatment intervention	Other medical intervention required, affecting on the ability to give a defined date for RT e.g. PEG insertions, Dental extraction
Complex/plan required	Initial request is for a simple radiotherapy treatment; however, a conformal plan is required to reduce does to organs at risk. Patient specific plan complexity including previous radiotherapy where advanced dosimetric evaluation is required
Late referral	Referral not received in radiotherapy within time to treat target.
Diagnostic information required	Information not available to support treatment
Replan	Repeat RT planning
TITA	Treat in turn
Complex/plan required	Initial request is for a simple radiotherapy treatment; however, a conformal plan is required to reduce does to organs at risk Patient specific plan complexity including previous radiotherapy where advanced dosimetric evaluation is required
Patient choice	Patient decision not to accept date for treatment
Doctor capacity	Insufficient capacity in doctors job plan
Rescan	Further detail is required in addition to the initial planning CT scan because of change identified (e.g. disease progression) or Patient internal anatomy does not comply with radiotherapy planning protocols on day of treatment (e.g. bowel prep/ bladder prep)
Late delineation	Clinical led mark-up of the treatment target volume required in advance of radiotherapy planning commencing
Linac capacity	Insufficient capacity on linac required to support treatment plan

Assurance

- Weekly capacity meetings to review identified breach patients to determine potential for clinical harm if deferred.
- Patients are prioritised and offered the first available appointment in response to the clinical urgency of their pathway - whilst considering the patients' needs and in accordance with the Access to treatment procedure.
- Where demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken and are thus booked according to clinical priority.
- All failures to meet WG time to radiotherapy targets are investigated at pathway level to identify maximum wait and delay reasoning.
- Waiting time breaches are reviewed at pathway level to identify causes and support improvement.
- A radiotherapy improvement plan is being finalised for end of May 26 to address breach reasons identified through the breach analysis

Radiotherapy – Key Areas of Focus

March 2026

	Capacity & Performance	Workforce	Pathway & Technology	Activity Reporting & Assurance
Key issues / risks	Demand occasionally exceeds capacity, particularly for Urgent Symptom Control. Data issues limit full performance assurance.	Major change programmes may impact operational capacity. Risk from unplanned absence.	Risk that pathway and technology benefits are constrained by capacity pressures.	Gaps in activity and income reporting reduce assurance and benchmarking capability.
Update from last month	CT capacity remained stable. Overall schedule performance 82%; Emergency 100% within 2 days. Data warehouse issues affected March reporting.	Maternity cover business case approved from April 2026 to protect linac capacity.	HyperArc SRS, Gynae Eclipse and Breast IMN solutions implemented. Ethos palliative treatments delivered at V@NHRU.	Activity reporting gaps identified; EHFRT prostate funding declined. Benchmarking work ongoing.
Mitigation	Escalation and clinical prioritisation used when demand exceeds capacity. Public holiday and linac scheduling mitigations in place.	Escalation routes established where service improvement work risks capacity.	Ongoing pathway development and improved management of treatment interruptions.	Joint work with Data, Finance and Physics to strengthen Aria data and reporting.
Actions for next period	Resolve data issues and continue V@NHRU ramp-up, including Urgent Symptom Control.	Implement maternity cover and monitor impact of IRS activity on capacity.	Implement Partial Breast Irradiation and Lower GI pathways; continue Ethos development.	Complete RT and brachytherapy reporting and progress benchmarking and Aria Core Insights readiness.

Radiotherapy – Comparative Performance

March 2026

				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
VCC	Scheduled	14 days	80%	16%	31%	23%	26%	16%	14%	20%	22%	29%	22%	N/A	N/A
VCC	Scheduled	21 days	100%	81%	83%	93%	94%	85%	82%	82%	84%	86%	79%	76%	82%
SWWCC	Scheduled	14 days	80%	28%	11%	7%	9%	19%	28%	7%	9%	12%	7%	9%	5%
SWWCC	Scheduled	21 days	100%	75%	60%	43%	34%	66%	80%	41%	18%	33%	17%	26%	16%
NWCTC	Scheduled	14 days	80%	5%	13%	20%	10%	9%	12%	6%	9%	9%	12%	10%	N/A
NWCTC	Scheduled	21 days	100%	24%	70%	56%	47%	51%	82%	79%	34%	23%	21%	20%	N/A

				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
VCC	Urgent SC	2 days	80%	11%	8%	18%	14%	11%	9%	6%	14%	35%	18%	N/A	N/A
VCC	Urgent SC	7 days	100%	58%	79%	80%	75%	76%	86%	78%	75%	82%	71%	59%	69%
SWWCC	Urgent SC	2 days	80%	39%	48%	42%	32%	49%	26%	45%	29%	19%	36%	13%	24%
SWWCC	Urgent SC	7 days	100%	75%	71%	73%	71%	63%	52%	65%	74%	59%	76%	69%	47%
NWCTC	Urgent SC	2 days	80%	24%	48%	18%	20%	35%	35%	25%	28%	24%	23%	15%	N/A
NWCTC	Urgent SC	7 days	100%	66%	83%	79%	80%	86%	91%	81%	84%	73%	88%	70%	N/A

- NWCTC performance data for March is not yet available.
- VCS performance against the 14-day scheduled treatment target is not available due to technical issues
- Complexity of case mix differs across cancer centres with more complex case mix in NWCTC treated at centres in north-west of England. Therefore direct radiotherapy performance for NWCTC, SWWCC and VCC not fully consistent.
- VCS performed better than SWWCC in March for scheduled treatments at 82% compliance compared to 16%.
- VCS performed better than SWWCC in the case of the urgent symptom control target – 69% compliance compared to 47%.

Radiotherapy – Comparative Performance

March 2026

				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
VCC	Emergency	1 day	80%	88%	91%	86%	95%	87%	91%	83%	82%	91%	83%	80%	100%
VCC	Emergency	2 days	100%	100%	100%	95%	100%	100%	100%	90%	100%	95%	100%	100%	100%
SWWCC	Emergency	1 day	80%	100%	100%	100%	88%	100%	100%	83%	100%	100%	92%	100%	100%
SWWCC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%
NWCTC	Emergency	1 day	80%	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%	50%	N/A
NWCTC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	N/A

				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
VCC	Elective Delay	7 days	80%	98%	96%	94%	99%	98%	95%	97%	98%	96%	95%	84%	89%
VCC	Elective Delay	14 days	100%	98%	99%	96%	99%	99%	97%	97%	100%	96%	95%	91%	90%
SWWCC	Elective Delay	7 days	80%	96%	98%	97%	100%	94%	97%	93%	98%	100%	99%	97%	96%
SWWCC	Elective Delay	14 days	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	98%	97%
NWCTC	Elective Delay	7 days	80%	83%	97%	100%	97%	100%	100%	98%	100%	95%	100%	98%	N/A
NWCTC	Elective Delay	14 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	98%	N/A

- 100% VCS emergency patients began treatment within the 2-day target COSCquality standard target.
- In the case of elective delays, VCS performance exceeded the quality standard target.

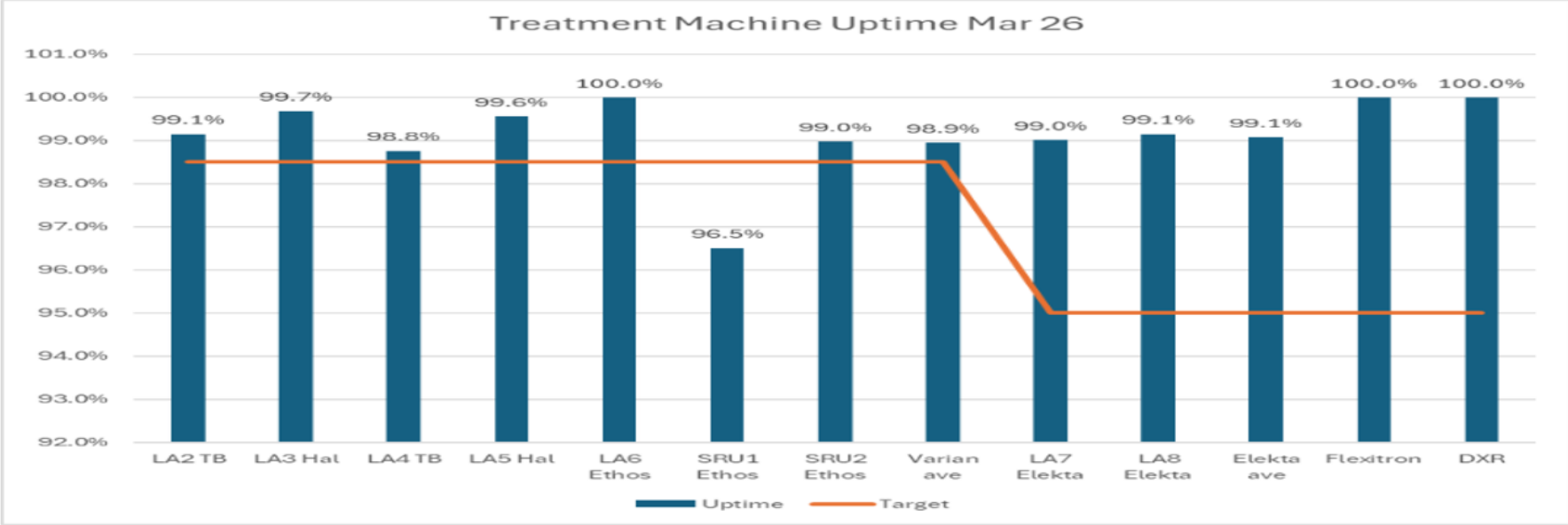
All Wales Comparative Performance - Overview

March 2026

				Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
VCC	Scheduled	14 days	80%	16%	31%	23%	26%	16%	14%	20%	22%	29%	22%	N/A	N/A
VCC	Scheduled	21 days	100%	81%	83%	93%	94%	85%	82%	82%	84%	86%	79%	76%	82%
VCC	Urgent SC	2 days	80%	11%	8%	18%	14%	11%	9%	6%	14%	35%	18%	N/A	N/A
VCC	Urgent SC	7 days	100%	58%	79%	80%	75%	76%	86%	78%	75%	82%	71%	59%	69%
VCC	Emergency	1 day	80%	88%	91%	86%	95%	87%	91%	83%	82%	91%	83%	80%	100%
VCC	Emergency	2 days	100%	100%	100%	95%	100%	100%	100%	90%	100%	95%	100%	100%	100%
VCC	Elective Delay	7 days	80%	98%	96%	94%	99%	98%	95%	97%	98%	96%	95%	84%	89%
VCC	Elective Delay	14 days	100%	98%	99%	96%	99%	99%	97%	97%	100%	96%	95%	91%	90%
SWWCC	Scheduled	14 days	80%	28%	11%	7%	9%	19%	28%	7%	9%	12%	7%	9%	5%
SWWCC	Scheduled	21 days	100%	75%	60%	43%	34%	66%	80%	41%	18%	33%	17%	26%	16%
SWWCC	Urgent SC	2 days	80%	39%	48%	42%	32%	49%	26%	45%	29%	19%	36%	13%	24%
SWWCC	Urgent SC	7 days	100%	75%	71%	73%	71%	63%	52%	65%	74%	59%	76%	69%	47%
SWWCC	Emergency	1 day	80%	100%	100%	100%	88%	100%	100%	83%	100%	100%	92%	100%	100%
SWWCC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%
SWWCC	Elective Delay	7 days	80%	96%	98%	97%	100%	94%	97%	93%	98%	100%	99%	97%	96%
SWWCC	Elective Delay	14 days	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	98%	97%
NWCTC	Scheduled	14 days	80%	5%	13%	20%	10%	9%	12%	6%	9%	9%	12%	10%	N/A
NWCTC	Scheduled	21 days	100%	24%	70%	56%	47%	51%	82%	79%	34%	23%	21%	20%	N/A
NWCTC	Urgent SC	2 days	80%	24%	48%	18%	20%	35%	35%	25%	28%	24%	23%	15%	N/A
NWCTC	Urgent SC	7 days	100%	66%	83%	79%	80%	86%	91%	81%	84%	73%	88%	70%	N/A
NWCTC	Emergency	1 day	80%	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%	50%	N/A
NWCTC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	75%	N/A
NWCTC	Elective Delay	7 days	80%	83%	97%	100%	97%	100%	100%	98%	100%	95%	100%	98%	N/A
NWCTC	Elective Delay	14 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	98%	N/A

Radiotherapy – treatment machine (Linac) uptime

March 2026



- 'Uptime' relates to the time a Linac machine is available for radiotherapy treatment over standard operating hours.
- The Varian average uptime across both sites was 98.9% which is above the target of 98.5% for the IRS contract.
- The Elekta average uptime was 99.1%. This exceeded the in-house target of 95%.
- The combined Linac, Flexitron and DXR uptime was 99.2% which is above the in-house target of 95%.

3.2 Welsh Blood Service

WBS PMF Highlights March 2026

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- **Stem Cell Register – volunteer recruitment exceeded target:** 770 new stem cell volunteers recruited in March, against target of 333. Cumulative total 6,426 vs annual target of 4,000, meaning full-year performance finished 61% above plan
- **Stem Cell Register – improved diversity in recruitment:** In March, 21% of recruited stem cell volunteers (who shared ethnicity) were from minority ethnic backgrounds, exceeding the 12.4% recruitment target; full year monthly average reported as 17.35%
- **Stem Cell Collections – exceeded target:** 50 collections delivered against a 2025/26 target of 40, meaning full-year performance finished 25% above plan

WBS PMF Highlights March 2026

- **Ethnic diversity increased across both whole blood panel and stem cell register,** with the highest levels recorded in Q4 for 2025/26 among those who shared their ethnicity
- **Laboratory Turnaround Times remained strong:** Red Cell Reference Serology 99% vs 90% target; Antenatal turnaround 93.7% vs 90% target; Foetal RHD Screening turnaround 100% vs 90% target
- **Donor experience and responsiveness:** 91% of whole blood donors rated experience as excellent (vs 85% target); 100% compliance with 'Putting Things Right' timescales (transitioning to 'Listening to People' approach in 2026/27)
- **Operational Resilience (Blood Establishment Computer System outage):** ePROGESA outage occurred 23-26 March 2026; managed through emergency planning arrangements with contingency processes in place to maintain services while recovery progressed.

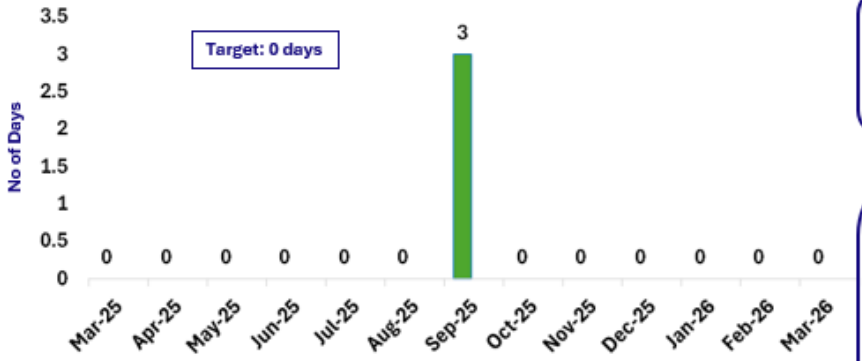
WBS ePROGESA Outage March 2026 – SABRE 156

- ePROGESA system outage occurred 23/03/2026 – 26/03/2026
- Identified as internal system failure (not related to a cyber incident)
- Contingency procedures enacted immediately – WBS Emergency Planning
  - Mutual Aid received to support: Adult Red Cells x 82; Pediatric Red Cells x 12; Adult Platelets x 146; Pediatric Platelets x 14
- Staff across WBS stepped up to support contingency working, ensuring continuity of service
- Close working with system supplier to resolve the issue
- Managed with a focus on safe, controlled restoration of service
- No impact on patient safety or treatment delivery

Red Cell Stock Level (below 3 days): O, A & B+ Groups

Gwasanaeth Gwaed Cymru
Welsh Blood Service

March 2026



Key Issues / Risks:

- Hospital demand for blood groups may not align with collection levels, causing stock imbalances.

Action / Mitigation Underway:

- Daily Resilience meetings to ensure immediate operational responses and mitigate any arising issues.
- Monthly Blood Supply Chain Planning Group meetings with focus on medium and long-term planning.
- Operational Assurance Framework in development - first iteration by Q1 2026/27.
- Exploring a donor recruitment and retention study with Health Technology Wales; bid submission planned Q1 2026/27.

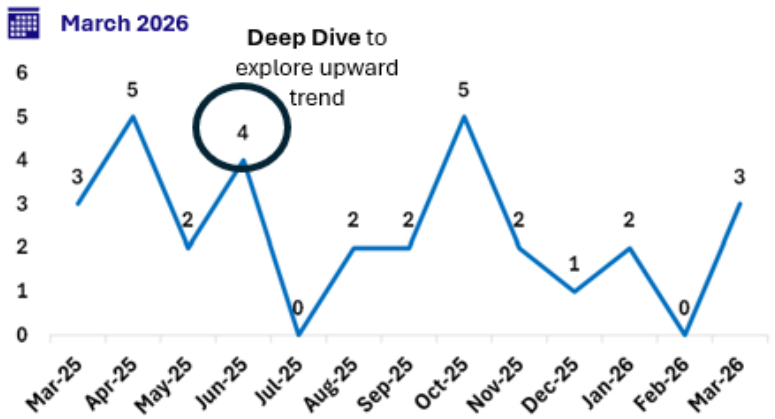
Updates on last month:

- All clinical demand was met for O, A & B+ groups, despite the Blood Establishment Computer (BECS) system outage between 23-26/03/2026.
- Red Blood Cells manufactured reached 97% of demand (% manufactured to issued). This is within tolerance and helped rebalance the age of stock.

Forecast / Next Month:

- Current performance is likely to continue in April 2026. Planning for the Bank Holiday period is underway.

WBS Incidents Reported to Regulator / Licencing Authority



Three Serious Adverse Blood Reactions and Events (SABRE) incidents were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in November.

Most recent SABRE reports relate to donor eligibility or transcription errors, with both processes remaining complex and prone to recurrence until more robust preventive measures are in place.

SABRE 155: An incorrect compatibility report was issued by the RCI laboratory due to a typing error in one of the donation numbers. The correct number was shown on both the units issued and the electronic delivery note. There was no impact on patient safety and no delay to patient treatment.

SABRE 156: An unplanned ePROGESA outage resulted in a temporary loss of system functionality, requiring the use of approved contingency processes. Donor activity and product safety were managed safely during the outage.

SABRE 157: A required donor deferral following a reported dog bite outside the UK was missed at a prior donation. This was identified at a subsequent visit in March; the correct deferral was applied and a look back and product recall initiated.

Action / Mitigation Underway:

- Work to simplify donor eligibility assessments and implementation of a new digital system in September 2026 will support a reduction donor-eligibility and transcription errors.

Quality Assurance – Incidents & Audits

March 2026

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority:

↑	**0** exceeding target date for closure (in reporting month)	Target: 0
→	**0** that remains overdue at month end	Target: 0
↓	**8.6%** overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

↓	**8** exceeding target date for closure (in reporting month)	Target: 0
→	**5** that remain overdue at month end	Target: 0
↑	Age of oldest open overdue incident – **48 days**	No target set

Non-conformances (critical and major) identified through internal/external audits:

	5 from internal audits in the last month	No target set
	3 from external audits in the last month	No target set
↓	**12%** overdue actions from open audit action plans	Target: <5%

Action / Mitigation underway:

Incident Management: Continued signs of improvement evident following implementation of the action plan.

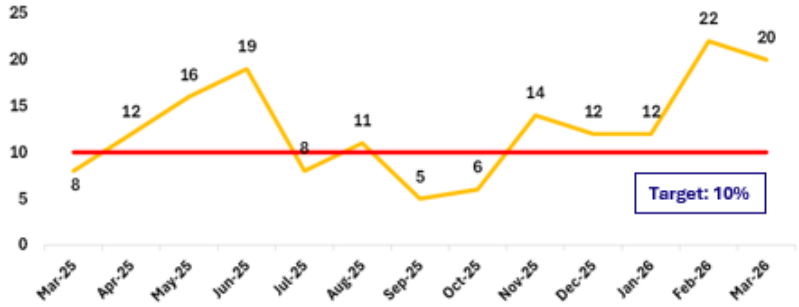
- **Targeted incident management support introduced**, including Datix refresher training, root cause analysis guidance, drop-in support sessions, clearer expectations on timely investigation and closure.
- Bitesize incident management learning delivered in March (50+ attendees).
- We anticipate overdue incidents to be considerably lower in April 2026.

Key: ↑ Increase in performance → Performance remained the same ↓ Decrease in performance

Time Expired Platelets

Gwasanaeth Gwaed Cymru
Welsh Blood Service

March 2026



- 199 units expired in March; 108 units (~50%) expired from 25th March onwards, coinciding with the Blood Establishment Computer (BECS) outage.
- Demand during/after outage was 142-147 units/week (~12% below average); mutual aid required to support outage therefore higher that actual usage due to lack of live visibility.
- BECS uncertainty required maximising in-house production on restoration to mitigate shortage risk the following week.

Key Issues / Risks:

- Forecasting is highly challenging due to the short shelf life and the fact that demand is driven entirely by real-time clinical need.
- Reducing production too quickly risks shortages, which would have a greater impact on patient care.

Action / Mitigation Underway:

- Exploring separating pooled and apheresis platelets within the target, as apheresis wastage more accurately reflects true platelet loss than pooled platelets derived from whole blood donations.

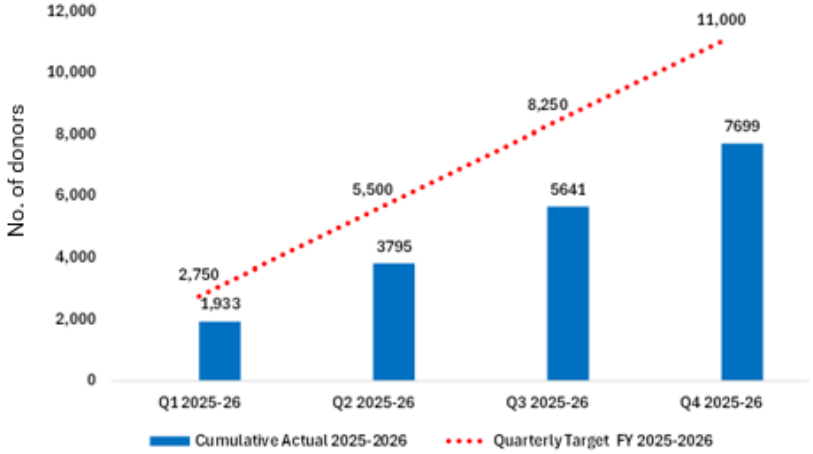
Forecast / Next Month:

- Performance in April is likely to be negatively impacted by bank holidays, which reduce collection and production capacity, combined with limited short-term flexibility within platelet planning tool.

New Whole Blood Donors (Quarterly Reporting)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

March 2026



Key Issues / Risks:

- Operational focus on donor retention and prioritisation of known blood groups to balance supply & demand which limits opportunities for recruitment of new whole blood donors.

Action / Mitigation Underway:

- ***Review new donor targets, noting they have not been reviewed recently, to ensure the target level is clearly understood and aligned to current service needs, supply requirements and future demand.***
- Re-balance effort between stem cell volunteer and whole blood donor recruitment, aiming to convert stell volunteers into regular blood donors.

Updates on Last Quarter:

- 2,058 new whole blood donors were recruited in Q4, against a target of 2,750.
- Despite not achieving target, the number of new donors is increasing year on year – 5,933 (2023/24); 7,186 (2024/25); 7,699 (2025/26

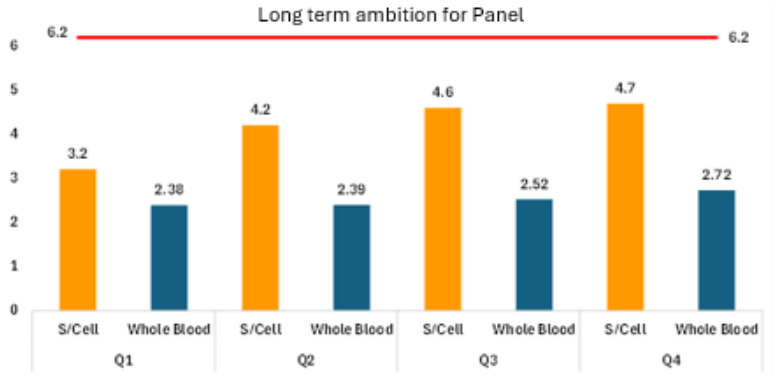
Forecast / Next Quarter:

- Performance is not expected to increase significantly while prioritising known blood groups. New donor recruitment is expected to continue to be below target in Q1 2026/27.

Inclusion across Whole Blood Donor Panel / Stem Cell Register

March 2026

Whole Panel Position 2025/26



UK Census Benchmark (Wales): 6.2%

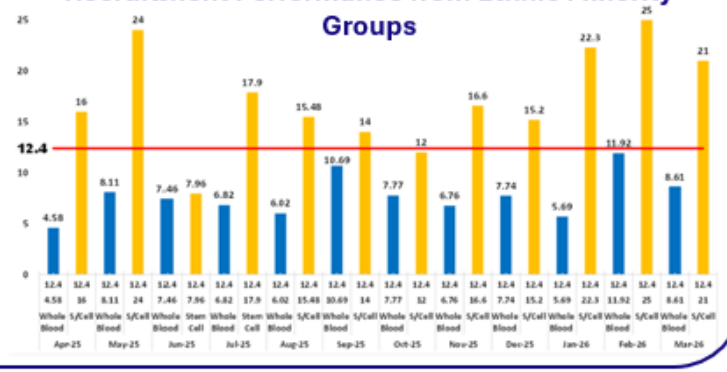
- **Whole Blood Donor Panel:** The proportion of the panel (who shared their ethnicity) reporting an ethnic minority background increased to 2.72%, the highest level recorded in 2025/26.
- **Stem Cell Register:** The proportion of the register (who shared their ethnicity) reporting an ethnic minority background increased to 4.7%, the highest level recorded in 2025/26.

Key Issues / Risks:

- Less diverse panels reduces the likelihood of finding compatible matches for patients from minority ethnic backgrounds, especially for stem cell and rare blood type needs.

Clear growth in stem cell volunteer recruitment (yellow); whole blood donor recruitment (blue) improves towards end of 2025/26.

Recruitment Performance from Ethnic Minority Groups



Panel gender split for Q4: **Whole Blood -** Male: 58%; Female: 42%
Stem Cell - Male: 51%; Female: 49%

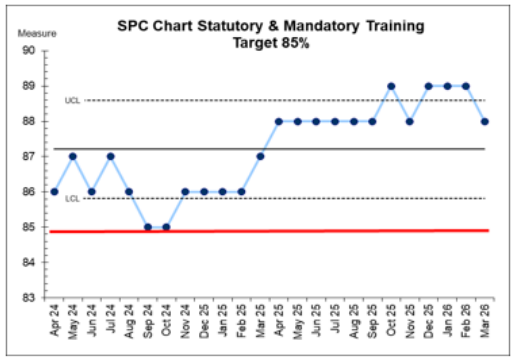
Forecast / Next Quarter:

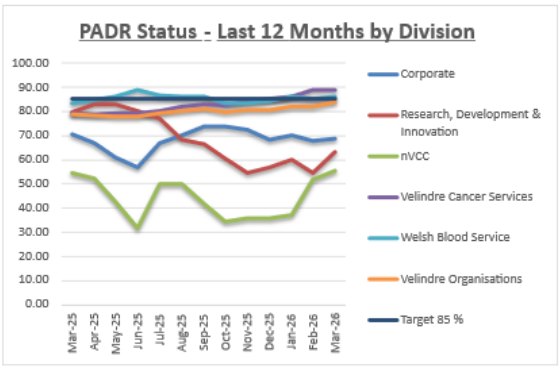
- Performance is expected to continue to improve in Q1 2026/27.

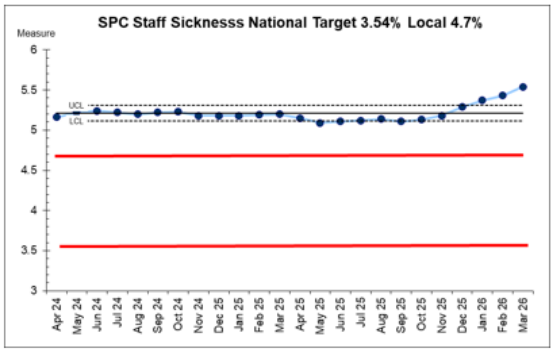
3.3 Workforce and Wellbeing

People, Wellbeing & Organisational Development

March 2026







Updates on Last Month:
- **PADR** – Ongoing management of action plans
- **Sickness** – Trust action plans following detail absence analysis are ongoing and progress towards target is being monitored

Forecast / Next Month:
- **PADR** – as systems for completion of PADR's improves we forecast an improving trend towards the KPI target of 85%
- **Sickness** – divisional action plans are drawn up aligned to the detailed data analysis.

Action / Mitigation Underway:
- Full review of policy and processes (back to basics) combined with data analysis to draft comprehensive and holistic action plans for improving KPIs.
- Fundamentals of Management Training Package launched with a plan to roll out more comprehensively across the Trust

Key Issues / Risks:
- Capacity of management time to undertake effective people management activities alongside clinical workload
- Capability and confidence of managers to effectively undertake people management activities

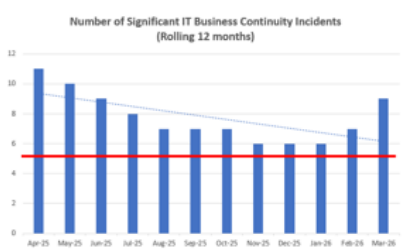
Ymddiriedolaeth GIG Prifysgol Felindre
Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

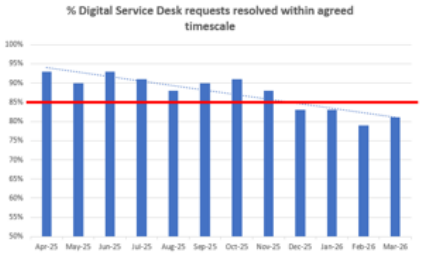
Velindre University NHS Trust
Excellent care, inspirational learning, healthier people

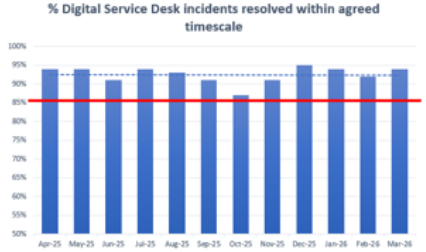
3.4 Digital Services

Digital Services

March 2026







Updates on Last Month:

- Service performance remains above the agreed percentage; Incidents performance increased in March. Factors to consider is Windows 11 migration project and seasonal variations on Requests.
- Two Major Incidents recorded (MI Reports to be completed):
  - eProgesa Outage on 23 March 2026
  - BT Wales Wide Outage on 25 March 2026
- Percentage of Cyber Security mandatory training above target again this month.

Forecast / Next Month:

- Digital Service improvement work ongoing to increase automation of tasks across the Digital Service Desk, to ensure current performance gains can be sustained over the long-term.
- Installation of capital funded technical refresh digital client devices and network/server infrastructure continues this month. Including migration from Windows 10 to Windows 11, Windows 11 now 98% complete with the remainder Windows 10 on extended support and due for replacement.

Action / Mitigation Underway:

- IMTP review progressing. Investigating the demand between business as usual and project work required, to mitigate future capacity issues.

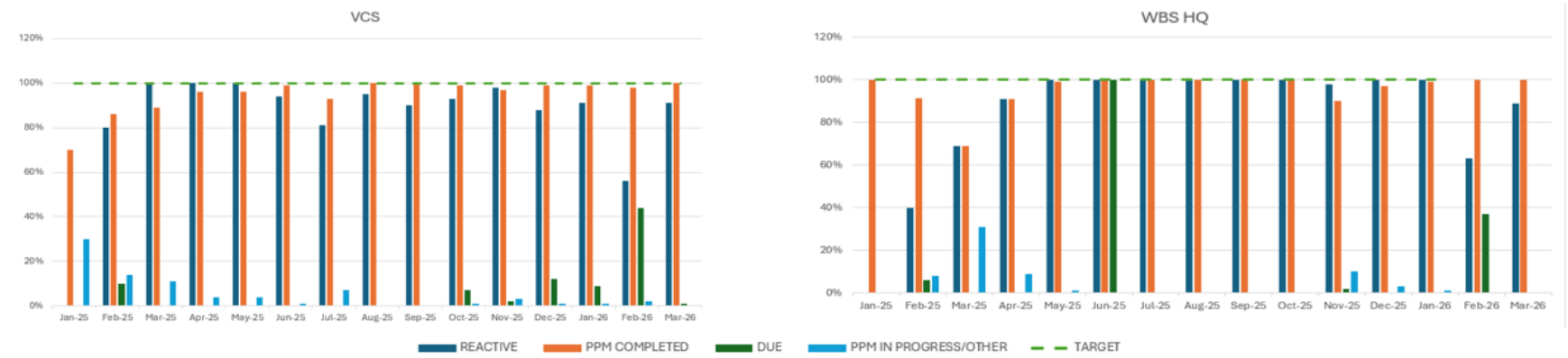
Key Issues / Risks:

- Capacity v Demand of requests on the IMTP.

3.5 Estates Infrastructure and Sustainability

Estates and Infrastructure

March 2026



Updates on Last Month:

VCS – PPM = 100% - Reactive = 92%
Trust HQ – PPM = 87% - Reactive = 66%
WBS HQ - PPM = 100% - Reactive = 89%
Dafen – PPM = 100% - Reactive = 100%
Wrexham – PPM = 100% - Reactive = 100%
Bangor – PPM = 100% - Reactive = 100%

Action / Mitigation Underway:

PPM - compliance has dropped at Trust HQ due to delay in contractor attendance
Reactive -

- VCS - 92% due to year end pressures, the works are scheduled for completion within month
- Trust HQ - 66% due to spare parts being needed, delivery and repair scheduled by May 2026
- WBS – 89% due to materials being required to complete works and a contractor needing to be engaged.

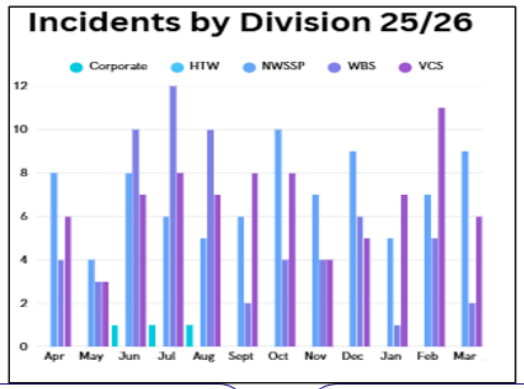
Forecast / Next Month: April 2026

- PPMs planned for VCS - 583
- PPMs planned for Trust HQ - 11
- PPMs planned for WBS sites - 130

Key Issues / Risks:

- The CAFM provider *Synbiotix* and Trust are in talks over the migration process to their new parent company's *SINGU* CAFM platform.
- WBS - AC Contract has identified remedial works, active discussions ongoing over the cost and programme to deliver these works

Health & Safety



March 2026

Updates on Last Month: Total of incidents

- **NWSSP – 9**
- **VCS - 6**
- **WBS – 2**
- **MIM (Trust Managed) - 0**
- **RIDDOR – 1**

Forecast / Next Month:
Work will continue the implementation of the HSMS governance framework across VCS and WBS, alongside further development of the Legal Register.
Annual report data gathering and audit programme development has started to support year-end assurance reporting.
Monitoring of incident trends will continue, with sharps injuries and slips/trips expected to remain the most prevalent categories. Further engagement with divisions will continue to strengthen reporting culture and improve accessibility to reporting systems.

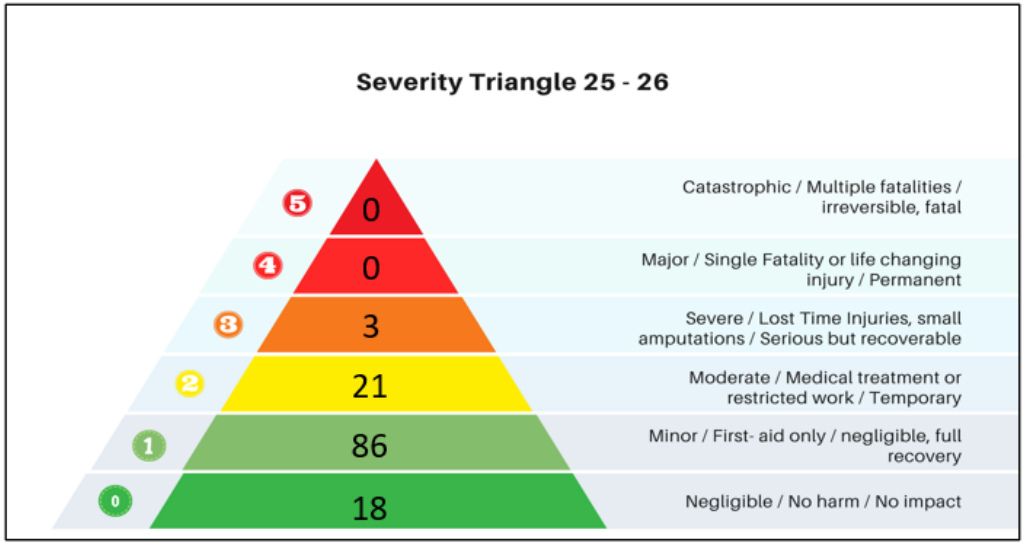
Action / Mitigation Underway:
To strengthen incident governance and support managers in progressing investigations, monthly **Open Datix meetings** will commence from April within the divisions. These sessions will support managers with open investigations, improve oversight of incident management and promote timely learning and closure of incidents.
Work also continues on the development of the Health & Safety Management System, including the Health & Safety Legal Register, alongside ongoing controls for sharps injuries, slips/trips and manual handling risks.

Key Issues / Risks:
Sharps injuries and slips/trips remain the most frequently reported incident categories across the organisation. While trends remain broadly stable, these hazards continue to present a persistent risk of staff injury.
One RIDDOR-reportable incidents occurred during the reporting period, bringing the year-to-date total of Severe-rated incidents to three.
In addition, several incidents remain open within the Datix system. While this does not indicate under-reporting, it highlights the need to strengthen oversight of incident investigation and closure to ensure organisational learning is captured.

Health & Safety

March 26

This slide demonstrates that most incidents were low harm. There are now 3 Severity 3 incidents. There were no catastrophic or major harm events.



Level 3 Incident Summary

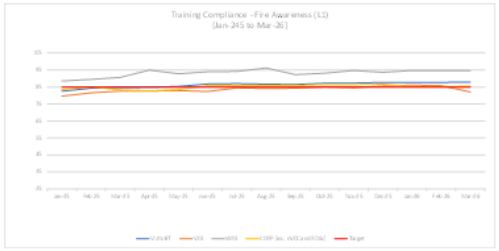
- 06/05/2025 - Incident type: Manual Handling Injury
- Area: WBS Collections
- Severity outcome >7 consecutive days lost work case

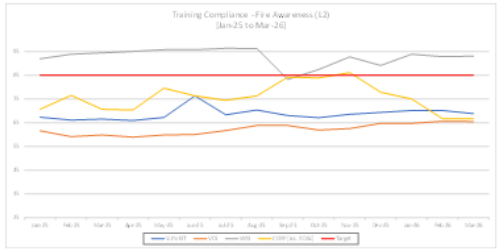
- 17/02/2026 - Incident type: Contact with object
- Area: WBS Collections
- Severity outcome > Fracture to wrist

- 18/02/2026 - Incident type: Manual Handling Injury
- Area: VCS Radiotherapy
- Severity outcome > Patient incident admitted to hospital

Fire Safety

March 2026





Updates on Last Month:

STRATEGIC

- Continuation with development of fire safety protocols – need to align with new Firecode Management document [HTM 05-01].
- All fire risk assessments [FRAs] uploaded onto 'new' FRA module
- Training compliance remains static with minor changes; Non-clinical compliance shows minor improvement but Clinical has dropped slightly.

VCS

- Number of FRA actions on FARS increased but number of actions closed also increased; however, further engagement with Risk Handlers required to ensure actions are taken within acceptable timescales.
- Continued improvements with training compliance but Clinical compliance still below accepted minimum benchmark.
- Remedial works on fire dampers completed.

WBS

- Number of FRA actions has reduced; improvement with number of actions closed; however, further engagement with Risk Handlers required to ensure actions are taken within acceptable timescales.
- Continued improvements with training compliance; compliance for both Non-Clinical and Clinical both above minimum benchmark.

Corporate

- *Development of action plan for nVCC transition and ongoing partial operation of oVCC*

Forecast / Next Month:

STRATEGIC

- Commence work on Principle 10 [Emergency Procedures] of HSMS
- Review and align fire safety KPIs with new Firecode Management document
- Initiate development of fire safety KPI dashboard to support alignment of KPIs with Firecode
- Develop better guidance for fire risk handlers identified in FRAs

VCS

- Schedule evacuation exercise for First Floor wards
- Schedule evacuation exercise for Main OPD
- Formation of VCS Evacuation & Security 'group' as sub-group of VCS Cynefin to support implementation of Principle 10.

WBS

- Remedial works on fire dampers to commence

CORPORATE

- Further work on FRA actions.

Action / Mitigation Underway:

VCS

- Engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved – **ONGOING ACTION**
- Schedule evacuation exercises for FF wards and Main OPD [aim to run exercises by end of May 2026] – **APRIL 2026**

WBS

- Engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved – **ONGOING ACTION**
- Evacuation Warden training rescheduled for **May 2026**.
- Remedial works on fire dampers [WBS HQ] – **APRIL 2026**

CORPORATE

- Risk owners contacted to remind to close out FRA actions – **APRIL 2026**

Key Issues / Risks:

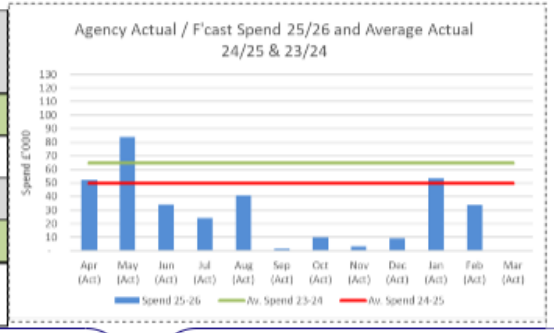
- Continued low compliance for fire safety training [VUNHST]
- Need for evacuation drills and exercises in all Services
- Ongoing issues around closure of risks identified in fire risk assessments and use by risk owners / further education on new FARS fire risk assessment module required.
- Alignment of emergency evacuation procedures with requirements of the Terrorism (Protection of Premises) Act 2025; this will include additional training burden which the Trust need to consider.

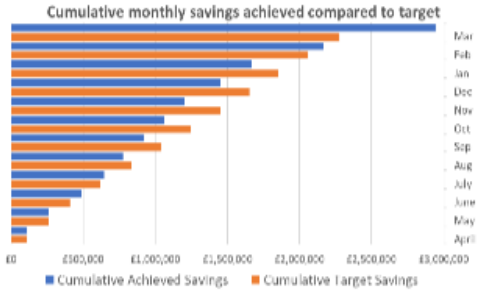
3.6 Finance

Financial Performance

March 2026

Trust Revenue Position (core)	24/25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Actual Cum £k	42	0	9	2	7	5	4	2	4	27	28	30	33
Target		0	0	0	0	0	0	0	0	0	0	0	0
Trust Capital Position	**24/25**	**Apr 25**	**May 25**	**Jun 25**	**Jul 25**	**Aug 25**	**Sep 25**	**Oct 25**	**Nov 25**	**Dec 25**	**Jan 26**	**Feb 26**	**Mar 26**
Actual Cum £m	35.972	3.015	1.565	2.594	3.880	4.608	5.811	8.338	9.496	10.871	13.724	16.342	20.593
Target £20.593m CEL		3.015	1.565	2.594	3.880	4.608	5.811	8.338	9.496	10.871	13.724	16.342	20.593





Updates on Last Month:

- The Trust has reported a small year to date underspend of £0.033m at the end of March which is in line with the 2025-26 IMTP planning assumptions.
- The Trust has met the Public Sector Payment Performance (PSPP) target of paying 95% of Non-NHS invoices within 30 days for 2025-26.
- The Trust has achieved the Capital Expenditure Limit (CEL).
- All savings schemes were RAG rated green earlier in the year. Some have underperformed and been replaced with new schemes. The total savings for the year has been met and exceeded by £0.663m.

Year End Position:

- The Trust has met its financial duty and is reporting a draft in year underspend of £0.033m for 2025-26.
- The Trust has achieved the Capital Expenditure Limit (CEL) for 2025-26.
- Revised savings plans led to an overachievement of the savings requirement for the year.

Action / Mitigation Underway:

- Urgent action required from Divisional / Executive Directors and SLT / SMT to ensure that saving schemes for 2026-27 are in place and start to deliver as expected.

Key Issues / Risks:

- Non delivery of full saving plans for 2026/27
- Commissioners not supporting Service investments above 1.77% core uplift funding
- VCS Service Transformation Investment
- Ability for Divisions to manage new / emerging Cost pressures

Ymddiriedolaeth GIG Prifysgol Felindre
Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust
Excellent care, inspirational learning, healthier people

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:		
Choose an item		
If yes - please select all relevant goals:		
• Outstanding for quality, safety and experience		☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		☐
• A beacon for research, development and innovation in our stated areas of priority		☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.		☐
• A sustainable organisation that plays its part in creating a better future for people across the globe		☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	06 -Organisational and Clinical Governance	
For more information: STRATEGIC RISK DESCRIPTIONS	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒

	Efficient ☒
	Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it.
	As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
For more information: https://www.gov.wales/socio-economic-duty-overview	*[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

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.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case.
	Narrative in this section should be clear on the following:
	Source of Funding:
	Choose an item
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
	Type of Funding:
	Choose an item
	Scale of Change
	Please detail the value of revenue and/or capital impact:
	Click or tap here to enter text
	Type of Change
	Choose an item
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT	
	Not required - please outline why this is not required

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

RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST MARCH 2026 (M12)

DATE OF MEETING	21/05/2026
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	Claire Bowden – Head of Financial Planning & Reporting Steve Coliandris – Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of March 2026. The three main issues are highlighted below: **1. Long Term Agreement (LTA) Financial values, Contract Rebase & VCS LTA Financial Performance** <u>LTA Financial Values</u>

	• The Trust has signed LTAs with all Commissioners including the 1.77% (£1.548m) uplift, although to avoid arbitration agreed a £0.825m reduction in income with Hywel Dda UHB. • Commissioners have not agreed additional funding above the 1.77% general uplift, for either WBS or VCS. In 2025-26 the Trust has managed the cost pressure for additional investment in capacity and quality & safety improvements across its services. <u>Contract Rebase</u> • All Wales DoFs have agreed to establish an LTA / commissioning group to review the historical LTAs across NHS Wales and make recommendations for how these are updated to current activity and cost. This will include recommendations on the principles around how commissioners manage the financial impact (gain / loss) of LTA re-basing. This group is unlikely to report back until the end of 2026/27 to inform 2027/28 financial planning. <u>VCS LTA Financial Performance</u> • The IMTP planned overperformance against 2019/20 baseline contract levels is £7.061m, this is a forecast increase in contract income of £2.048m against the 2024-25 out-turn and plan set at IMTP. The marginal income overachievement was held to support the underachievement on Radiotherapy activity and underlying cost pressures within VCS. **2. Integrated MediumTerm Plan (IMTP) – Financial Plan / Forecast** • A balanced three-year IMTP financial plan, covering the period 2025-28 was approved by Welsh Government.

	• The Trust has achieved a minor year end draft underspend of £0.033m for the full year 2025-26. • The ability to maintain a balanced underlying position is challenging due to the significant cost pressures and risks which have materialised since the submission of the IMTP. Despite this, the draft IMTP for 2026-29 reflects a balanced brought forward position which is expected to be maintained over the course of the IMTP. • The general discretionary uplift of 1.1% (£1m) that has been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment. • The Trust has also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding which will be removed recurrently in 2026-27 and is now facing a further challenge from HD on the baseline funding with a risk of c£0.290m. • The Trust has faced 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 £0.605m and are provided to the Trust via the LTAs as per the Trust funding model. Discussions are ongoing regarding the historic ring fenced allocations with a current gap in the position between Velindre and Hywel Dda of £0.290m. However, there is agreement from Hywel Dda UHB that on the Trust providing evidence to support these funding arrangements that Hywel Dda UHB will settle the full cash allocations. **3. Key Financial Targets / KPIs**

	• **Revenue Balance:** The Trust has reported a draft full year underspend of £0.033m at 31st March 2026. • **Public Sector Payment Performance (PSPP):** The Trust has achieved the PSPP target of paying 95% of Non-NHS invoices within 30 days. • **Capital Expenditure Limit (CEL):** The Trust has achieved its CEL, reporting a small underspend of £0.010m. **Savings Target:** All savings schemes were RAG rated green earlier in the financial year. However c£0.300m of recurrent schemes were not expected to achieve the full value of savings planned and were replaced with non-recurrent schemes. Following the WG Finance Touch Point meeting in January, the Trust was challenged to review the underlying position reported in the draft IMTP which resulted in a further £0.300m of bank interest being brought in recurrently to the savings plans to help ensure that a balanced position will be carried forward into 2026-27. Accountancy gains of £0.392m were also recognised in month 12 in respect of aged creditor payments that were no longer required.

RECOMMENDATION / ACTIONS	The Trust Board is asked **NOTE** the contents of the March 2026 financial report and in particular: • The year to date and forecast revenue and Capital out turn position, and PSPP performance. • The latest position on Velindre Cancer Service LTA income for 2025-26 from our commissioners. • The position with commissioners on the contract rebase agreement, and the potential

	dispute with HD UHB regarding the WG direct funding allocations. • The year end position of the Trust savings delivery.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	27/04/2026
Quality, Safety & Performance Committee	07/05/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR – Financial Performance	Level 4 - Increased extent of impact from actions

APPENDICES	
Appendix 1	Trust Finance Report – March 2026
Appendix 2	nVCC Finance Report – March 2026

1. SITUATION / BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of March 2026.

1.2 The financial information included within this report relates to the Core Trust (including HTW). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Full Year £m
Revenue	Variance	0.003	0.033
Capital* (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.098	20.593
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	94.9%	96.5%

Note that the capital spend includes £0.250m funded by a Home Office grant in respect of an irradiator in WBS

2.2 Revenue Budget

The core Trust has reported an in month underspend of £0.003m leading to a **year end underspend of £0.033m**.

As in previous years the Trust accumulated non-recurrent income during 2025-26 from several sources including significantly higher levels of bank interest, overachievement of VCS activity and accountancy gains.

The extraordinary non recurrent income generated in 2025-26 enabled £1.5m of expenditure to be suspended for service activities which had approved Charitable Funds

support. These costs were managed within Velindre UNHS Trust core funding from non-recurrent income received in year, and therefore £1.5m of funding earmarked to support the cancer services remained within the Charity. This was approved by the Charitable funds Committee on the 10th March 2026 and the impact factored into the Trust's overall Financial Plan.

The ability to maintain a balanced underlying position is challenging due to the significant cost pressures and risks which have materialised since the submission of the IMTP. Despite this, the draft IMTP for 2026-29 reflects a balanced brought forward position which is expected to be maintained over the course of the IMTP.

Savings

All schemes were RAG rated green earlier in the year. However, some recurrent schemes did not achieve the full value of savings planned and were therefore replaced with other schemes.

Following the WG Finance Touch point meeting in January the Trust was challenged to review the underlying position reported in the draft finance IMTP which resulted in a further £0.300m of bank interest being brought in recurrently to the savings plans to help ensure that a balanced position will be carried forward into 2026-27.

Accountancy gains of £0.392m were also recognised in month 12 in respect of aged creditor payments that were no longer required.

LTA Income

During 2024-25 LTA activity performance underachieved against the income growth target set by c£0.240m, which resulted in marginal income not matching the level of service investment that was made to support capacity within VCS. As LTA activity in year improved in 2025-26, it was no longer flagged as a financial risk, and the in year overachievement was held to support the underachievement on radiotherapy income and underlying cost pressures within VCS.

A risk emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as vacancies, non recurrent funding support, contract performance income for wider services, and non pay reductions.

LTA Contract Position

The formal agreement of the Trust income planning assumptions was summarised within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025 that included a 1.77% general uplift. All LTAs for 2025-26 were signed, including the Hywel Dda UHB LTA.

The Trust agreed with Commissioners an uplift to LTA values of 1.77% which amounted to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding which will be removed recurrently in 2026-27 and is facing a further challenge from HD on the baseline funding with a risk of c£0.290m.

The general discretionary uplift of 1.1% that has been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment.

Commissioners did not agree any additional funding above the 1.77% general uplift, for either WBS or VCS. The Trust managed the pressure for additional capacity invested in outpatients, ambulatory care, SACT and imaging services during 2023-24 and 2024-25 to meet the rising demand and cancer waiting times. Whilst the Velindre Collective Commissioning Group for Cancer had agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, no commitment was made this year. The Trust re-submitted the service growth investments to our Commissioners on the 22nd October 2025 in line with the IMTP governance timeline process for 2026-27 with confirmation from all commissioners that no funding support will be provided.

LTA Contract Rebase

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 2004-5 to a ‘current activity’ baseline and NICE consumption. How commissioners decide to manage the financial impact (gain / loss) is for them to agree, but that should not prevent the Trust from moving to charging on current activity and consumption from 2026-27. However, it’s important to note that without commissioners collectively agreeing how the financial impact will be managed across Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards.

The Trust has faced 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 £0.605m and are provided to the Trust via the LTAs as per the Trust funding model. Discussions are ongoing regarding the historic ring fenced allocations with a current gap in the position between Velindre and Hywel Dda of £0.290m. However, there is agreement from Hywel Dda UHB that on the Trust providing evidence

to support these funding arrangements that Hywel Dda UHB will settle the full cash allocations.

2.3 PSPP Performance

During March 2026 the Trust (core) achieved a compliance level of 94.9% (February 98.4%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of 96.5%. The Trust full year compliance (including hosted) is 97.3% compared to the target of 95%.

2.4 Reserves

The financial strategy for 2025-26 again included an emergency reserve of £0.500m which was accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In July, £0.345m of the reserve was allocated to mitigate the unfunded element of the increase in Employer's National Insurance contributions.

A review of the recurrent and non-recurrent reserve position remains underway and is being considered alongside several key factors such as the VCS marginal income risk, LTA contract rebase risk, achievement of the 2025-26 savings target, and a review of currently committed support towards Trust investment, transformation and delivery programmes. Approval of funding recurrently is currently on hold to support the Trust in carrying a balanced underlying position into 2026-27.

WG have directed that from 2026-27 onwards, the emergency reserve must be used to support the underlying position on a recurrent basis.

2.5 Financial Risks

There were several financial risks that could have impacted on the successful delivery of a balanced position for 2025-26. They were either mitigated or sufficiently managed to enable the core Trust to report a small draft underspend of £0.033m.

2.6 Capital

All Wales Programme

The Trust secured required funding from WG in relation to the All Wales Programme for 2025/26 and a number of adjustments / requests made during the annual review of requirements in October were accommodated.

The Trust has been provided a funding award letter towards the OBC/ FBC stage for the WBS TGI infrastructure scheme, however progression is currently paused whilst the Trust works with the contractor to understand the proposed step up in costs for delivery of the

scheme. In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed cost is not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained. The revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard.

Discretionary Programme

The discretionary allocation of £2.000m represents an increase of 4.65% on the £1.911m provided during 2024-25 which was fully spent. The overspend seen in 2025/26 was offset by underspends on All Wales schemes.

The Trust's Capital Planning Group considered and approved the allocation of the discretionary programme for 2025/26 at their meeting in May and this was approved by the Executive Management Board (EMB) on the 29th May 2025.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
	Select all relevant domains below

QUALITY AND SAFETY IMPLICATIONS / IMPACT	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**
QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	Not required - not a strategic decision
	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].

	Click or tap here to enter text

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	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of an **underspend of £0.033m** for March 2026, which is in line with the IMTP plan. **Source of Funding**: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item

	Scale of Change Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Board Assurance Framework (BAF).
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recipients are provided with detail on the risks and any actions required from them to mitigate / remove the risk are highlighted.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Individual risks to be managed with the financial envelope for 2025-26. Overall financial and sustainability risks reported and managed through the BAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below

	Availability of resources to implement work / changes needed and successful negotiations with Commissioners.
All risks must be evidenced and consistent with those recorded in Datix	

Gwasanaeth Canser Felindre
Velindre Cancer Service

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31ST MARCH 2026

TRUST BOARD
21ST MAY 2026

1. Introduction

The purpose of this report is to outline the financial position and performance for the month and year ended 31st March 2026 including the performance against financial savings targets, highlight any remaining financial risks of relevance to future years, and confirm the actions taken to deliver the IMTP Financial Plan for 2025-26.

2. Background / Context

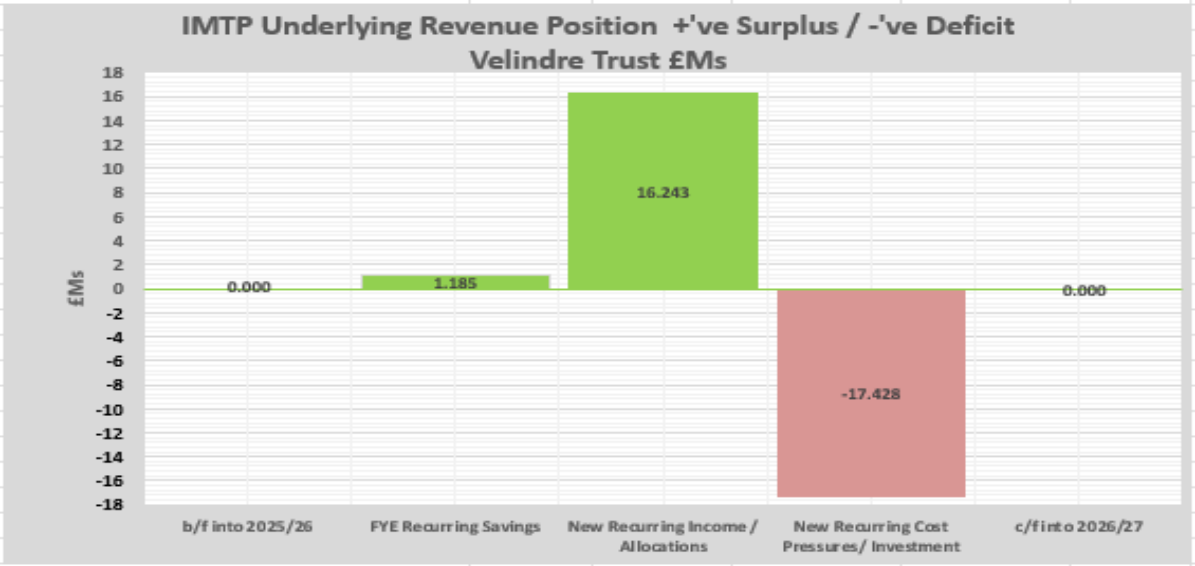
The draft Trust IMTP Financial Plan for the period 2025-2028 was set within the following context:

- The Trust submitted a balanced three year IMTP, covering the period 2025-26 to 2027-28 to Welsh Government on the 31st March 2025.

- For 2025-26 the Plan included:
  - A balanced position brought forward from 2024-25,
  - FYE **of new cost pressures / Investment** of **-£17.428m,**
  - offset by **new recurring Income** of **£16.243m,**
  - and recurring FYE **savings schemes** of **£1.185m,**
  - Allowing **a balanced position** to be carried into 2026-27.

- The 1.77% core discretionary uplift (sustainability) funding will be required to fund the significant underlying cost pressures, investment in capacity beyond marginal cost, and the revenue investment decisions in relation to the Trust's major infrastructure and equipment projects.

- **To achieve a balanced financial position, the savings target set for 2025-26 was required to be achieved, all anticipated income was needed to be received, and any new emerging costs pressures were needed to be either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2025/26	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2026/27
Velindre NHS Trust	0.000	1.185	16.243	-17.428	0

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Full Year £m
Revenue	Variance	0.003	0.033
Capital* (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.098	20.593
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	94.9%	96.5%

Note that the capital spend includes £0.250m funded by a Home Office grant in respect of an irradiator in WBS

Performance against Planned Savings Target

	Unit	Current Month £m	Full Year £m
Efficiency / Savings	Variance	0.552	0.663

Revenue

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust has also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding which will be removed recurrently in 2026-27 and is facing a further challenge from HD on the baseline funding with a risk of c£0.290m.

The general discretionary uplift of 1.1% that has been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment.

As in previous years the Trust accumulated non-recurrent income during 2025/26 from several sources including significantly higher levels of bank interest, overachievement of VCS activity and accountancy gains.

The extraordinary non recurrent income generated in 2025/26 enabled £1.5m of expenditure to be suspended for service activities which had approved Charitable Funds support. These costs were managed within Velindre UNHS Trust core funding from non-recurrent income received in year, and therefore £1.5m of funding earmarked to support the cancer services remained within the Charity. This was approved by the Charitable funds Committee on the 10th March 2026 and the impact was factored into the Trust's overall financial position.

Capital

The approved Capital Expenditure Limit (CEL), excluding leases, for the year ended 31st March 2026 was **£20.353m**. This represented all Wales Capital funding of **£18.353m**, and Discretionary funding of **£2.000m.** A grant of £0.250m was also received from the Home Office to fund an irradiator in WBS, resulting in a **total Capital Budget of £20.603m** for the year.

The Trust reported total Capital spend to 28th March 2026 was £20.593m, therefore achieving an underspend of £0.010m.

The Trust's final CEL for 2025/26m is broken down as per the table below. For completeness, the grant funding from the Home Office agreed in year is also included:

	Approved CEL 2025/26 £m	Full Year Spend £000s	Year End Variance 2025/26 £m
All Wales Capital Programme			
nVCC Enabling Works	3.683	3.973	(0.290)
nVCC Enabling Works QRA	0.550	0.161	0.389
nVCC Project	6.376	6.559	(0.183)
nVCC Project QRA - MIM	0.185	0.052	0.133
Integrated Radiotherapy Solution (IRS)	1.350	1.398	(0.048)
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	0.510	0.522	(0.012)
Whitchurch Hospital Site Disposal	0.860	0.843	0.017
WBS HQ Continuity Business Case OBC/FBC fees	1.000	0.867	0.133
WBS Fleet Replacement Programme	0.605	0.546	0.059
DPIF - RISP	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.184	0.001
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.057	0.029
WBS Plasma for Fractionation	0.030	0.030	0.000
Non-Radiology Ultrasound Replacement	0.048	0.058	(0.010)
Radiology Ultrasound Replacement	0.132	0.096	0.036
VPAG Funding - Equipment	0.037	0.036	0.001
Positron Emission Tomography (PET) Fees nVCC	0.042	0.047	(0.005)
Additional Digital Allocation	0.386	0.389	(0.003)
End of Year Funding	0.568	0.570	(0.002)
End of Year Equipment funding December 2025-26	0.024	0.025	(0.001)
End of Year Digital funding January 2025-26	1.065	1.092	(0.027)
National Programme Theatre Laptop	0.001	0.001	0.000
Total All Wales Capital Programme	18.353	18.136	0.217
Discretionary Capital	2.000	2.207	(0.207)
Grant Funding	0.250	0.250	0.000
	20.603	20.593	0.010

PSPP

During March 2026 the Trust (core) achieved a compliance level of **94.9%** (February 98.4%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of **96.5%**. The Trust full year compliance (including hosted) is **97.3%** compared to the target of 95%.

Efficiency / Savings

An in-depth review of the Trust's savings plan was undertaken during the IMTP process which produced a target of £2.280m for 2025-26.

The overall Trust savings performance as at 31st March 2026 shows the year's planned savings of £2.280m were **overachieved by £0.663m**. **Actual delivery for the year was £2.943m**.

In year there were challenges in achieving the full values against the original plan, in particular the achievement of recurrent saving schemes with divisions finding replacement schemes that were non-recurrent in nature.

Following the WG Finance Touch point meeting in January the Trust was challenged to review the underlying position reported in the draft finance IMTP which resulted in a further £0.300m of bank interest being brought in recurrently to the savings plans to help ensure that a balanced position will be carried forward into 2026-27.

Accountancy gains of £0.392m were also recognised in month 12 in respect of aged creditor payments that were no longer required.

Revenue Position

Full Year Underspend			
Type	Full Year Budget (£m)	Full Year Actuals (£m)	Forecast Full Year
Income**	(268.955)	(279.982)	11.027
Pay **	109.635	115.049	(5.414)
Non Pay	159.320	164.900	(5.579)
Total	**0.000**	**(0.033)**	**0.033**

The overall position against the full year revenue budget to the end of March 2026 is **an underspend of £0.033m**.

**Each year in March the Trust is required to recognise notional income and pay costs in relation to additional 9.4% employer's pension contributions that Welsh Government pay on behalf of the Trust directly to the Pensions Agency. For 2025/26, this has resulted in £7.451m additional income and pay costs being reflected in the ledger which is reflected in the full year variances of the table above, however have a nil effect on the overall financial position.

Revenue Position Highlights / Key Issues

Underlying Position

The Trust submitted a balanced IMTP Financial Plan for 2025-28 and is expected to maintain this position over the course of the 3-year planning period. Outlined in that plan were some significant financial risk and challenges, particularly in the first year, due to the uncertainties at the time around the income it would receive to cover the committed capacity investment in Velindre Cancer Services.

The formal agreement of the Trust income planning assumptions has been summarised within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025 that included a 1.77% general uplift. Signed LTAs are in place with all organisations, although, as previously mentioned, the Trust has had to agree a significant loss in income with Hywel Dda UHB.

The ability to maintain a balanced underlying position is challenging due to the significant cost pressures and risks which have materialised since the submission of the IMTP. Despite this, the draft IMTP for 2026-29 reflects a balanced carried forward position which is expected to be maintained over the course of the IMTP.

Income

Analysis of the Trust income is shown in the table below, with commentary on any significant variances described in the relevant sections within this report:

Cumulative (£11.277m overachieved)			
Type	Full year Budget (£m)	Full year Actual (£m)	Full year Variance (£m)
Core Income - HB / WHSSC	121.695	122.110	-0.415
Nice/ High Cost Drugs	68.434	68.373	0.061
WBS Wholesale Blood Products	31.323	31.350	-0.027
WBS Transplantation Services	0.042	0.042	0.000
WBS Blood Components	0.840	1.128	-0.288
Home Care Drugs	2.940	3.384	-0.445
Private Patient	2.938	3.385	-0.447
VCC Over Activity	7.061	8.166	-1.105
Radiotherapy Activity Income	3.324	2.287	1.037
IRS Programme	0.792	0.792	0.000
Radiation Protection	1.323	1.400	-0.077
Staff Recharges	0.841	0.789	0.052
One Wales Palliative and EOL Care	1.436	1.518	-0.083
Velindre Charity	2.929	2.823	0.106
Other Charity	0.010	0.021	-0.011
RD&I***	4.565	5.192	-0.627
HTW	1.723	1.617	0.105
Other Operating Income**	16.739	25.854	-9.115
Total	268.955	280.232	-11.277

** Other Operating Income includes £7.451m notional income from WG in respect of additional employer's pension contributions paid on behalf of the Trust

***RD&I full year budget includes £1.408m of Velindre Charity income.

The variance reported against the Radiotherapy Activity income as at month 12 is offset by vacancies, non recurrent funding support, contract performance income for wider services, and non pay reductions: these are non-recurring mitigations in addressing the underperformance against planned contract income levels as per business case. The underperformance of income will be recurrently offset in part via the allocation of contract income from wider Cancer services and anticipated growth in future financial years.

The HTW variance was offset by an underspend on expenditure and therefore has no impact on the HTW financial position reported as breakeven within the Trust ledger.

The table reflects the pass through by the Trust's Commissioners of the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2025-26 pay inflation was confirmed by Welsh Government, although any shortfall such as staff increments were met by additional savings or absorbed by Service Divisions and Corporate Departments. Funding from Welsh Government in respect of the additional Employer's National Insurance Contributions from April 2025 was confirmed at 82.93% of that required in 2025-26, leaving a shortfall of £0.345m which was funded recurrently from the Trust reserves.

Commissioners did not agree any additional funding above the 1.77% general uplift, for either WBS or VCS. The Trust managed the pressure for additional capacity invested in outpatients, ambulatory care, SACT and imaging services during 2023-24 and 2024-25 to meet the rising demand and cancer waiting times. Whilst the Velindre Collective Commissioning Group for Cancer had agreed to undertake a more detailed review of the SACT Business Case submitted as part of the IMTP process, no commitment was made this year. The Trust re-submitted the service growth investments to our Commissioners on the 22nd October 2025 in line with the IMTP governance timeline process for 2026-27 with confirmation from all commissioners that no funding support will be provided.

Further details in relation to VCS and WBS income are included within the relevant sections below.

VCS Long Term Agreement (LTA) Contract Performance

The Trust agreed with Commissioners an uplift to LTA values of 1.77% which amounted to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding which will be removed recurrently in 2026-27 and is now facing a further challenge from HD on the baseline funding with a risk of c£0.290m.

The general uplift of 1.1% for 2026-27 is expected to be passed through from Commissioners without adjustment.

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. How Commissioners decide to manage the financial impact (gain / loss) is for them to agree, but that should not prevent the Trust from moving to charging on current activity and consumption from 2026-27. However, it's important to note that without Commissioners collectively agreeing how the financial impact will be managed across Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards.

Hywel Dda UHB unilaterally forced the Trust to move to an LTA based on actual activity delivered each financial year i.e. a cost per case LTA, and the Trust began conversations with its three main commissioners, however, we will not reach agreement in time to recharge on an actual activity basis for 2026/27. Any change to the LTA baseline will need to be cost neutral to the Trust.

The Trust has faced 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 £0.605m and are provided to the Trust via the LTAs as per the Trust funding model. Discussions are ongoing regarding the historic ring fenced allocations with a current gap in the position between Velindre and Hywel Dda of £0.290m. However, there is agreement from Hywel Dda UHB that on the Trust providing evidence to support these funding arrangements that Hywel Dda UHB will settle the full cash allocations.

A risk emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as vacancies, non recurrent funding support, contract performance income for wider services, and non pay reductions.

In addition, the Trust wrote to its Commissioners on the 8th August 2025 requesting funding support of £0.278m for the additional recurrent costs that emerged since the FBC and the go live date where the first patient was treated on the 19th June 2025. The Trust were informed that they would not be supporting these additional costs, the impact of which was factored into the plan and year end position.

The tables below set out the projected year end LTA income performance based on data to 28th February 2026 (note the data supplied is one month behind the rest of this report due to reporting timelines) by Commissioner and main service delivery areas. The forecast increase in marginal income represents activity performance in excess of 2019/20 baseline contracted activity volumes.

The IMTP planned overperformance against 2019/20 baseline contract levels is £7.061m (this is a forecast increase in contract income of £2.048m against the 2024-25 out-turn and plan set at IMTP stage), split across organisations as shown below:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda (7A2)	0.865	-0.024	0.840	-3%	0.015	-0.039
Swansea Bay (7A3)	0.455	0.003	0.495	1%	0.014	-0.011
Cardiff & Vale (7A4)	16.048	3.062	20.143	20%	2.520	0.542
Cwm Taf Morgannwg (7A5)	14.285	2.328	17.701	17%	1.937	0.391
Aneurin Bevan (7A6)	19.812	2.979	24.281	15%	2.462	0.517
Powys (7A7)	1.080	0.350	1.512	32%	0.120	0.230
NHS Wales Joint Commissioning Committee	2.259	0.411	2.821	18%	-0.007	0.418
Total	**54.803**	**9.109**	**67.792**	**17%**	**7.061**	**2.048**

The marginal income overachievement largely in outpatients and SACT preparation was held to support the underachievement on the Radiotherapy activity and underlying cost pressures within VCS.

The table below analyses the above comparison to base contract value per Commissioner by contract currency / service area from a financial perspective:

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Radiotherapy Planning	5.905	0.459	6.364	8%	0.022	0.436
Radiotherapy Delivery	13.508	-0.046	13.462	-0%	-0.174	0.128
Nuclear Medicine	1.031	-0.052	0.979	-5%	-0.032	-0.020
Radiology Imaging	3.149	0.773	3.921	25%	0.646	0.127
Preparation for Systemic Anti-Cancer Therapy	2.918	1.015	3.933	35%	0.659	0.356
Delivery of Systemic Anti-Cancer Therapy	6.884	1.765	8.649	26%	1.926	-0.161
Ambulatory Care Services	1.405	0.461	1.866	33%	0.367	0.093
Outpatient Services	10.455	4.341	14.796	42%	3.443	0.898
Inpatient Admitted Care	6.162	0.394	6.556	6%	0.203	0.191
Contract Adjustments	3.388	0.000	7.269	0%	0.000	0.000
Total	**54.803**	**9.109**	**67.792**	**17%**	**7.061**	**2.048**

The following table provides an analysis on the same contract currency / service area but from an activity perspective:

Activity Performance Per Contract Currency	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Radiotherapy Planning	3,916	3,985	69	2%	3,794	191
Radiotherapy Delivery	53,586	48,853	- 4,733	-9%	50,060	- 1,207
Nuclear Medicine	1,738	1,562	- 176	-10%	1,528	34
Radiology Imaging	9,103	15,309	6,206	68%	14,002	1,307
Preparation for Systemic Anti-Cancer Therapy	25,262	38,562	13,300	53%	37,202	1,360
Delivery of Systemic Anti-Cancer Therapy	31,867	47,128	15,261	48%	47,751	- 623
Ambulatory Care Services	7,874	10,818	2,944	37%	9,701	1,117
Outpatient Services	59,960	93,108	33,148	55%	91,043	2,065
Inpatient Admitted Care	9,072	10,177	1,105	12%	9,652	525
Contract Adjustments	-	-	-	0%	-	-
Total	**202,378**	**269,500**	**67,122**	**33%**	**264,733**	**4,767**

As can be seen, Radiotherapy Delivery remained a key factor which is under review aligned with the Radiotherapy under activity performance financial risk.

This activity is shown below on a Commissioner basis:

Activity Performance Per Commissioner	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Hywel Dda (7A2)	1,202	1,029	-173	-14%	963	66
Swansea Bay (7A3)	1,200	1,264	64	5%	1,162	102
Cardiff & Vale (7A4)	60,809	84,727	23,918	39%	82,794	1,933
Cwm Taf Morgannwg (7A5)	59,964	75,324	15,360	26%	74,013	1,311
Aneurin Bevan (7A6)	74,098	98,357	24,259	33%	99,839	-1,482
Powys (7A7)	3,619	5,944	2,325	64%	5,003	941
NHS Wales Joint Commissioning Committee	1,486	2,855	1,369	92%	959	1,896
Total	**202,378**	**269,500**	**67,122**	**33%**	**264,733**	**4,767**

As mentioned elsewhere in this report, Hywel Dda UHB have requested a recurrent reduction in the LTA financial value from 2026/27 given a reduction in activity where patients have been re-directed to Swansea Bay UHB, however the Trust is challenging this as whilst we did see a drop in patients from Hywel Dda between the period 2019-20 and 2024-25, activity levels have now returned back to 2019-20 levels and represent only a 13% reduction against the baseline.

The following are cost pressures / service developments within VCS which have been communicated with the Trust Commissioners as part of the IMTP process:

Area	Cost Pressures	2026/27 £'000	Recurrent / Non Recurrent
New - Radiation Services	SBAR 1 - Radiotherapy Breast	100	R
VCS25/2602	No SBAR - CA&V Lab Services SLA (C204) Note: partial funding ringfenced within draft IMTP 2026-29	300	R
Planning, Performance and Support Services	SBAR 2 - Compliance with the NHS Wales National Standards of Healthcare Cleanliness Aug 2025	100	R
Systemic Therapies	SBAR 3 - BBV (Blood Borne Virus) screening	62	R
Systemic Therapies	SBAR 4 - Immunotherapy Cardio Toxicity baselining	104	R
Systemic Therapies	SBAR 5 - Closed system drug transfer Note: funding ringfenced within draft IMTP 2026-29	560	R
Systemic Therapies	SBAR 6 - Expansions of SACT Treatment Capacity	1,012	R
SST Services	No SBAR - Echocardiogram	TBC	R
Inpatient, Acute and Palliative Care	SBAR 7 - Enhanced Care Provision at VCS	1,551	R
Inpatient, Acute and Palliative Care	No SBAR - ctDNA DNA	262	R
	Total	3,651	

WBS Position Update

WBS has been managing a number of financial risks within the service that support supply chain sufficiency, demand and patient safety. In addition, since the publication of the Infected Blood Inquiry in May 2024, the service will be required to improve patient safety for transfusion wherever possible. The Trust submitted six Welsh Blood Service business cases to JCC relating to key service areas for consideration that help either maintain or improve the safety of the supply chain for the transfused patients in Wales. These cases were:

1. Plasma for Medicines: Implementation of the Welsh Government Policy for the collection, processing and supply of plasma for the manufacture of Immunoglobulin and Albumin products;
2. Red Cell Immuno-haematology Laboratory: £0.251m for additional capacity 24/7 for the Red Cell Immuno-haematology Laboratory;
3. Haemoglobin S screening: £0.052m for implementation of Haemoglobin S (HbS) testing to comply with national guidance;
4. Blood Component Development: £0.703m for investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns;
5. Buccal Swab Pathway: £0.259m for introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel;

6. Blood Donation Team Resilience: £0.266m for additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.

JCC has not approved additional funding for any of the business cases for WBS. This places a significant increased financial risk on the Trust as these cases are necessary to maintain and improve quality and safety, so has inevitably been forced to make some investment at financial risk. The cases were re-submitted to JCC on 8th October, for consideration of funding as part of the 2026-27 IMTP process. If these cases are again not supported, funding will need to be sought via Welsh Government following recommendations from the IBI report.

The Trust Medical Director has recently briefed the Deputy Chief Medical Officer (DCMO) regarding the Infected Blood Inquiry (IBI) report recommendations. WBS colleagues are progressing work on the Blood Transfusion related recommendations. Prior to this, in October 2025 Jeremy Griffith, WG, visited the WBS Talbot Green site. Following the visit, Jeremy shared his intention to recommend the tour to other senior Welsh Government officials, including the Cabinet Secretary, and noted several key WBS priorities: including the WBS digital transformation projects, refurbishment plans for the centre at Talbot Green, and the plasma collection ambitions. This tour was undertaken on 29th January 2026 when WBS were pleased to welcome Jeremy Miles MS, to Talbot Green headquarters where he was joined by his Senior Private Secretary, Lowri Llewelyn and Catherine Cody, Senior Policy Manager in the Quality and Nursing Directorate, WG. This was an opportunity for the Cabinet Secretary to see first-hand the scale, expertise, and importance of the behind the scenes work that underpins patient care every day in NHS Wales.

As previously advised, the Trust has assumed that Welsh Government and / or Joint Commissioning Committee (JCC) will fund the Phase 2 (Option 2 Apheresis collection of Plasma) which will not be progressed until funding is approved. Phase 2 requires significant funding which over time will be offset by cost savings to Health Boards on medicine products.

Pay Highlights / Key Issues

The table reflects the pass through by the Trust's Commissioners of the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2025-26 pay inflation was confirmed and funded by Welsh Government and staff increments were met by additional savings or absorbed by Service Divisions and Corporate Departments.

Several posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. The majority of these posts have however now been funded recurrently as part of the 2024-25 and 2025-26 IMTP process. The remaining unfunded posts are currently under review alongside the LTA activity to try and align the cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

In addition to the savings plans and the shortfall in pay award VCS (£0.600m), WBS (£0.550m) and Corporate (£0.200m) held a recurrent vacancy factor target which is expected to be achieved to support a balanced financial position for 2025-26.

Non Pay Key Issues

Each Division holds both a general reserve to meet unforeseen costs and a savings target / cost improvement Plan (CIP). The Trust savings target for each division in 2025-26 has been set at VCS £1.043m, WBS £0.705m, RD&I £0.230m and Corporate £0.302m.

In 2025-26 the Trust again set an emergency reserve of £0.500m in case of a requirement to support non-recurrent expenditure which cannot be managed or migrated at Divisional level during the period. £0.345m of this reserve has now been allocated the manage the cost pressure arising from the shortfall in funding of the increase in Employer's National Insurance Contributions from April 2025.

The remainder of the Trust reserves and previously agreed unallocated investment funding was held in month 12 and was released into the position to support the end of year financial position.

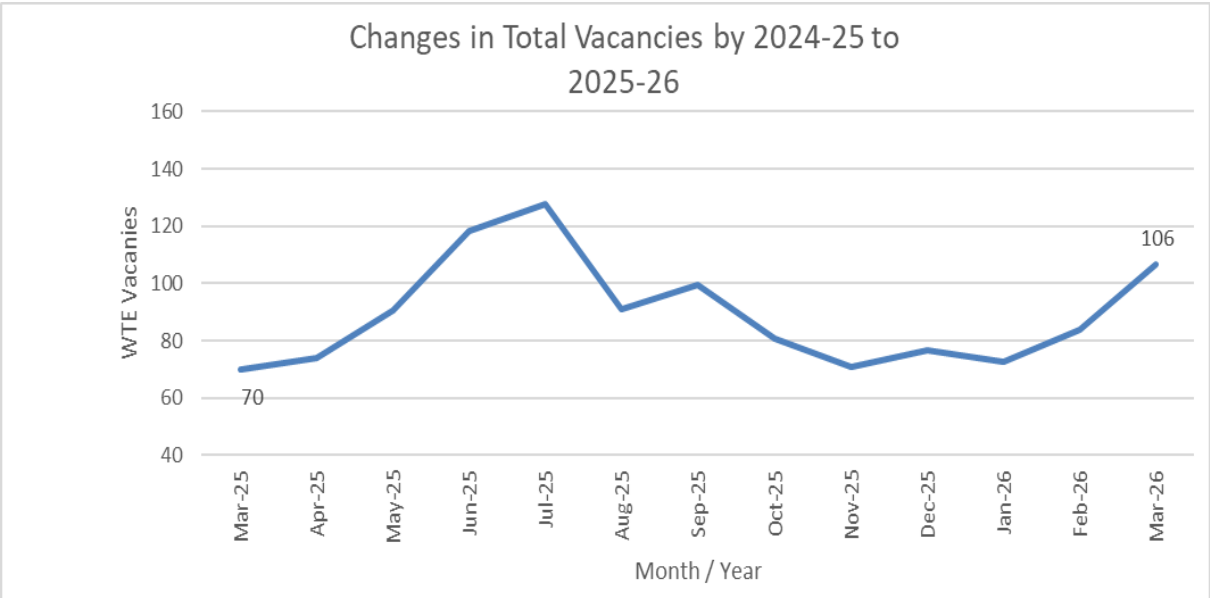
WG have advised the Trust that from 2026/27 so Trust can no longer hold an emergency reserve, and it must be used to support the underlying position.

3.1 Pay Spend Trends (Run Rate)

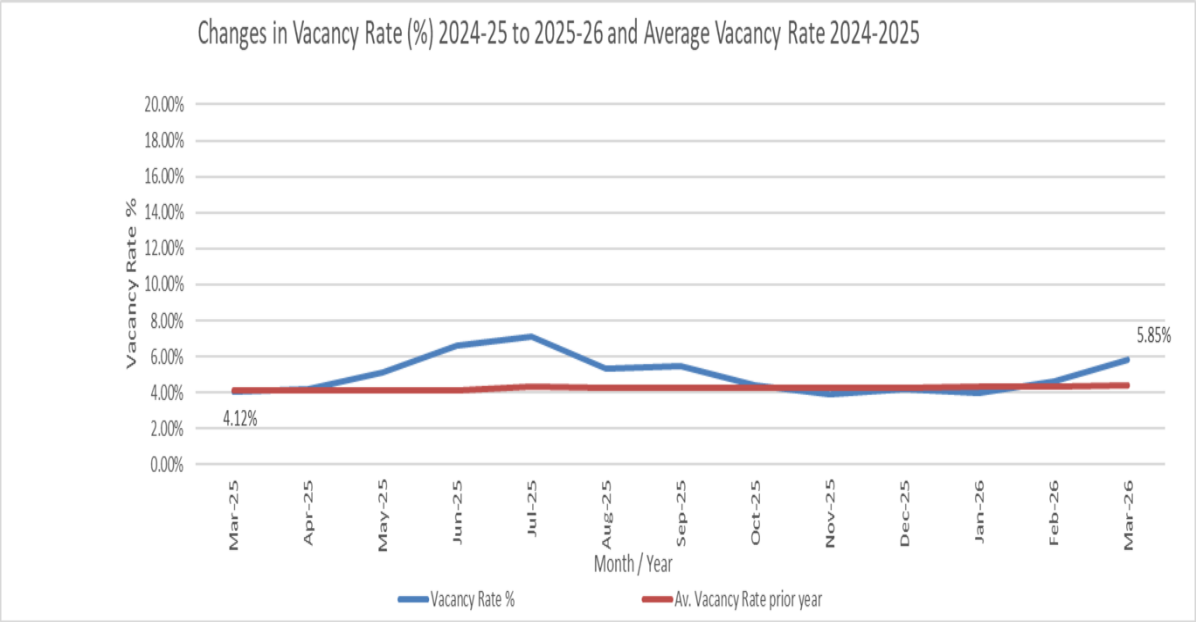
As of March 2026, the current staff in post is 1,714 WTE (February 1,736). The number of vacancies is 106 WTE (February 84), which represents a vacancy rate of 5.85% (4.6% February) against the budget of 1,820 WTE. The vacancy gap is largely being met using overtime or bank staff and is also supporting each of the division's vacancy factor savings target. In line with the WG requirement to cease the use of agency posts, currently only a few remain, and the Trust is keen in future months to only utilise agency posts where options to fill via bank and fixed term contracts are not possible, and there is an unavoidable service need.

The largest number of vacancies are seen within VCS: 55 WTE. Vacancies are spread across many other services, particularly Allied Health Professionals (5 WTE), Admin & Clerical (9 WTE) Medical (16 WTE), and Additional Clinical Services (16 WTE), Healthcare Scientists (9 WTE), offset by overestablishment in Nursing & Midwifery (6 WTE).

WBS currently are reporting 30 WTE vacancies. Healthcare Scientist posts are no longer overestablished, although this remains the case for Nursing & Midwifery (2 WTE) while funding from related business cases to JCC has been requested. These are offset by Additional Clinical Service vacancies (19 WTE) which are currently being recruited to.



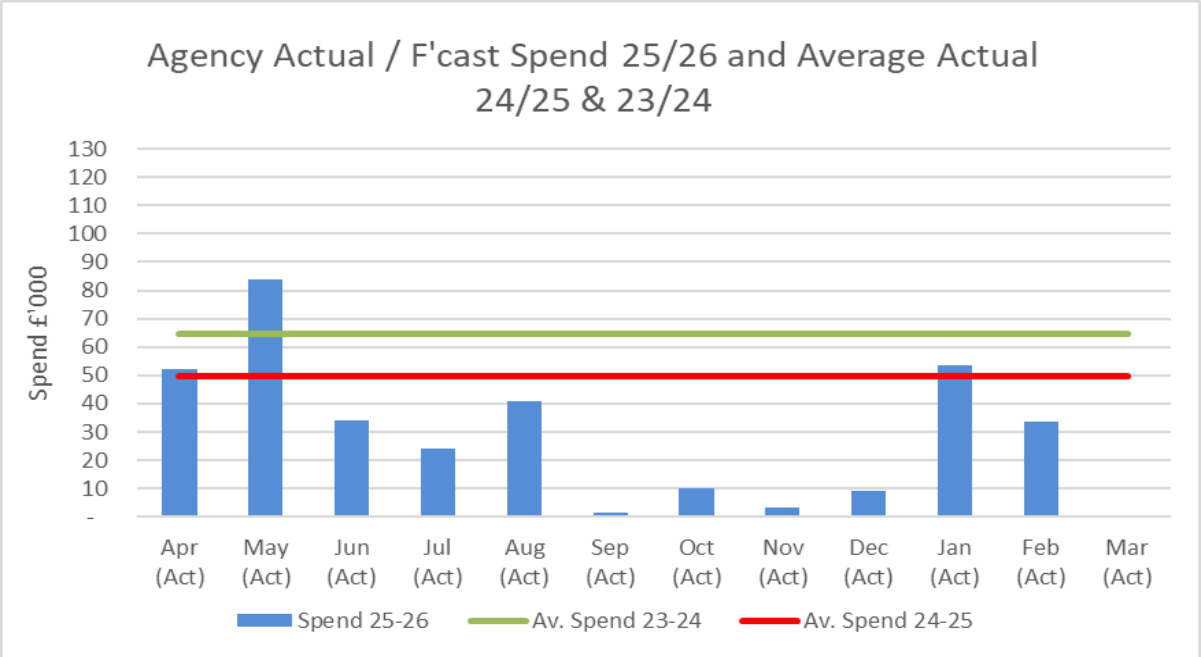
The total Trust vacancies as of March 2026 are 106 WTE (February 83 WTE): VCS (55 WTE), WBS (30 WTE), Corporate (12 WTE), RD&I (8 WTE), nVCC (0 WTE) and HTW (1 WTE).



The spend on agency staff in March 2026 was a credit of **£0.008m** (February £0.034m) with a total year spend of **£0.337m** (£0.596m 2024/25).

In line with the Value & Sustainability agenda the Trust has made significant progress in moving away from the dependence on agency staff. Minimal, exceptional spend is forecast only where service needs can only be met via this option.

It is important that processes are in place to ensure future short term or emergency staff requirements can be met from bank or fixed term contracts without further agency involvement unless absolutely essential to maintain services.

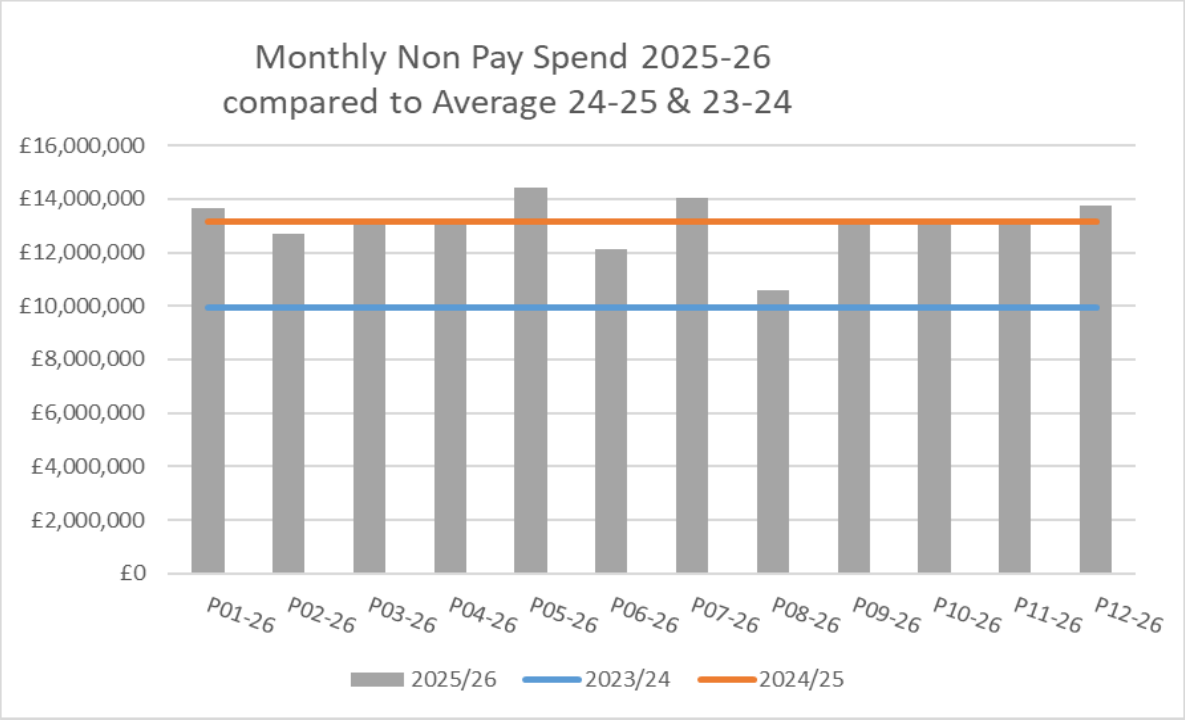


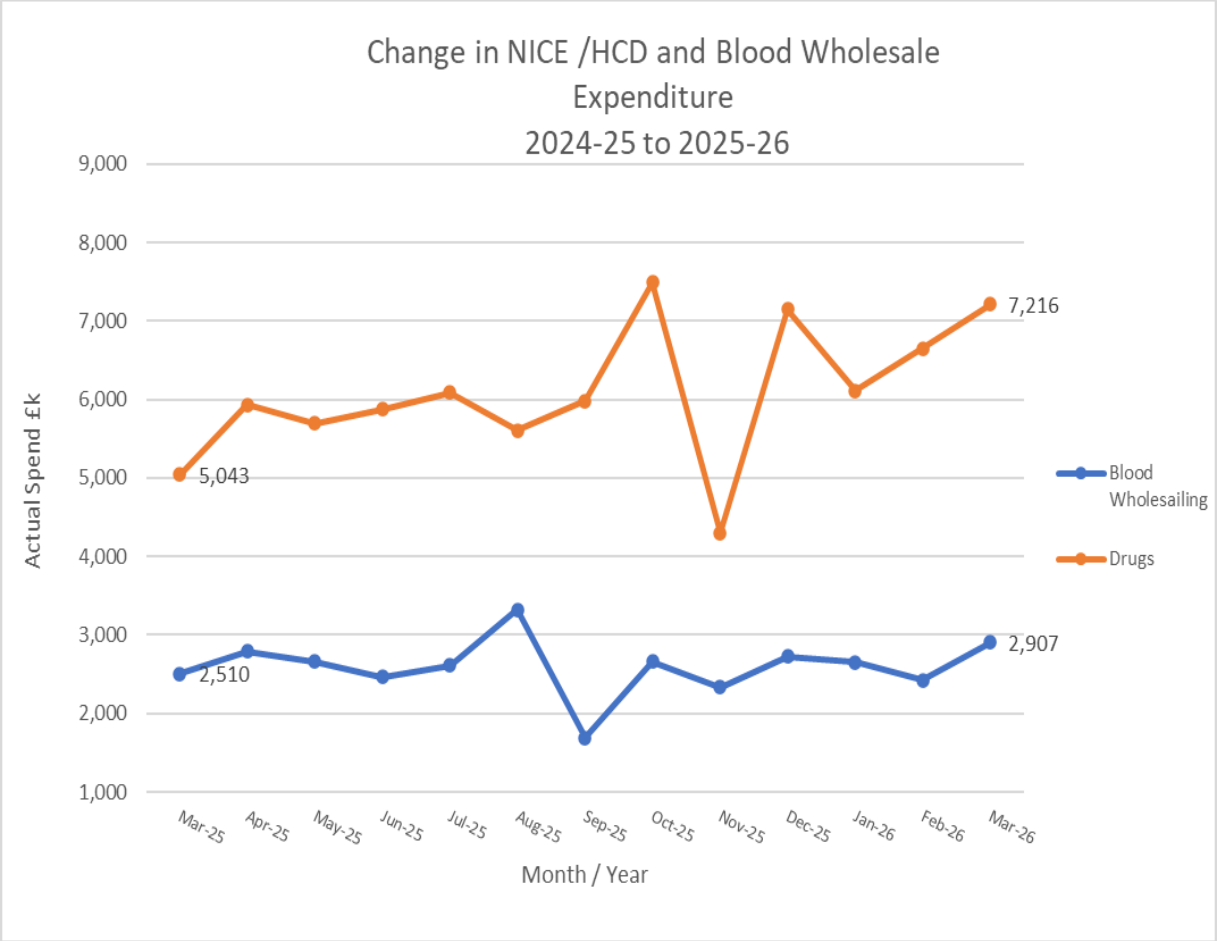
3.2 Non Pay

Non-Pay average spend for 2024/25 was £13.1m per month which was a £3.2m increase from the previous whole year. The largest movement was in non-cash as a result of the accelerated depreciation charge on the VCS hospital and the impairment charges associated with the nVCC Asda works (£1.8m average per month). NICE and HCD drugs (£0.7m) and blood wholesale costs (£0.5m) increased which were offset by income recharges to Health Boards. Other small movements included an increase in Clinical Services & Supplies (£0.2m) and General Supplies, Service, Maintenance & Facilities (£0.1m). All other costs remained fairly static when compared with the year on year average.

The non-pay average monthly spend for 2025/26 stands at £13.0m. NICE and HCD drugs (£6.175m) and blood wholesale average costs to date (£2.605m) have increased which were offset by an income increase via recharges to Health Boards. Non-Cash (Impairment charges) are lower by (-£0.435m), mainly due to the charge incurred on the nVCC Asda works during 2024/25. 'Other' charges average costs are generally comparable.

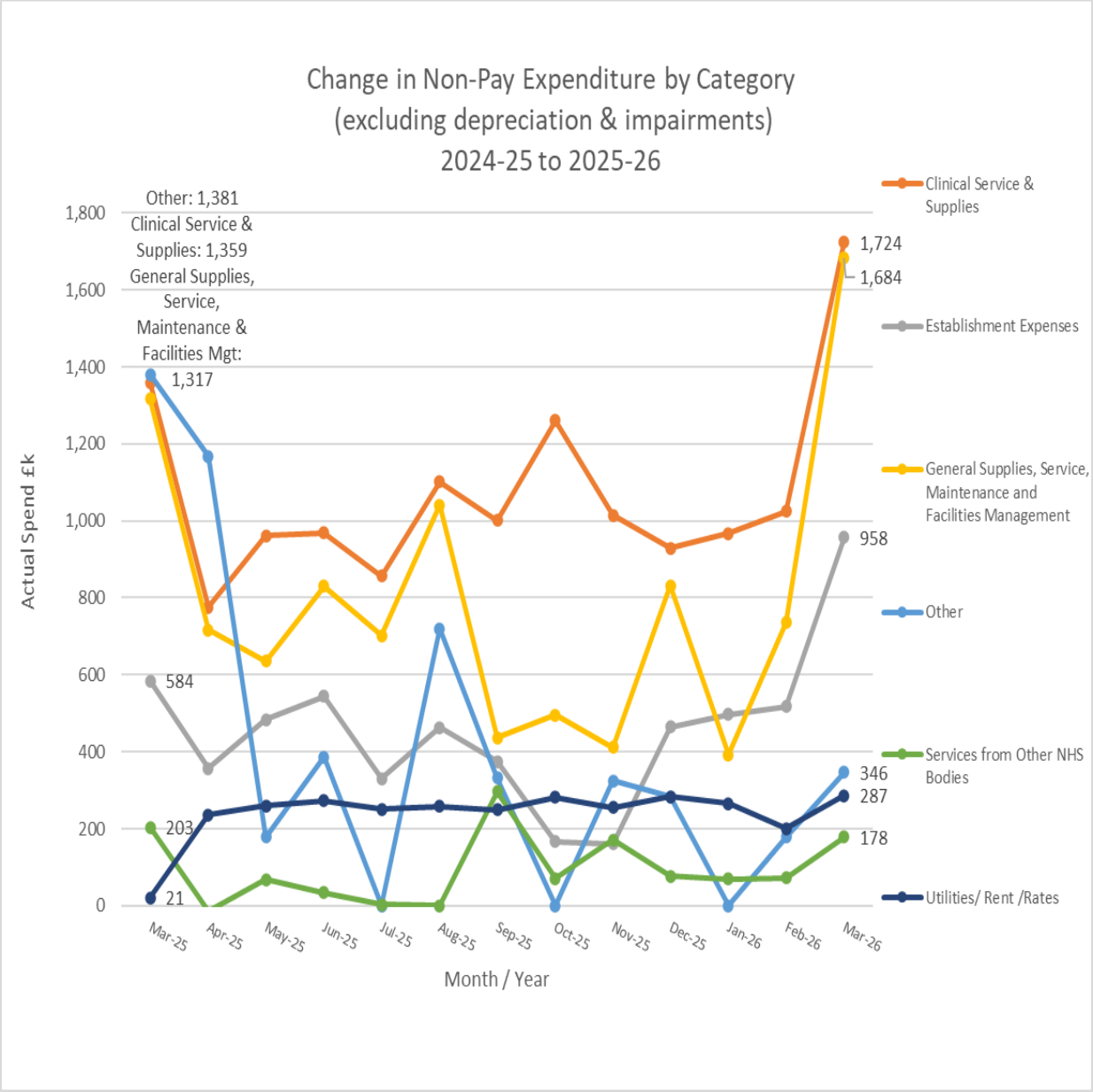
The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2025 to March 2026 compared to the average spend across the financial year 2023/24 and 2024/25.





Blood wholesaling costs are demand led and therefore difficult to predict. The reduction seen in September included an adjustment relating to August which was required due to an inaccuracy in August reporting caused by system issues.

Spend on drugs in month 8 was lower than forecast in month 7. In month 7 a higher than expected value of actual expenditure was reported. Following investigation, the reasons for both are mainly due to advanced stock purchases made in month 7 which reduced the amount of expenditure in month 8.



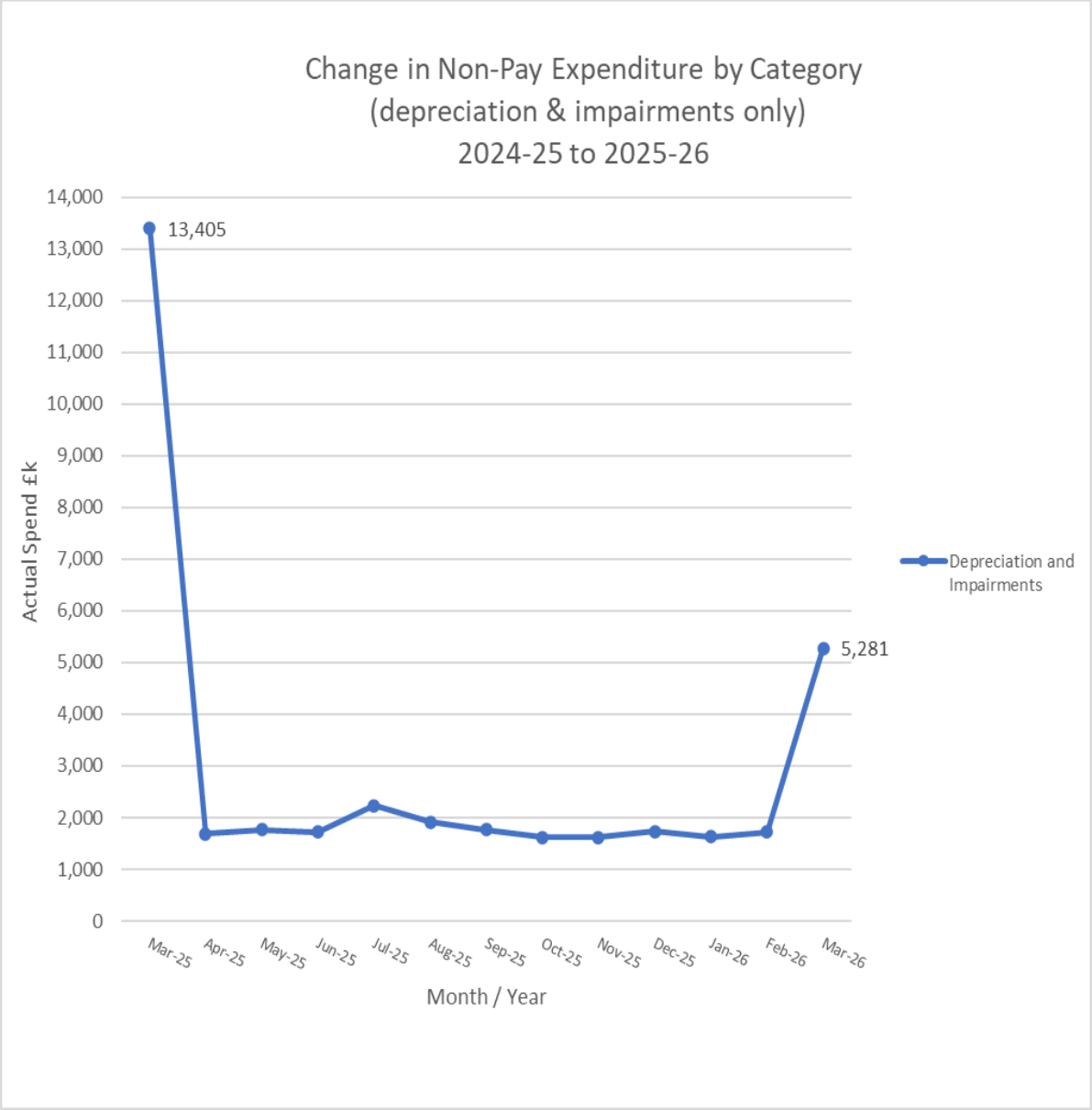
Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

The reduction seen in May 2025 for other costs relates to a provision for legal costs of £1.184m which was made in error in April and has been corrected in May. A reduction is again seen in July which is due to the reimbursement of legal costs by WRP of £1.369m, with further legal costs being recognised in August, as reflected above. Legal costs paid by the Corporate division in March have resulted in the spike seen in the graph.

Establishment expenses have reduced in month 7 due to recovery of some VAT (£0.173m) previously paid to HMRC as a result of an annual review exercise. This has been treated as a reduction in expenditure.

General supplies, services and facilities management, and clinical service and supply costs in month 12 are significantly higher than month 11 as all costs relating to the financial year are captured before close. This can be seen in the March 2025 column of the graph.

Depreciation and impairment charges have been excluded from the graph above given their significant values in February & March 2025. For clarity, these are shown separately below.



The Depreciation value included in the above graph for includes £10.593m accelerated depreciation in March 2025 relating to the building and assets of the current Velindre Cancer Centre. An impairment charge of £3.433m was recognised in March 2026 in respect of the nVCC programme and is the reason for the in month increase.

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.280m for 2025-26 which equates to 2.8% of the Trust's core LTA income and is required to support the level of investment plans and cost pressures within the system.

Of the £2.280m total savings target £1.185m is recurrent and £1.095m is non-recurrent, with £1.560m being categorised as actual saving schemes and the balance of £0.720m being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £1.043m (46%), WBS £0.705m (31%) RD&I £0.230m (10%) and Corporate £0.302m (13%).

All schemes were RAG rated green earlier in the year. However, some recurrent schemes did not achieve the full value of savings planned and were therefore replaced with other schemes.

Some of the underperforming schemes were expected to deliver recurrent savings (c£0.300m) and earlier in this year were replaced with non recurrent savings schemes. In addition, and following feedback from WG colleagues, a review of bank interest forecast in this year and the next resulted in recognition of an additional £0.300m being achievable as additional income generation on a recurrent basis. This negates the previously forecast c£0.300m negative underlying position and ensures the Trust carries a balanced financial position into 2026-27.

Performance

The Trust savings performance as at 31st March 2026 is an achievement of £2.943m savings against a full year plan of £2.280m, aided by the introduction of replacement schemes where others were underperforming.

The saving schemes identified at the start of the year as part of the IMTP were created using smart actions to strengthen accountability, monitor progress and delivery.

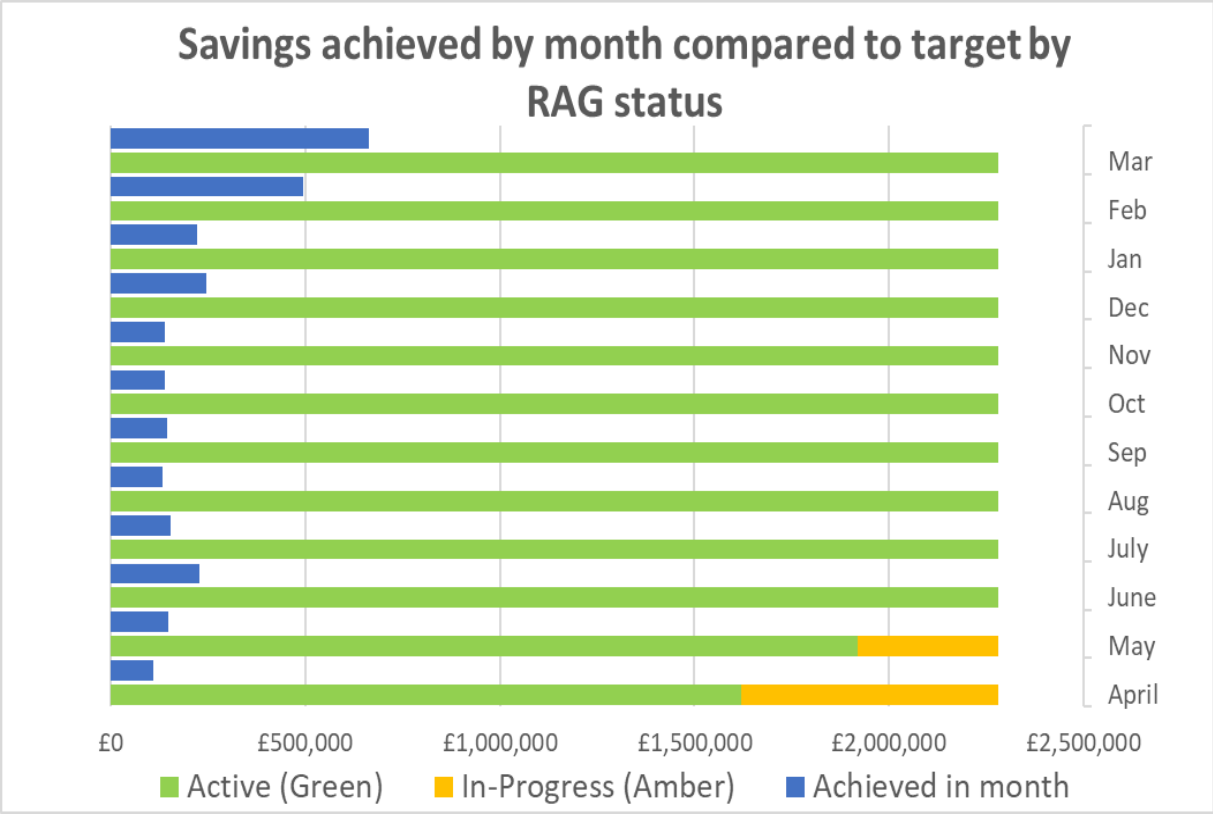
The Trust is currently firming up plans for the savings schemes included in the IMTP 2026-29.

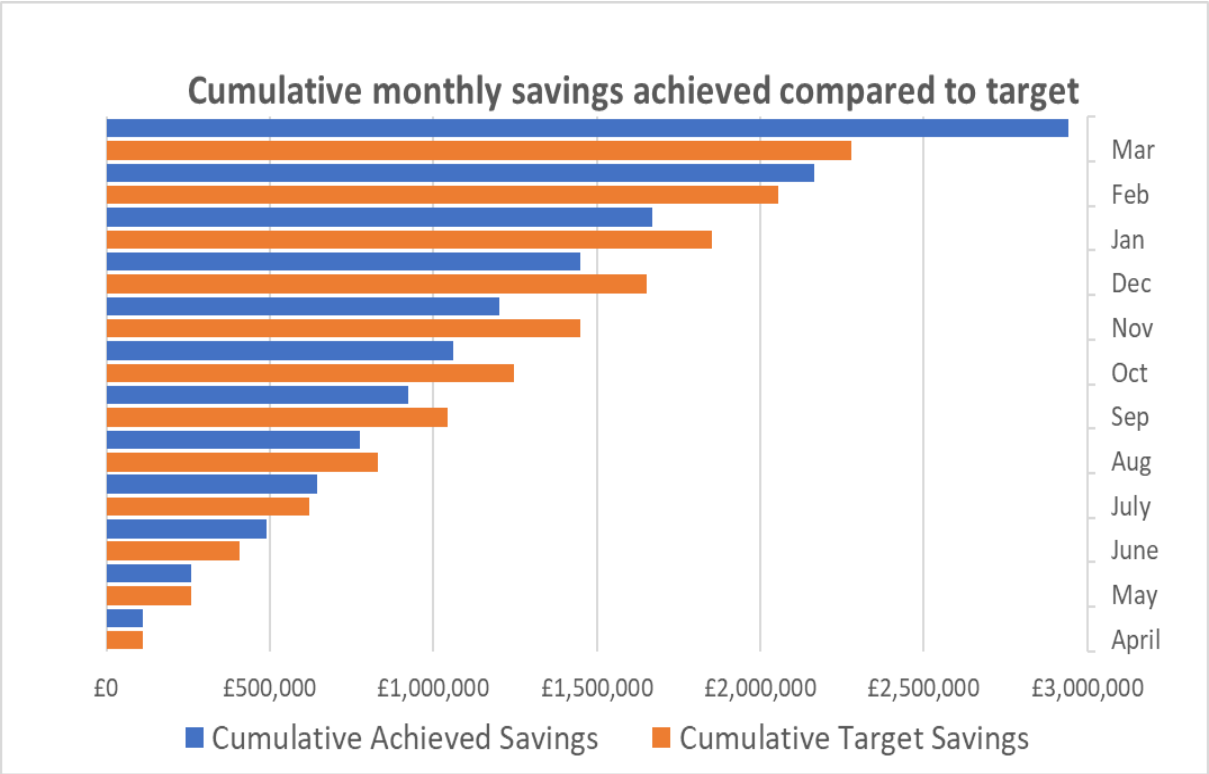
Savings performance is reported through the monthly Divisional finance reports and discussed / monitored via the VCS Divisional Triumvirate / OMB and WBS SMT. In addition, a monthly finance and performance review meeting is being established where Execs will review saving performance ensuring early sight of underperformance or issues.

It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the savings target is met and on a recurrent basis.

ORIGINAL PLAN	TOTAL £000	Planned £000	Actual £000	Variance £000
VCS TOTAL SAVINGS	**1,043**	**1,043**	**1,043**	**0**
			100%	
WBS TOTAL SAVINGS	**705**	**705**	**705**	**0**
			100%	
CORPORATE TOTAL SAVINGS	**302**	**302**	**602**	**300**
			199%	
RD&I TOTAL SAVINGS	**230**	**230**	**201**	**(29)**
			87%	
TRUST ACCOUNTANCY GAINS	**0**	**0**	**392**	**392**
TRUST TOTAL SAVINGS	**2,280**	**2,280**	**2,943**	**663**
			129%	

Scheme Type	Division	Recurrent / Non-Recurrent	RAG Rating	TOTAL £000	Planned £000	Actual £000	Variance £000
Savings Schemes							
Radiation Services Agency Premium Reduction	VCS	NR	Green	15	15	15	0
Establishment Vacancy Control	VCS	R	Underperforming	150	150	37	(113)
Establishment Vacancy Control	VCS	NR	Underperforming	100	100	25	(75)
Procurement Supply Chain Contracting Cost Reductions	VCS	R	Replaced	50	50	0	(50)
Review of SLAs to mitigate / reduce service support	VCS	R	Green	30	30	30	0
3rd party SACT provision (medicines at home)	VCS	R	Green	150	150	150	0
3rd party SACT provision (medicines at home)	VCS	NR	Green	70	70	70	0
Establishment Vacancy Control	WBS	R	Green	100	100	100	0
Procurement Supply Chain Contracting Cost Reductions	WBS	R	Replaced	100	100	0	(100)
Optimised level of stock retention	WBS	NR	Green	150	150	150	0
Demand planning: collections (aspheresis price saving)	WBS	R	Green	40	40	40	0
Demand planning: processing volumes	WBS	NR	Green	60	60	60	0
Process efficiencies	WBS	R	Green	30	30	30	0
Process efficiencies	WBS	NR	Green	20	20	20	0
Establishment Vacancy Control	Corporate	R	Green	50	50	50	0
Energy cost reduction	Corporate	R	Green	85	85	85	0
Establishment Vacancy Control	RD&I	R	Replaced	30	30	0	(30)
Establishment Vacancy Control	RD&I	NR	Replaced	50	50	0	(50)
Add Establishment Vacancy Control	VCS	NR	Underperforming	128	128	22	(106)
Add Establishment Vacancy Control	WBS	NR	Green	55	55	55	0
Add Establishment Vacancy Control	Corporate	NR	Green	67	67	67	0
Add Establishment Vacancy Control	RD&I	NR	Replaced	30	30	0	(30)
3rd party SACT provision (medicines at home)	VCS	NR	Green	In year scheme	0	106	106
Total Saving Schemes				**1,560**	1,560	1,112	(448)
Income Generation							
Private Patients Increased Fees Upon Renewed Contract	VCS	R	Green	150	150	150	0
Private Patients Income Overachievement	VCS	NR	Green	150	150	150	0
Maximising income - operational services	VCS	R	Green	50	50	50	0
Sale of Plasma	WBS	R	Green	50	50	50	0
Interest on bank income above budget	Corporate	NR	Green	100	100	100	0
R&D Commercial Income Generation	RD&I	R	Green	120	120	120	0
Sale of Plasma	WBS	NR	Green	100	100	100	(0)
Marginal activity income	VCS	NR	Green	In year scheme	0	188	188
Marginal activity income	VCS	NR	Green	In year scheme	0	50	50
R&D Commercial Income Generation	RD&I	NR	Green	In year scheme	0	81	81
Sale of Plasma	WBS	NR	Green	In year scheme	0	100	100
Interest on bank income above budget	Corporate	R	Green	In year Scheme	0	300	300
Total Income Generation				**720**	720	1,439	719
Accountancy Gains							
Write back of aged creditors	Trust	NR	Green	In year Scheme	0	392	392
Total Accountancy Gains				**0**	0	392	392
TRUST TOTAL SAVINGS				**2,280**	**2,280**	**2,943**	**663**
						129%	


Savings achieved by month compared to target by RAG status
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
Active (Green)
In-Progress (Amber)
Achieved in month


Cumulative monthly savings achieved compared to target
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
Cumulative Achieved Savings
Cumulative Target Savings

5. Reserves

The financial strategy for 2025-26 again included an emergency reserve of £0.500m which was accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In July, £0.345m of the reserve was allocated to mitigate the unfunded element of the increase in Employer's National Insurance contributions.

A review of the recurrent and non-recurrent reserve position was undertaken and considered alongside several key factors such as the VCS marginal income risk, LTA contract rebase risk, achievement of the 2025-26 savings target, and a review of currently committed support towards Trust investment, transformation and delivery programmes. Approval of funding recurrently is currently on hold to support the Trust in carrying a balanced underlying position into 2026-27.

WG have directed that from 2026-27 onwards, the emergency reserve must be used to support the underlying position on a recurrent basis.

6. Cost Pressures

National and local cost pressures included in the submitted IMTP 2026-29 are shown in the table below and are split by division and analysed between having a recurrent or non recurrent impact:

National / General Cost Pressures	Division	Recurrent/ Non-Recurrent	2026/27 £K
NHS SLA Increase 1.11% 26/27, (1.0% 27/28 & 28/29) (TBC)	Trust	Rec	38
Non-Pay Inflation 2.5% 26/27 (2.5% 27/28 & 28/29) (TBC)	Trust	Rec	120
Digital Microsoft Agreement	Trust	Rec	165
Increase in Welsh Risk Pool Costs	Trust	Non-Rec	948
BMA Pay Negotiations (TBC)	Trust	Rec	300
Total National Cost Pressures			**1,571**
Local Cost Pressures	**Division**	**Recurrent/ Non-Recurrent**	**2026/27 £K**
RISP	VCS	Rec	183
Marginal Income underachievement	VCS	Rec	500
C&V Pathology SLA	VCS	Rec	157
VCS Pay Increments (Unfunded 2025-26 Pay Award) (50%) TBC	VCS	Rec	208
SACT Closed System Drug Transfer	VCS	Rec	560
Blood donation Haemacue forecast volumes	WBS	Rec	94
UK Forum Costs	WBS	Rec	32
Contract Price increases inc rent and rates (above general inflation)	WBS	Rec	159
WBS Pay Increments (Unfunded 2025-26 Pay Award) (50%)	WBS	Rec	87
RD&I Pay Increments (Unfunded 2025-26 Pay Award) (50%)	RD&I	Rec	48
VCS Estate running costs	Corporate /VCS	Non Rec	300
Corporate Pay Increments (Unfunded 2025-26 Pay Award) (50%)	Corporate	Rec	53
Digital Infrastructure / Contract Support	Corporate /Trust	Rec	212
Unfunded Posts to support service delivery (VCS & WBS)	VCS / WBS	Rec	707
Sense maker system - Patient / Donor story Infrastructure	Trust	Rec	8
Redress Support - Band 5 legal support	Corporate / Trust	Rec	44
Total Local Cost Pressures			**3,352**
Total Cost Pressures			**4,922**

This table will be included in future reports with relevant commentary throughout 2026-27 to enable the impacts to be tracked, and any additional cost pressures to be explicitly discussed in this section of the report.

7. End of Year Forecast / Risk & Opportunity Assessment

Whilst the Trust submitted a three year balanced financial plan, there were significant financial risks and challenges to deliver this plan, particularly during 2025-26 due to the uncertainties around the income it will receive to cover the committed capacity investment in Velindre Cancer Services.

The Trust recognises these and took / is taking appropriate actions as set out below, to ensure risks were / are managed and mitigated against. All areas of delivery are risk assessed, and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

As highlighted earlier significant cost pressures and risks had materialised since the IMTP planning stage which had either been managed or mitigated during 2025/26 to ensure that the Trust

achieves the outturn forecast position of breakeven and maintains a balanced underlying position going forward.

All previously reported risks have either materialised or been managed for 2025-26. However, risks outlined below may have a financial impact on future years:

Commissioners not supporting Service Investment / Growth in VCS and WBS - *likelihood: medium, value £TBC 2026/27*

As described earlier in this report, several service growth investments had been presented to the Trust Commissioners, with early indication that only the SACT Treatment Capacity Expansion may have been considered for funding support. However, no commitment was made this year. The Trust re-submitted the service growth investments to our Commissioners on the 22nd October in line with the IMTP governance timeline process for 2026/27. However, confirmation was received from all Commissioners that no funding support would be provided.

2025/26 marginal income growth was held to support the VCS income underperformance on radiotherapy and the underlying divisional cost pressures.

The Trust received confirmation from JCC that they would not fund any of the WBS Business cases which were submitted to JCC as part of the 2025/26 IMTP process. The business cases were re-submitted on 8th October 2025, for consideration as part of the 2026-27 IMTP process. If these cases are again not supported, funding will need to be sought via Welsh Government following recommendations from the IBI report.

This risk was removed from the risk table reported to WG for 2025-26 but remains under consideration as outlined due to the potential impact for future years.

Radiotherapy Activity Income Shortfall – *likelihood: medium, value £0.250m 2026-27*

A risk emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as vacancies, non recurrent funding support, contract performance income for wider services, and non pay reductions.

The risk was removed from the risk table reported to WG for 2025-26 but remains under consideration as outlined due to the potential impact for future years.

Cost Pressure Arising from VCS Restructure – *likelihood: medium, £369k recurrently from 2026/27*

The restructure did not result in a financial pressure in 2025/26, with part year costs being managed within the divisional position. However, there will be an ongoing need once all posts are filled, to confirm the value and identify priority funding from 2026-27 uplift funding.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

<u>Opportunities</u>

Overachievement of Bank Interest – *removed for 2025/26*

Following a review of anticipated cash balances and potential interest rates, this opportunity was removed from the opportunities reported to WG.

8. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL 2025/26 £m	Full Year Spend £000s	Year End Variance 2025/26 £m
All Wales Capital Programme			
nVCC Enabling Works	3.683	3.973	(0.290)
nVCC Enabling Works QRA	0.550	0.161	0.389
nVCC Project	6.376	6.559	(0.183)
nVCC Project QRA - MIM	0.185	0.052	0.133
Integrated Radiotherapy Solution (IRS)	1.350	1.398	(0.048)
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	0.510	0.522	(0.012)
Whitchurch Hospital Site Disposal	0.860	0.843	0.017
WBS HQ Continuity Business Case OBC/FBC fees	1.000	0.867	0.133
WBS Fleet Replacement Programme	0.605	0.546	0.059
DPIF - RISP	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.184	0.001
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.057	0.029
WBS Plasma for Fractionation	0.030	0.030	0.000
Non-Radiology Ultrasound Replacement	0.048	0.058	(0.010)
Radiology Ultrasound Replacement	0.132	0.096	0.036
VPAG Funding - Equipment	0.037	0.036	0.001
Positron Emission Tomography (PET) Fees nVCC	0.042	0.047	(0.005)
Additional Digital Allocation	0.386	0.389	(0.003)
End of Year Funding	0.568	0.570	(0.002)
End of Year Equipment funding December 2025-26	0.024	0.025	(0.001)
End of Year Digital funding January 2025-26	1.065	1.092	(0.027)
National Programme Theatre Laptop	0.001	0.001	0.000
Total All Wales Capital Programme	18.353	18.136	0.217
Discretionary Capital	2.000	2.207	(0.207)
Grant Funding	0.250	0.250	0.000
	20.603	20.593	0.010

The approved Capital Expenditure Limit (CEL), excluding leases, for the year ended 31st March 2026 was **£20.353m**. This represented all Wales Capital funding of **£18.353m**, and Discretionary funding of **£2.000m.** A grant of £0.250m was also received from the Home Office to fund an irradiator in WBS, resulting in a **total Capital Budget of £20.603m** for the year.

The Trust reported total Capital spend to 28th March 2026 was £20.593m, therefore achieving an underspend of £0.010m.

In line with fixing the CEL on 31st October 2025, the Trust confirmed the latest position on the Capital programme which resulted in additional funding of £2.650m being requested, and £10.033m being given back to WG during 2025/26 with a request that the £10.033m is re-provided post 1 April 2026:

i. £8.771m for the nVCC project;
ii. £0.120m for the IRS SRU in addition to the £0.400m returned earlier in the year;
iii. £1.142m in respect of the reduced value required in year for the full OBC and FBC Enabling Works in relation to the WBS Talbot Green Infrastructure.

The Trust CEL has been updated to reflect the changes for 2025/26, and discussions are underway in respect of the opening 2026/27 CEL.

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital during 2025-26 to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required to complete the OBC stage of the WBS TGI scheme. WG colleagues were made aware that to produce a completed OBC / FBC stage there is a total funding requirement of £2.142m, with a total of £1.000m confirmed for use in 2025/26 of which £0.867m was spent. The Trust managed this underspend within the overall programme and therefore this did not prevent the Trust achieving its capital target.

In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed costs are not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained. The revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard.

The Trust has received a revised funding award letter from DHCW relating to RISP for 2025-26, following a change in accounting treatment due to IFRS 16 which impacted on the expenditure split between revenue and capital. £0.214m was added to the Trust CEL for 2025-26 which was be utilised to pay the supplier in March 2026 for work undertaken to prepare for the go live date in early 2026/27. A small contingency for remaining costs of c£0.005m has been ringfenced from the Trust discretionary capital allocation in 2026-27. The current forecast revenue expenditure assumes a contract extension with the incumbent supplier until November 2026 with funding ringfenced in the IMTP commencing 2026 for dual running of contracts.

The Trust also received an award letter for both revenue and capital funding for phase 1 of the plasma fractionation case.

The Welsh Histocompatability and Immunogenetic Service (WHAIS) project is included within the Trust CEL for 2025-26 at a value of £0.185m, with a further £0.034m required in 2026-27 and therefore ringfenced in the capital discretionary allocation to support validation work that year.

In relation to the Integrated Radiotherapy Solution (IRS), the Trust received funding during 2025-26 to support the enhanced functionality and capability of two of its treatment machines. However,

a request was made and agreed by WG Capital Colleagues to re-profile the funding for the enhancements on one machine into 2027-28 when the nVCC is open.

The Trust Chief Executive Office and Executive Director of Finance met with the Deputy Director of Capital Estates & Facilities in WG on 19th January 2026 to discuss the IRS, and on the 5th of February shared a summary case seeking approval for additional capital funding of £7m to enable Velindre to take advantage of new technology that Varian has developed since the IRS solution was tendered over 3.5 years ago. Following the Trust & WG Capital Review meeting on 17th March 2026, it was indicated by the Deputy Director of Capital Estates and Facilities in WG that the £7m additional capital investment request was positively received by the Cabinet Secretary. The Trust subsequently received a funding letter detailing this award and addition to the 2026/27 CEL dated 24th March 2026.

The discretionary allocation of £2.000m represents an increase of 4.65% on the £1.911m provided during 2024-25 which was fully spent. The overspend seen in 2025/26 was offset by underspends on All Wales schemes.

The Trust's Capital Planning Group considered and approved the allocation of discretionary capital funding for 2025/26 at its meeting in May and this was approved by the Executive Management Board (EMB) on 29th May 2025. An update in relation to the allocation of the 2025/26 discretionary programme was provided to the February 2026 EMB meeting. Plans for allocation of the 2026/27 discretionary funding allocation will be shared with EMB in a separate paper once confirmed.

2025/26 Performance

The actual expenditure to March 2026 on the All-Wales Capital Programme schemes was £18.136m: this is broken down as shown in the table above.

The spend on the Discretionary Capital programme was £2.207m plus a further £0.250m which was funded via a grant from the Home Office.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The schemes that were included in the IMTP for 2025-26 and beyond is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2025-26	2026-27	2027/28	Further Years	Total All Wales Schemes

	£m	£m	£m	£m	£m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	**25.526**	**56.774**	**6.999**	**0.000**	**89.299**
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	2.457	5.762	17.292	41.600	67.111
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913
WBS Fleet Replacement	0.364	0.738	1851	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC
Total Unapproved Capital Schemes	**6.575**	**8.187**	**21.385**	**42.100**	**78.247**
Total All Wales Capital Plans	**32.101**	**64.961**	**28.384**	**42.100**	**167.546**

The table below shows the plan within the submitted IMTP 2026-29 to Welsh Government. Discussions regarding the All Wales schemes and their inclusion on the 2026-27 CEL are continuing, and a plan for utilisation of the Discretionary allocation will be shared with EMB once confirmed.

All Wales Approved and Unapproved Capital Schemes	2026-27 £m	2027-28 £m	2028-29 £m	2029-30 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC	36.123	3.472	0.000	0.000	0.000	39.595
TCS nVCC (IRS Implementation Phase 3)	1.702	0.579	0.000	0.000	0.000	2.281
TCS nVCC Enabling Works	0.393	0.000	0.000	0.000	0.000	0.393
Integrated Radiotherapy Solution (IRS)	17.155	0.180	0.000	0.000	0.000	17.335
EPMA (DPIF)	0.025	0.000	0.000	0.000	0.000	0.025
Talbot Green Infrastructure (WBS)	1.142	0.000	0.000	0.000	0.000	1.142
Fleet Replacement (WBS)	0.882	1.465	0.000	0.000	0.000	2.347
Positron Emission Tomography	0.256	0.000	0.000	0.000	0.000	0.256
Total Approved Capital Schemes	**57.678**	**5.696**	**0.000**	**0.000**	**0.000**	**63.374**
All Wales Unapproved Schemes						
Whitchurch Hospital Site	0.280	0.000	0.000	0.000	0.000	0.280
nVCC – Project - Quantified Risk - MIM	3.243	0.000	0.000	0.000	0.000	3.243
nVCC – Project - Quantified Risk - Public Sector	4.716	3.085	0.000	0.000	0.000	7.801
nVCC – Enabling works - QRA	0.449	0.000	0.000	0.000	0.000	0.449
nVCC - QRA Public Sector Draw Down	0.059	0.000	0.000	0.000	0.000	0.059
WBS TGI Infrastructure	10.000	14.000	14.000	14.000	8.000	60.000
WBS Plasma for Fractionation	0.000	0.910	0.002	0.000	0.001	0.913
WBS BECS Blood Management System	1.840	1.187	0.000	0.000	0.000	3.027
RISP	TBC	TBC	TBC	0.000	TBC	0.000
Backlog Maintenance (WBS)	0.532	0.215	0.000	0.000	0.000	0.747
Asset Replacement (WBS)	0.250	0.000	0.530	0.000	0.000	0.780
WLIMS 2.0	TBC	TBC	TBC	0.000	TBC	0.000
WHAIS Phase 2	TBC	TBC	TBC	0.000	TBC	0.000
Digital CRM Multi Case Functions (WBMDR, AOS	TBC	TBC	TBC	0.000	TBC	0.000
Digital IT Infrastructure	0.500	0.500	0.500	0.500	0.000	2.000
Other Digital Service Developments	TBC	TBC	TBC	0.000	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	0.000	TBC	0.000
Enhanced Care Unit (VCS)	TBC	TBC	TBC	0.000	TBC	0.000
oVCC Decommissioning	1.000	0.000	0.000	0.000	0.000	1.000
IRS Machine Mix and Hypersight	7.200	0.000	0.000	0.000	0.000	7.200
nVCC Digital Enabling Works	0.737	1.442	0.000	0.000	0.000	2.179
Total Unapproved Capital Schemes	**30.806**	**21.339**	**15.032**	**14.500**	**8.001**	**89.678**
Total All Wales Capital Plans	**88.484**	**27.035**	**15.032**	**14.500**	**8.001**	**153.052**

9. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

The year end position is currently being drafted as part of the year end accounts process and will be shown in the month 1 2026/27 report.

10. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

The cash flow for the year is being finalised as part of the year end accounts process and will be included in the month 1 2026/27 report.

DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
VCC	(53.302)	(54.624)	(1.322)
RD&I	(0.694)	(0.926)	(0.232)
WBS	(24.810)	(24.467)	0.343
Sub-Total Divisions	**(78.807)**	**(80.017)**	**(1.210)**
Corporate Services Directorates	(17.183)	(16.140)	1.043
Delegated Budget Position	**(95.989)**	**(96.157)**	**(0.167)**
nVCC	(0.197)	(0.195)	0.002
Health Technology Wales	(0.272)	(0.272)	0.000
Trust Income / Reserves	96.458	96.657	0.199
Trust Position	**0.000**	**0.033**	**0.033**

The in month position for the core Trust is an underspend of £0.003m, leading to a full year **underspend of £0.033m.**

The Trust accumulated non-recurrent income during 2025/26 from several sources including significantly higher levels of bank interest, overachievement of VCS activity and accountancy gains. This extraordinary non recurrent income generated enabled £1.5m of expenditure to be suspended for service activities which has approved Charitable Funds support. The above table incorporates this suspension of charges to the Charity.

VCS

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
Income	**98.247**	**99.271**	**1.025**
Expenditure			
Staff	64.119	64.615	(0.496)
Non Staff	87.430	89.280	(1.850)
Sub Total	**151.549**	**153.895**	**(2.346)**
Total	**(53.302)**	**(54.624)**	**(1.322)**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of March 2026 was an **overspend of (£1.322m)**.

Income at month 12 represents a full year overachievement of **£1.025m** which is largely a result of overachievement of additional activity, home care drugs, palliative care and private patient income (offset by underachievement of radiotherapy income).

During 2024-25 LTA activity performance underachieved against the income growth target set by c£0.240m, which resulted in marginal income not matching the level of service investment that was made to support capacity within VCS. As LTA activity in year improved in 2025/26, it was no longer flagged as a financial risk, and the in year overachievement was held to support the underachievement on radiotherapy income and underlying cost pressures within VCS.

A risk emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as vacancies, non recurrent funding support, contract performance income for wider services, and non pay reductions.

VCS reported a full year overspend of **£(0.496)m** against staff. Snr Medical costs continued to be the largest pressure for VCS (resulting in an overspend of £0.721m to date), however, have significantly reduced following funding being provided during 2024-25 from the Trust Discretionary uplift in funding, agreed as a part the IMTP. NQN student streamlining has begun and contributed to the year overspend by £0.356m. The recent divisional restructure also contributed to this overspend at c£0.176m. The vacancies have been helping to support the posts appointed at risk, and the divisional savings target and vacancy factor.

Non-Staff Expenditure for the full year was **£(1.850)m** overspent which includes overspends of £0.990m for additional drug expenditure, postage costs of £0.270m, £0.121m in respect of M&SE disposables, and £0.250m for the pathology SLA. The Division will need to ensure it understands the causes of these cost increases and put steps in place to mitigate them.

WBS

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
Income	**37.505**	**38.430**	**0.925**
Expenditure			
Staff	20.826	20.506	0.320
Non Staff	41.489	42.390	(0.901)
Sub Total	**62.315**	**62.897**	**(0.582)**
Total	**(24.810)**	**(24.467)**	**0.343**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of March 2026 was **an underspend of £0.343m**.

WBS recognised an overachievement of **£0.925m** on income due predominantly to an increase in activity for the bone marrow registry (£0.472m), sale of plasma (£0.423m) and exportation (£0.078m).

Regarding the first item, this is promising given that last year there had been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, and is still yet to show significant signs of recovery despite the significant swab testing taking place at the beginning of last financial year. Whilst it was originally expected that the payback from the additional swabs would start to be realised before the end of last financial year it is showing positive improvement now, although, remains a significant risk. WBS continue to run campaigns to try and grow the panel in locations such as schools and universities and raise awareness through advertising on platforms such as social media, however it was recognised that the target was too high and was partly funded on both a recurrent and non-recurrent basis as part of the 2025-26 IMTP process thus reducing the target for this year.

Staff underspend of **£0.320m** to date is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source, offset by some vacancies within the service, and the release of a 2024/25 year end accrual in respect of time off in lieu, and overtime costs. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team have created an unfunded post analysis to determine and monitor the current year and recurrent cost pressure. Some posts were recognised and funded as part of the Trust IMTP for 2025-26. Vacancies across multiple cost centres are helping to support these pay pressures.

WBS reported a full year non-staff overspend of (**£0.901m)**. The largest cost pressure is the divisional savings target, partly offset by activity related performance.

Corporate

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m	Notional Income and Expenditure for Employer's Pension Contributions paid by WG £m	Full Year Variance Excluding Notional Pension Income & Expenditure £m
Income	**5.741**	**14.196**	**8.454**	**(7.451)**	**1.003**
Expenditure					
Staff	18.182	23.457	(5.275)	7.451	2.176
Non Staff	4.742	6.879	(2.137)	0.000	(2.137)
Sub Total	**22.924**	**30.336**	**(7.412)**	**7.451**	**0.039**
Total	**(17.183)**	**(16.140)**	**1.043**	**0.000**	**1.043**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of March 2026 was an **underspend of £1.043m**.

The notional income and expenditure recognised in March, described earlier in this report, is processed via the Corporate division and therefore the variances for both income and staff costs on the ledger include these values. The table above therefore shows the variances both including and excluding this adjustment for clarity.

The Trust continued to benefit from receiving high levels of bank interest as a result of interest rate rises over the last couple of years, however with interest rates decreasing the Trust can expect to see this benefit reduce over the coming months. There has also been a significant recovery of previously VAT paid to HMRC, as a result of an annual review exercise.

Several vacancies within the division has resulted in a year to date underspend and is offsetting the divisional savings target. However, this is unlikely to continue with additional staffing requirements currently being reviewed.

Non-pay overspend is again expected and largely relates to divisional CIP target and additional non pay spend currently processed via the Corporate Management budget. Funding has been provided as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2025-26. The expectation is that these costs will be removed with the move to the nVCC.

RD&I

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
Income	**4.565**	**5.192**	**0.627**
Expenditure			
Staff	4.403	4.611	(0.208)
Non Staff	0.857	1.507	(0.650)
Sub Total	**5.260**	**6.118**	**(0.858)**
Total	**(0.694)**	**(0.926)**	**(0.232)**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of March 2026 was an **overspend of £0.232m**.

Aligned with the previously forecast out-turn underspend position for RD&I, the month 12 position includes 3 distinct increases in expenditure: the recognition of a Cardiff University staff recharges in excess of plan (£0.100m), non delivery of establishment savings (£0.100m) and commissioned consultancy charges (£0.050m). These recognised pressures were managed within the Trust Out-turn performance.

nVCC – (Revenue)

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
Income	**0.048**	**0.044**	**(0.004)**
Expenditure			
Staff	0.222	0.209	0.013
Non Staff	0.023	0.030	(0.007)
Sub Total	**0.245**	**0.239**	**0.005**
Total	**(0.197)**	**(0.195)**	**0.002**

nVCC Key Highlights / Issues

The reported revenue financial position for the nVCC Programme at the end of March 2026 is a small underspend of £0.002m.

A fuller financial analysis including the capital expenditure and forecasts for the programme is attached as appendix 2.

HTW (Hosted Other)

	Full Year Budget £m	Full Year Actual £m	Full Year Variance £m
Income	**1.723**	**1.617**	**(0.105)**
Expenditure			
Staff	1.883	1.675	0.208
Non Staff	0.111	0.214	(0.103)
Sub Total	**1.994**	**1.889**	**0.105**
Total	**(0.272)**	**(0.272)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of March 2026 was **breakeven**.

HTW is funded directly via WG other than the pay award which is passed through the Trust commissioners in the same way as the core Trust.

Trust Board	
TRUST RISK REGISTER UPDATE	
DATE OF MEETING	21 May 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 committee to have effective oversight and assurance of the way in which risks are being managed across the Trust. • provides the committee with a summary of activity related to the status of the risks and associated movement.
RECOMMENDATION / ACTIONS	The Board 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.

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
Executive Management Board	27.04.2026
Quality, Safety and Performance Committee	07.05.2026
Audit Committee	12.05.2026

The Executive Management Board reviewed the Trust Risk Register, noting the addition of new risks, confirmation that one risk had reduced, and that others remained static pending further review. EMB emphasised the importance of ensuring risks are appropriately categorised (particularly safety versus performance), sufficiently evidenced, and fully reviewed ahead of committee consideration.

The Quality, Safety and Performance Committee emphasised the importance of clearly articulating risks—particularly workforce and financial risks—within papers, ensuring that delays, assumptions, and system-wide impacts are transparently reflected. The Committee also required clarification regarding the status of the risk management replacement solution as a Once for Wales procurement.

Audit Committee queried the target dates for some risks and noted their nearing deadlines. Audit Committee also asked that a plan for procuring and implementing the new risk management system be presented to the Committee's September meeting.

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 30 March 2026 Executive Management 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 three new risks on to the Trust Risk Register, which can be viewed in Appendix 1:

- 3216
- 3677
- 3893

2.3 There are three risks with a reduced current risk rating reduced below the reporting threshold since the last reporting cycle. The risk can be viewed in Appendix 1, section 2:

- 3856 – Work was completed on this risk in January 2026 and verified on completion resulting in there no longer being a risk, therefore the risk is closed.
- 3795 – Target risk score achieved.
- 3889 – Current risk rating has reduced below the threshold for reporting to Trust Board.

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

- A total of 19 risks reporting onto the public Trust Risk Register.
- Six risks with a score of 12 or above reported in the safety/quality domain.
  - Two on the VCS register
  - Four on the WBS register
- Thirteen risks with a score over 15 or above reported in other domains.
  - Four on the VCS register
  - Three on WBS register
  - Six on the Corporate risk register.

3.0 Risk Themes

The main risk themes coming through on the Trust Risk Register are:

1. **Capacity, demand, and flow constraints impacting safety**
    - Insufficient SACT day case capacity causing treatment delays.
    - Booking/scheduling pressure causing delays and potential breaches.
    - Treatment helpline demand/complexity exceeding the current workforce model and access to timely clinical decision-making.
2. **Workforce sustainability, capability, and leadership capacity**
    - Recruitment/funding gaps (e.g., specialist radiographer/sonographer posts) risking retention and service development.
    - Staff stress/burnout and changing priorities due to digital demand exceeding team capacity.
    - Corporate leadership instability due to multiple interim executive roles and vacancies.
3. **Digital/IT delivery, dependency and transition risk**
    - Reliance on national programmes/providers (notably DHCW) creating schedule, integration, time/cost/quality risks (e.g., RISP/WLIMS/EPMA, WHAIS, FEDIS).
    - System transitions causing operational patient safety risk (e.g., limited access to prior images during RISP transition).
    - Ageing/legacy systems (e.g., SERIF/LIMS) creating safety and service risk and driving workarounds.
4. **Clinical quality and operational process control**
    - Risks from pre-/post-examination processes, transcription/manual handling, and incomplete/incorrect system imports (e.g., antibody results import issues).
    - Risks from reporting/authorisation workflow weaknesses (examples shown in the “decreased/closed” section too).
5. **Infrastructure and business continuity**
    - Loss of electrical supply risk leading to loss of service and production (WBS Llantrisant).
    - System failures (e.g., Blood Establishment Computer System) risking ability to supply blood.

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 with risk peers across NHS Wales during the reporting period. While there is currently no appetite for a once-for-Wales

solution, there is support for a collaborative approach to developing requirements and sharing market intelligence. This reflects the fact that some Health Boards are already operating different systems. Health Boards and Trusts have therefore agreed to continue working together to identify shared requirements, exchange learning and coordinate supplier engagement where this adds value.

The Trust's Task and Finish group agreed to:

- Continue to work on a full set of specification requirements, informed by the peer group work being undertaken across NHS Wales and by shared learning from other Health Boards and Trusts where similar needs have been identified.
- Complete the planned supplier demonstration days on 8th May 2026 (now completed) and 19th June 2026, before using the learning from these sessions to finalise requirements and support progression to procurement in the early autumn.

Risk Management Framework Review

EMB considered the review of the Trust's Risk Management Framework in March and April 2026. Supporting procedural documents have been reviewed by the Risk and Assurance Manager will be finalised over the coming weeks with the support of divisional workshops. The documentation is currently being reviewed by the external consultant supporting Board and Governance Development.

5. SUMMARY OF MATTERS FOR CONSIDERATION

The 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 belowNo - 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.

6. RISKS

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

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).

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

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	Chief Operating Officer	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)	→	1. 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	15.04.26 Continued use of trials chair capacity. Scoping taking place over additional chair capacity in NHH as an short term action whilst working up business case. SACT improvement Group work continues with highlight reports now going to SACT Steering Group for oversight

TRUST RISK REGISTER – April 2026

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).

								Target date: 30.06.2026		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. 2. 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.	
2	3714 24.06.25	VCS	Safety	Chief Operating Officer	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)	**16** (4x4)	**6** (2x3) Target date: 01.06.26		Using staff from Treatment Line, DQ staff and med records to support team Over time offered to all staff. Staff allowed to carry out working from home. Equipment to be provided. Recruitment to vacant posts - 1xB5, 2xB4	08.04.2026 Risk reviewed by Directorate SLT (31 March). Additional actions added re. escalation and clinical capacity to support prioritisation.
15+ Risks in other domains											
3	3832 02.12.25	VCS	Safety	Chief Operating Officer	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 31.10.26		SBAR, QIA, Risk Assessment to be presented at QSREB complete Escalation to procurement for tender of products, following Board approval Financial business case development Education and training for CSTDs for rapid role out	13.04.2026 Risk reviewed by Directorate SLT 31 March. Action due dates updated. Trials of products to start week commencing April 20

TRUST RISK REGISTER – April 2026

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).

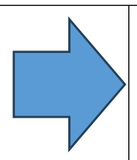
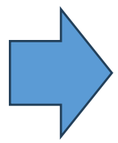
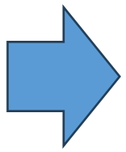
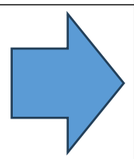
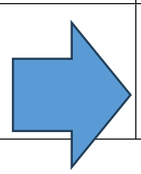
4	3893 *new to TRR Accepted 19.03.2026	VCS	Quality	Head of Radiation Services	There is a risk to workforce sustainability and service development as a result of the absence of funding to appoint a Reporting Radiographer and Sonographer, leading to potential loss of staff with critical skills and failure to develop a radiographer led reporting service.	**16** (4x4)	**16** (4x4)	**3** (3x1) Target date 21.07.26	New risk	1. Facilitate recruitment of additional radiography staff	15.04.2026 The primary risk is a workforce and retention risk, linked to the potential loss of staff who have completed specialist reporting training supported by significant organisational investment. There are recognised quality implications, as the service is currently unable to implement a skill mix model aligned with national workforce guidance. This impacts service resilience and limits future service development. The risk is time critical, as training was approved prior to commencement in 2024 and both staff are now fully trained and ready for appointment. Without substantive funding, there is a high likelihood these staff may be lost, resulting in reduced capability and loss of return on investment.
5	3216 *new risk due to increase in rating	VCS	Safety	Executive Director of Nursing, Allied Health Professionals and Health Science	There is a risk to timely, safe, and reliable management of unwell patients contacting the treatment helpline as a result of increased volume of calls, increased complexity of patients, inappropriate use of the helpline, and current workforce model including difficulty in accessing timely appropriate clinical decision making	**15** **(5x3)**	**15** **(5x3)**	**5** (5x1) Target date: 01.08.26	↑		10.04.2026 Risk has increased from 10 - 15 as a result of increased incidents. Nurse Consultant allocated to clinical lead by 30th April 2026. Current risks will be reviewed and mitigations will be assessed.
6	3677 *new to TRR due to increase in rating	VCS	Quality	Head of Radiation Services	There is a risk to the Velindre Cancer Services Radiology Service as a result of lack of access to a proportion of prior images from other organisations during the RISP transition phase leading to potential clinical patient safety risks.	**20** (5x4)	**20** (5x4)	**3** (3x1)	↑	• CAV and AB to submit a request to Fuji to enable a DICOM retrieve function from Velindre.	15.04.26. This risk will reduce once access to imaging is established. Actions in progress are: DHCW are supporting these discussions, and the issue was escalated to the Chief Digital Officer yesterday to secure support from Digital colleagues in CAV and AB. A meeting was held

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).

								Target date:01.6.26		• Relevant firewalls to be opened and connectivity established. • Technical connections and workflows to be tested and confirmed.	today to agree next steps, however the risk score cannot be reduced until connections are fully implemented and operational. This is both a project and an operational risk. It is recorded on the project risk register, and the service was advised to also include it on the local operational risk register due to its impact on live service delivery. 06/04/2026 Risk score increased to 20 by the service as CTM and SBUHB are now live and reporting and MDTs are being affected. DHCW have been working with Fuji (incumbent supplier) to support connectivity requirements within NHS Wales. Multiple CCNs have been requested and submitted, however progress is slow and Velindre have no control or oversight of other organisation connectivity arrangements. Due to the technical aspect, multiple options, continual change and complexity, Radiology management are struggling to understand the position to advise local teams. The RISP project team are supporting discussions to understand the CCN and connectivity position to help inform the service and ways of working.
	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
7	3418 03.07.25	WBS	Quality/ Safety	Chief Operating Officer	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 28.6.26	⇨	1. Introduction of LIMS to mitigate the risk of manual transcription errors	30/04/2026 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. The LIMS system was implemented in March 2026 and currently in post go-live monitoring, the risk will be reviewed on finalisation of post go-live reports.
8	3716 24.06.25	WBS	Quality	Chief Operating Officer	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	⇨	• Ensure that Immulink information sent manually only contain current sample results. Update to LAB-066 Printing and reporting of results from NEO Iris. SOP is in draft awaiting review • Update the middle ware so that it no longer supports the reuse of sample numbers, this will be done via change management process. •	30.04.2026 No change to risk- managing manually and no further incidents. Mitigation will be implementation of LIMS estimated September 2026

TRUST RISK REGISTER – April 2026

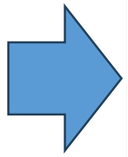
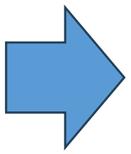
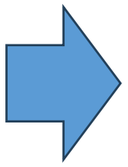
To note, risk scores are calculated by multiplying the impact (first number in brackets) of the risk by the likelihood of the risk (second number in brackets).

9	3887 19.02.26	WBS	Quality	Chief Operating Officer	There is a risk to quality as a result of HNA antibody results either not imported or partially imported into HistoTrac leading to delays in testing or incorrect treatment paths for patients.	**12** (3x4)	**12** (3x4)	**3** (3x1) Target date: 01.10.2026		Phase 2 activity - install and perform validation	20.04.2026 WHAISIT Phase 2 Verto has been submitted (PR000585) and is awaiting resource allocation at CPG (planned 21/04/2026). Planned timeline is May 2026-Feb 2027. The fix for the Fusion Multi HNA antibody utility is the top priority. Current trend stable until CPG April 2026.
10	3388 07/05/24	WBS	Quality	Chief Operating Officer	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: 30.6.2026		1. Develop and validate interface between FEDIS and eMPI+WRRS when available	30.04.2026 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). Awaiting DHCW to resolve final outstanding issue with reporting to WCP (potentially a network/server issue). Until this issue is resolved, the project cannot progress to UAT and Validation (end to end testing by the laboratory SME) and implementation
	15+ Risks in other domains										
11	3801 14.10.25	WBS	Performance and Service Sustainability	Chief Operating Officer	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) Target Date: 25.06.26			30.04.2026 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). The issue with code 560 has now been resolved. However, a new issue with reporting to WCP was identified during System Integration Testing (potentially a network/server issue), which needs to be resolved with DHCW. Until this issue is resolved, the project cannot progress to UAT and Validation (end to end testing by the laboratory SME) and implementation. Timelines for resolving this outstanding issue have not been provided by DHCW, therefore the risk cannot be reduced.
12	3643 11/04/2025	WBS	Quality/Safety	Chief Operating Officer	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) Expected date: 01.07.2026		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.	20.04.2026 FMEA reviewed, fully updated and re-circulated via e-sign 14/04/2026. Reminder for remaining signatories sent 20/04/2026. Additional risks added- no increase to overall risk rating
13	3306 15/01/25	WBS	Performance and Sustainability	Chief Operating Officer	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	**20** (5x4)	**15** (5x3)	**5** (5x1)		Review of risk assessment required	20.04.2026 No change to risk, continue to manage PPM programme across the site

					and production at Welsh Blood services Llantrisant.			Target date: 28.09.26		
Corporate										
15+ Risks in other domains										
14	3865 19.01.26	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		1. Confirm timescales for recruiting into permanent roles 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)	21.04.2026 Progress is being made on managing this risk. A recruitment partner has now been appointed and a plan in place for outstanding executive recruitment commencing with the CEO post in May.
15	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: 01.06.26		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.	20.04.2026 Exec team are supporting additional prioritisation and resourcing for the Digital plan with the intent to agree a final version by the end of April. The plan currently contains several unfunded items requested by the services. Additional digital / clinical leadership capital funding for the next two years has been secured from Welsh Government
16	3646 15.04.2025	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.	21.04.2026 The WLIMS 2.0 programme remains high-risk for delivery. The latest proposed national dates for the Blood Transfusion services is Sept '26. Local work on testing is progressing well and WBS resources are directly supporting the National programme.

TRUST RISK REGISTER – April 2026

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).

17	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: 31.05.26		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	21.04.2026 WG implementation group considering all issues. Actions: 1.Annual accounts and accountability report, including relevant compliance reporting, to be approved by Trust Board. June 2026. 2.Assurance mapping to be reviewed and completed by end of June 2026. 3.Clinical governance review underway. Aim to be completed by no later than end of June 2026.
18	3633 15.04.25	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: 28.05.26		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.	21.04.2026 FEDIS and WHAIS interfaces are still being progressed by DCHW. Plans are being closely monitored. WHAIS has gone live successfully and the integration will form part of Phase 2 requirements.
19	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: 31.05.26		Risk reviewed. Due to the change note for RISP, resetting the date of EPMA project starting.	21.4.2026 RISP went live on April 20.04.2026 as planned with improvements to the availability of prior images from Health Boards EPMA remains on track for October 2026 go-live. WLIMS remains high-risk with the latest proposed go-live plan for Sept 2026 for the blood transfusion services. Programme has high WG scrutiny.

TRUST RISK REGISTER – April 2026

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 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
3856	WBS	Quality	Director of Welsh Blood Service	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)	→	Business planning. Change board. SMT oversight. Work was completed during January 2026 and verified on completion. Therefore, this risk has passed and can be closed.
3795 16.10.25 *Target rating reached	WBS	Quality	Director of Welsh Blood Service	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)	**8** (4x2)	**8** (4x2)	↓	01.04.2026 Updated risk in line with target risk- as actions have been implemented to mitigate the initial risk scoring. Updated the risk review to 01/10/2026 in line with expected implementation of new LIMS system which will further mitigate risk- at this point a new FMEA will be developed and signed. Target Risk achieved. SOPs updated, implemented and reporting staff trained/competency assessed.
3889 22.02.26 *Reduced below threshold	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	There is a risk to Performance and Service Sustainability as a result of lack of system functionality in HistoTrac to support service monitoring e.g. visual dashboard, leading to being unable to capture and monitor KPIs.	**15** (3x5)	**9** (3x3)	**6** (3x2)	↓	10.04.2026 HistoTrac 'ad-hoc' queries have been written to query any data required for monthly finance figures. Other simple KPIs can be manually calculated using HistoTrac filtering/searching. Agreement that March 2026 KPI figures will be calculated alongside Q1 2026 in June, once new KPI dashboard is built. Risk decreasing with these measures put in place.

TRUST BOARD	
BOARD ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	21 May 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 • Gill Knight, 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 Trust Board with the latest updates to the Board Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board 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
Executive Management Board	27.04.2026
Strategic Development Committee	05.05.2026
Quality, Safety and Performance Committee	07.05.2026
Audit Committee	12.05.2026

EMB noted the current overall assurance position and agreed this was appropriate at present, subject to improved clarity on committee ownership and reporting.

The BAF will continue to be presented to committees in its current form in the short term, while longer-term improvements to structure and governance are developed.

The Strategic Development Committee considered the new template and asked that target date and carry-over trend mapping be included earlier in the document for ease of reference. This change has been implemented as part of the BAF documentation presented to Trust Board.

The Quality, Safety and Performance Committee noted the need for further clarity around BAF06 People and OD, highlighted as requiring better articulation around scale and volume of staff affected, impact of delays on staff wellbeing and expected mitigation or support plans. This aligns with BAF expectations around risk clarity, robustness of controls, and reliance on accurate data for assurance.

The Audit Committee asked that the risk trend analysis information be incorporated into the new BAF documentation, ensuring that long-standing risks remain visible over time despite rewording or restructuring. The Committee endorsed ongoing work to align BAF risks with specific Committees as part of the wider governance review to enable more detailed scrutiny within relevant Committees.

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 Dashboards

1. SITUATION

1.1 The Trust Assurance Framework (TAF) was established in 2020. 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, the Trust Board agreed a refreshed set of strategic risks in March 2025, aligned to the Trust's strategic objectives. This assessment has been updated to reflect the refreshed Board Assurance Framework (BAF) strategic risks from April 2026, as set out in the table below, and confirms that the updated reporting template and the refreshed strategic risk summary are included as part of this update.

BAF strategic risks FY 2025-26		**Refreshed BAF strategic risks – April 2026**	
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.	01	There is a strategic risk that increasing complexity and demand across our specialist services - cancer and blood - will impair the Trust's ability to deliver timely, safe and sustainable national services, impacting patient outcomes, donor services, clinical quality, and organisational reputation.
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.	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 if the Trust cannot deliver its ambitious change programmes.
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.	03	There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.
04	There is a strategic risk of failing to retain the Trust's University status.	04	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.
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.	05	There is a strategic risk that the Trust fails to effectively embed its role as a sustainable organisation - outside of main infrastructure and specific centrally led activity - resulting in a failure to improve the health of the population we serve and non-compliance with the Well-being of Future Generations Act's requirements
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	06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values
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	07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical services, reduced quality and efficiency of care constrained decision-making, systems 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.
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.	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.
09	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	09	
10	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		Removed as a standalone risk (elements reflected within New 2 and New 9)

	deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence		
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 an optimised workforce supply and shape.		Removed from refreshed set (workforce impacts referenced within New 6)

2.3 BAF 09 is a strategic risk regarding the nVCC project, proposed for consideration in private, as it contains commercially sensitive information.

3 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

4 RISKS

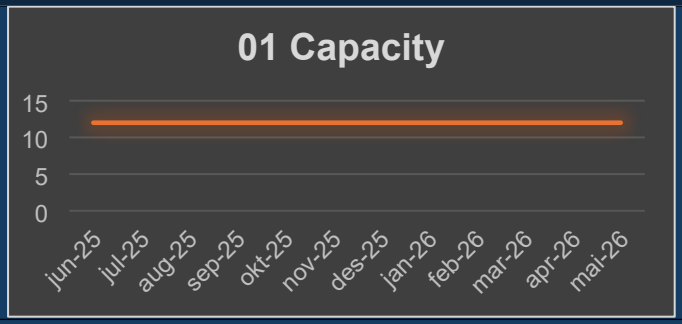
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must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

Risk 01	There is a strategic risk that increasing complexity and demand across our specialist services - cancer and blood - will impair the Trust's ability to deliver timely, safe and sustainable national services, impacting patient outcomes, donor services, clinical quality, and organisational reputation.	Date Risk Raised	Current Risk Score
		1 April 2026	12
		Last Review Date	
		29 April 2026	

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 Radiotherapy Services is planned and supported via the IRS rollout. The SACT service continues to receive sustained focus. However, progress is being limited by the level of performance and activity data available to the teams to information the capacity planning to deliver the consistency required but for the 'as is' and future service, at the Hub and spokes. The operationalisation 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.

Associated Strategic Objectives	Outstanding for quality, safety and experience. • Provide harm free care, the best outcomes and a great patient and donor experience. • Listen to and learn from the experiences patients and donors have of our care to drive continuous improvement. • Be an organisation which consistently demonstrates Compassionate Leadership in everything we do.	**Exec Lead**	Chief Operating Officer
		Assurance Level	2
		Risk Appetite	Cautious

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	2	4	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	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	**12**
	3216	There is a risk to timely, safe, and reliable management of unwell patients contacting the treatment helpline as a result of increased volume of calls, increased complexity of patients, inappropriate use of the helpline, and current workforce model including difficulty in accessing timely appropriate clinical decision making	**15**

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	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.	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. WBS has commissioned a piece of work mapping workforce requirements	WBS Director	December 2026

			to support Health Boad blood banks with Health Education and Improvement Wales support. In addition, WBS is tendering for a consultancy to support production of an Outline Business Case to map digital requirements for NHS Wales to support delivery of the Infected Blood Inquiry recommendation to map patient outcomes.		
	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.	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. March 2026 Cases resubmitted to commissioners. JCC Commissioners have agreed to meet with WBS in May 2026 to understand case requirements for both transfusion and transplantation services. **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.	WBS Director	March 2027
	01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing	Revised Modelling being undertaken by the Data & Insights Team using the GE	VCS Director	August 2026

		capacity within the outpatient facility and providing care closer to home for the patient	model used for the FBC. It is recognised that this model is not granular enough for the level of detail required and a specification has been drafted next stage model. likely to be August 2026. In the meantime, the teams are using the data provided for initial planning discussions. Velindre@ Operational Boards are being established to support a collaborative approach to the work required.		
	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	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. The GE model has been re-run and more detail is required, a more comprehensive / granular model will be commissioned.	VCS Director	February 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance

Joint blood stock planning with Health Boards (SLAs, Blood Health Plan, regular reviews) Routine stock resilience planning and UK mutual aid coordination Business continuity arrangements for core services (BIAs, contingencies, BCPs, shortage plans) Governance to balance BAU delivery with strategic programmes (WBS Futures/CPG)	No real-time “vein-to-vein” data / business intelligence to link Health Board activity changes, blood issuing patterns, demand, and patient outcomes **(**dependent on external digital systems outside WBS control; being progressed via Infected Blood Inquiry-related programmes). Variation in demand management / blood utilisation across Health Boards and within clinical teams (inconsistent practice drives inappropriate use and affects demand).	SLA reviews with Health Boards; BHNOG KPI monitoring; operational escalation routes and local operational planning groups (e.g., SE Wales demand modelling; service area operational planning). Reporting through WBS SLT / VCS Divisional Team to EMB; oversight via COO/EMB, QSP Committee and Board; Trust-wide Clinical & Scientific Board. Welsh Government Quality, Planning & Delivery Reviews; regulatory inspections (e.g., MHRA, HTA); escalation via EPRR/Local Resilience Forum where needed; UK Blood Services MoU/mutual aid; Internal Audit, Wales Audit Office and regulator audits.	Limited assurance on demand-related decision-making: WBS cannot validate alignment between issuing patterns, Health Board activity changes and patient outcomes due to lack of real-time “vein-to-vein” data Limited independent assurance on standardisation of utilisation: insufficient independent assurance that variation in blood utilisation across Health Boards/clinical teams is being effectively addressed and sustained

Risk 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 if the Trust cannot deliver its ambitious change programmes.	Date of Risk: 1 April 2026 Last Review Date: April 2026	Current Risk Score: 16

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.

Associated Strategic Objectives	Outstanding for quality, safety and experience • Provide harm free care, the best outcomes and a great patient and donor experience • Listen to and learn from the experiences patients and donors have of our care to drive continuous improvement • Be an organisation which consistently demonstrates Compassionate Leadership in everything we do • Be recognised as 'Outstanding' by Health Inspectorate Wales, the Medicines and Healthcare Products Regulatory Authority and UK and international peers for the services we provide	**Exec Lead**	Director of Nursing, AHPs & Healthcare Science, Executive Medical Director & Chief Operating Officer
		Assurance Level	3
		Risk Appetite	Cautious

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	5	20	4	4	16	4	4	16	4	4	16	4	4	16	3	3	9

Associated Risks	Risk ID	Risk Title	Current Risk Score
	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
	3306	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.	12
	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	16
	3832	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
	3216	There is a risk to timely, safe, and reliable management of unwell patients contacting the treatment helpline as a result of increased volume of calls, increased complexity of patients, inappropriate use of the helpline, and current workforce model including difficulty in accessing timely appropriate clinical decision making	15
	3677	There is a risk to the Velindre Cancer Services Radiology Service as a result of lack of access to a proportion of prior images from other organisations during the RISP transition phase leading to potential clinical patient safety risks.	20
	3418	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
	3716	There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.	12
	3887	There is a risk to quality as a result of HNA antibody results either not imported or partially imported into HistoTrac leading to delays in testing or incorrect treatment paths for patients.	12
	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.	16
	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	16

	Action ID	Action Detail	Progress Notes	Action Lead	Target Date

Action to Address Gaps	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.	Some enhancements made to PMF further work required in respect of mortality metrics, PROMs and increasing patient experience feedback at VCS	Executive Director of Strategic Transformation Planning and Digital	**March 2026**
	02.02	Deliver a programme of quality and safety investigation training for all potential investigation leads.	Investigation training commenced in November 2025- training dates in place through to end March 2026.	Director of Nursing, AHP and Health Science	March 2026
	02.03	Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.	Trust digital PROMS system is in place for 4 pathways. Plan in place to roll out across VCS over the next 2 years. Work is ongoing to import the data to facilitate meaningful analysis and ease of access for clinicians for direct patient care.	Executive Director Finance	March 2026
	02.04	Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.	Implementation well under way – on track to have in place by Oct 2026	Chief Digital Officer	March 2026
	02.05	Fully implement all Trust required IBI recommendations.	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	Chief Operating Officer	October 2026
	02.06	Implement the revised Putting things Right regulations: Listening to People.	Implementation plan being enacted. Only draft statutory guidance document provided by WG as of 16.3.26- final document WG correspondence regarding the phased implementation plan awaited.	Director of Nursing, AHP and Health Science	March 2026
	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	Average of 16% feedback for WBS. An increase to 12% VCS patients provided feedback in Quarter 3. New national People Experience framework being implemented on target for completion by April 2026 as noted.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	March 2026
	02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Some strengthening undertaken within last 6 months. Draft clinical services priority document provided to QSP (March 26). Further work required as part of governance review	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	March 2026

	02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	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.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	March 2026
	02.10	To refresh and relaunch Trust patient safety framework.	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience and revised LTP regulations	Director of Nursing, AHP and Health Science	March 2026
	02.11	Implement the BCUHB Quality Dashboard and balanced score card	Site visit held – project / implementation plan required - timescales for delivery unclear	Chief Digital Officer	March 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Capacity & demand management: routinely assessed as part of IMTP. Quality & safety oversight: routine monitoring through performance/quality frameworks (e.g., PMF and AMaT tracker). Patient/donor experience feedback: mechanisms to capture experience and feed learning into improvement. Clinical outcomes review: structured mortality review and the Medical Examiner Service to identify issues and learning. Workforce capability & learning: Velindre Oncology Academy to support training and development.	Capacity & demand control: GE model being re-run and additional Business Intelligence Tools being scoped. Quality & safety oversight: routine monitoring through corporate/divisional performance and regulatory tracking (PMF and AMaT). Experience feedback control: processes to capture patient/donor experience and use it for learning and improvement. Outcomes surveillance: mortality review and Medical Examiner Service arrangements to identify issues and drive learning. Workforce capability: Velindre Oncology Academy to strengthen skills, training and development.	Executive Management Board (EMB) and the Quality, Safety & Performance Committee (QSPC), plus benchmarking/peer review and external-facing oversight forums such as the Regional Cancer Board and JET & IQPD. Internal Audit, plus external scrutiny from HIW, HEIW, and Wales Audit Office audit activity. Regional Cancer Meeting and WRP audits (noted alongside patient experience controls).	PROMs assurance gap: *No current PROMs reporting into the Performance Management Framework (PMF).* *Balanced Scorecards for each service not in place.* Board-level quality assurance gap: *Quality dashboard not in place* (limiting routine assurance to Board/committees). Mortality assurance gap: *Mortality metrics not all in place* (so assurance on mortality/outcomes is incomplete). Patient/donor voice assurance gap: *Patient/donor voice is not being systematically/formally fed into meeting structures at all Trust levels* (weakening assurance that learning from experience is embedded).

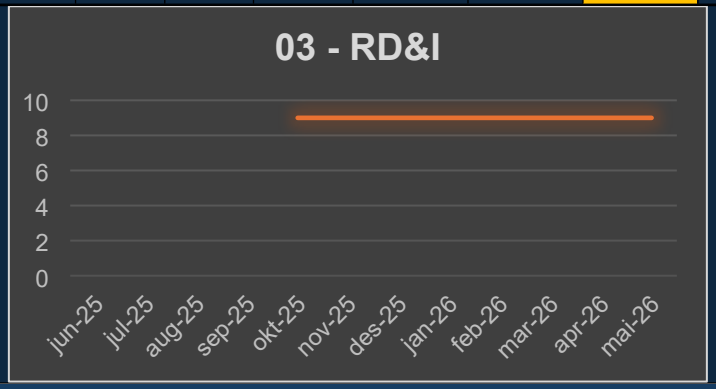
Clinical audit**:** audit systems and processes to check compliance and drive improvement.	Clinical audit & compliance: audit systems to test adherence to standards and support continuous improvement.		

Risk 03	There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.	Date of Risk 1 April 2026 Last Review Date April 2026	Current Risk Score 9

Executive Summary	An inability to deliver research and innovation limits the continuous improvement of high-quality care and outcomes. There is a strategic risk that the Trust is unable to deliver the Velindre Cancer Service and Welsh Blood Service Research Strategies and not fully embedding innovation activities in line with the national Innovation Framework. This would reduce clinical effectiveness and outcomes of care; reduce national and international reputation; and dilute the ability to attract research funding partnership and highly skilled staff, ultimately undermining the delivery of the Trust's strategic objectives.

Associated Strategic Objectives	Research, Development and Innovation • Deliver world class research, development and innovation to improve tomorrow's care • Accelerate the implementation of research and new discoveries to improve patients' and donors' experiences and outcomes • Prioritise research, development and innovation that is clinically relevant and patient- and donor-centred • Build a sustainable culture of multiprofessional RD&I involving the whole organisation • Publish and promote research of the highest quality which achieves UK and international recognition	Exec Lead	Medical Director
		Assurance Level	5
		Risk Appetite	Open

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	3	12	-	-	-	-	-	-	-	-	-	3	3	9	3	2	6



Associated Risks	Risk ID	Risk Title	Current Risk Score
	Nil return		

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	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 OECI Designation criteria and partnership theme.	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	Associate Medical Director for RD&I / Head of R&D / Research Delivery Manager	April 2026

			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 OECI 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.		
	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.	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	To be actioned	April 2026

			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.		
	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.	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP		

			Project Board where relevant). External oversight and review including Health and Care Research Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits and Welsh Government oversight.		

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Research strategies defining Trust ambitions for research & innovation in line with national priorities (Trust Cancer Research Ambition, WBS Strategy, WG Innovation Framework) Delivery plans for research governance/delivery are monitored to assure progress on delivery Benchmarking research activity (via OECI accreditation membership and UK peer cancer centre comparisons) Engagement with UK / National bodies Cardiff Cancer Research Partnership (CCRP) Welsh Blood Service research governance	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP Project Board where relevant). External oversight and review including Health and Care Research Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits and Welsh Government oversight.	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP Project Board where relevant). External oversight and review including Health and Care Research	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP Project Board where relevant). External oversight and review including Health and Care Research Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits and Welsh Government oversight.

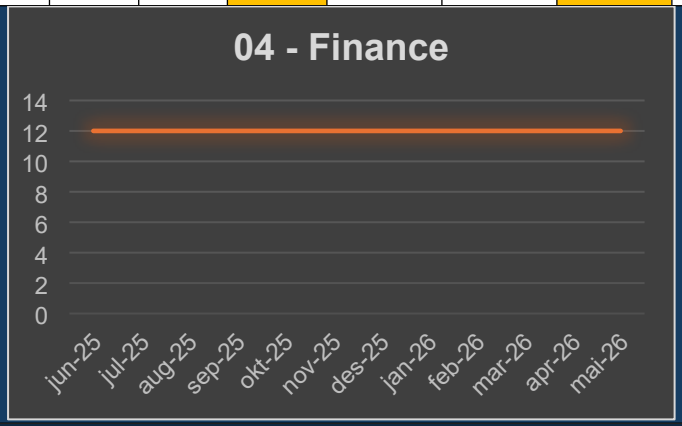
		Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits and Welsh Government oversight.	

Risk 04	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.	Date of Risk	Current Risk Score
		1 April 2026	12
		Last Review Date	
		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. Risk score trend: The risk score has remained static since the last period, and has been considered in line with the development of the IMTP.

Associated Strategic Objectives	• Outstanding for quality, safety and experience • A leading provider of clinical services that always meet, and routinely exceed, expectations • A sustainable organisation which contributes to a better world for future generations across the globe	Exec Lead	Director of Finance
		Assurance Level	4
		Risk Appetite	Cautious

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	Nil return		

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	09.01	Development of VBHC programme of work to identify areas of unwarranted variation and actions to improve	Assurance provided through review at SDC and QS&P Committees. Digital PROMS platform operational for Prostate, Lung Neuro-oncology and CUP (Colorectal is on pause pending work to restart). Work underway to deploy within wider Urology, VAP and Palliative care as part of phase 2• PROMS Questionnaires - national sets agreed for Breast and work ongoing for Colorectal • SST Data Insights Dashboard in use on an ongoing basis Self administration pathway for denosumab subcutaneous injections team working on a scaleable solution. • 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 Genetic Haemochromatosis donor pathway project will be supported for a further year to achieve a sustainable solution. The audit on Frailty collection phase is now complete. Findings to be shared soon. This will identify the scale of opportunity to improve outcomes and resource use for frail patients in the long term	Director of Finance Chief Operating Officer Deputy Director of Finance	2027
	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	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	EDoF / EDoSTP&D / DDoF / DDoP	Ongoing

			current financial position and discuss disinvestment options and financial recovery. 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	All FCPs have been reviewed and updated. FCPs have now been included on the Finance Intranet page for access by the service. Following completion of the 2025/26 accounts, further analysis will be undertaken to review any processes that may benefit from establishing FCPs.	EDoF / EDoSTP&D / DDoF / DDoP	2026/27
	09.04	Development of Investment Appraisal process and prioritisation framework	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. The investment appraisal will be developed in conjunction with shaping the soon to be created Finance & Planning Committee which have overall control and oversight over Trust investment decisions	EDoF / EDoSTP&D / DDoF / DDoP	October 2026
	09.05	Identification of business development and external funding opportunities	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	EDof / EDirector of Planning / COO / VCS Director	2026/27

			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 EDoF / EDoSTP&D / COO 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. A revised charging tariff had been agreed with an implementation date of 1st July 2025 with further rates from 1st November 2025. Contract negotiations are actively underway with those insurers that have specific queries and		

			those involving payment of old debts. 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 reported a LTA activity over performance for 2025-26 which was used to mitigate the risk on the RSU activity underperformance.		
	09.06	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.	Review of contract currency is currently underway in VCS to understand the true cost of service. However, given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2026-27 (see next item).	EDof / EDirector of Planning / COO / VCS Director	2026/27
	09.07	LTA contract with Commissioners and re-basing exercise	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.		2026/27

			This resulted in a £0.825m loss in income recurrently from Hywel Dda UHB on NICE & HCD. 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 (c£0.290m) and are provided to the Trust via the LTAs as per the Trust funding model. Agreement was reached with HD by the 28th February, which was the deadline for agreeing to funding principles, with HD agreeing to fully fund the direct allocations subject to the Trust providing evidence. This evidence will be provided w/c 13th April following year end. A Deputy Director of finance task and finish group for Commissioning has been established with the first meeting having taken 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 midway through 2026-27.		
	09.08	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	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, with a particular focus on reviewing non-pay expenditure during qtr 1 following year end.	Divisional Directors	June 2026

	09.09	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. The project team is working with UGI SST within VCS to incorporate anaemia management within the neo-adjuvant pathway.		
	09.10	Strengthen the effectiveness and assurance of core financial controls covering statutory reporting, P2P, financial systems, debtors and treasury management and tax compliance.	Preparation of the draft 2025/26 Annual Accounts, Financial Returns & Remuneration Report is underway, with lessons learnt from prior years embedded into the timetable and working paper approach. Early & ongoing engagement with Audit Wales and Welsh Government is supporting consideration of key accounting judgements & disclosures.	EDoF, DDof	Ongoing

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
FSLTV1 – Divisional Financial Outturn (Detective) FSLTV2 – Quarterly Finance Reviews (Detective)	LTA activity capture and currency mapping is weak — some activity is not being identified and charged to commissioners. While additional system/process controls have been introduced (partly mitigating issues), a residual weakness remains,	Budget holders (reports and training) Touch point meetings / Divisional Senior Leadership Teams	LTA activity performance monitoring: a review has provided assurance that controls are in place, but assurance is not yet fully “closed” because the review process needs to continue as routine practice, and a contract model review is underway to ensure the Trust is recovering income that reflects the cost of service.

FSLTV3 – Divisional Performance Review (Detective) FSLTV4 – Executive and Trust Board Reporting (Detective) FSLTV5 – Statutory and Mandatory Financial Reporting (incl. Annual Accounts) (Detective) FSLTV6 – Monthly Finance and Performance Meetings (Mitigating) FSLTV7 – Collective Commissioners Review (Preventative) FSLTV8 – Investment Appraisal (Preventative) FSLTV9 – Financial Strategy / Medium Term Financial Plan / Budget Setting (Preventative) FSLTV10 – Scheme of Delegation and Delegated Financial Authority (Preventative) FSLTV11 – Value Based Healthcare programme (Detective) FSLTV12 – Procure to Pay monitoring (Detective)	particularly relating to Radiotherapy IRS implementation, which is being addressed with Service and Business Intelligence.	Executive budget holders / Programme SROs Oracle financial system controls Requisitioners / budget holders (P2P), Private Patients lead (debtors), etc. Divisional finance reports & performance; Finance Business Partners Executive finance reports; Senior Finance Team Trust Board finance reporting (incl. MMRs, Welsh costing returns) Committees and groups: QSP Committee, Audit Committee, PSPP Group, Capital Planning & Delivery Group, Executive Management Board, Strategic Development Committee, VBHC steering committee, VAT working group, etc. Specific monitoring: Debtors reporting; Fixed assets register reporting; Counter fraud reports; Procurement compliance reporting; LTA performance monitoring / Collective commissioning group LTA reporting	

FSLTV13 – Debtors / Cash monitoring (Detective) FSLTV14 – Discretionary Capital Financial Planning and Reporting (Mitigating) FSLTV15 – Major Capital Programmes monitoring (Detective) FSLTV16 – Counter Fraud (Preventative) FSLTV17 – Tax management (Detective) FSLTV18 – Procurement (Preventative)		Internal Audit External Audit External oversight/advisory bodies	

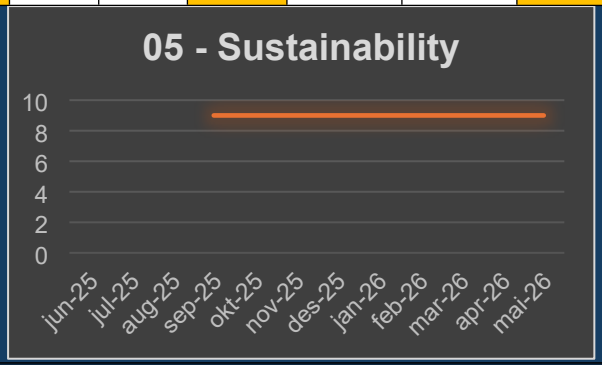
Risk 05	There is a strategic risk that the Trust fails to effectively embed its role as a sustainable organisation - outside of main infrastructure and specific centrally led activity - resulting in a failure to improve the health of the population we serve and non-compliance with the Well-being of Future Generations Act's requirements	Date of Risk	Current Risk Score
		1 April 2026	9
		Last Review Date	
		April 2026	

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

Associated Strategic Objectives	Sustainability
	• Deliver the Trust strategic goal on sustainability: *"A sustainable organisation that plays its part in creating a better future for people across the globe."*
	• Embed sustainability into corporate governance and decision-making, specifically:
	  ○ integrate sustainability into all governance routes and
	  ○ ensure capital decisions/business cases consistently include environmental/sustainability considerations
	• Embed sustainability into clinical care delivery, by integrating sustainability into clinical pathways/models of care
	• Embed sustainability into organisational culture and responsibilities, by including sustainability
	.
		Exec Lead	Director of Place, Portfolio and Partnerships

		Assurance Level	4
		Risk Appetite	Open

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	3	9	3	3	9	3	3	9	3	3	9	2	2	4



Associated Risks	Risk ID	Risk Title	Current Risk Score

	Nil				
Action to Address Gaps	**Action ID**	**Action Detail**	**Progress Notes**	**Action Lead**	**Target Date**
	5.1	Embed sustainability considerations into capital project decision-making processes, including mandatory environmental impact assessments in business cases	Draft environmental impact assessment template developed. Discussions underway with Capital Project Manager.	Trust Sustainability Manager / Capital Projects Lead	March 2026
	5.2	Include sustainability and Well-being of Future Generations duties in all job descriptions and recruitment materials	Review of current job descriptions underway prior to developing draft wording prepared for future recruitment packs.	Trust Sustainability Manager /Workforce Lead	March 2026

Key Controls Established	**Key Gaps in Controls**	**Assurance**	**Key Gaps in Assurance**
Governance & organisational approach: “Creating Wider Value” approach, performance reporting/highlight reports, alignment to Well-being Objectives in governance/board papers, oversight via Climate Action Board. Clinical sustainability: Sustainable Care Models supported by review through the Clinical Sustainability MDT, environmental policy/divisional environmental statements, and ISO 14001 internal audits. Carbon & energy: “Carbon Zero” delivered through site Sustainability Implementation Plans (SIPs), site-level energy monitoring, and building management/energy optimisation, with supporting governance groups. Sustainable estates/capital projects: “Sustainable Infrastructure” built into capital programmes (e.g., nVCC/TGI), project risk registers, design review processes and specialist sustainability input; aiming for BREEAM standards.	Sustainability is not yet fully integrated into all governance routes and capital decision-making (i.e., not consistently embedded in how decisions are made). Sustainability is not yet embedded in clinical pathways (the new Clinical Sustainability MDT is under development and not yet part of standard practice). Sustainability is not included in all job descriptions/recruitment materials (so it isn’t consistently built into roles/responsibilities, including Well-being of Future Generations duties).	Performance reporting / highlight reports Site Sustainability Implementation Plans (SIPs), including site-level energy and waste monitoring Trust Travel Plan (2022–2027), Cycle to Work scheme, annual travel survey Waste Management Policy, segregation/recycling at source, single-use plastic phase-out Climate risk assessments and site emergency preparedness plans Sustainability induction/training, staff engagement programmes and awards Environment Policy, divisional Environmental Statements, Environmental Manual Capital project delivery controls (e.g., nVCC/TGI activity, project risk registers) Climate Action Board (regular oversight) ISO 14001:2015 Management Group FRESH Group (Fire, Risk, Estates, Sustainability & Health and Safety)	Capital projects may be approved without consistent consideration of environmental impacts. Embedding sustainability in clinical pathways is under development and not yet integrated into standard practice (Clinical MDT not yet fully operational). Sustainability is not currently part of standard recruitment materials or role profiles, with an opportunity to align to Well-being of Future Generations requirements.

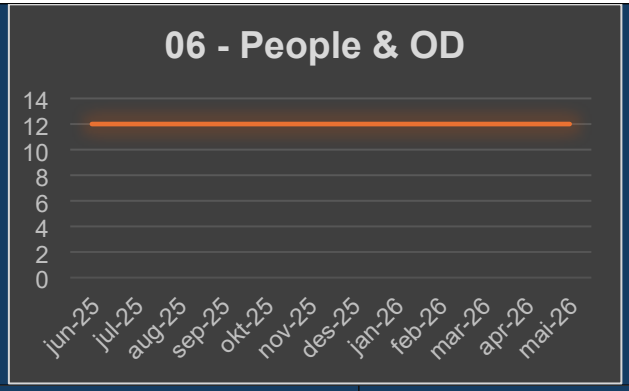
Waste & resources: Waste management policy, segregation/recycling at source, single-use plastic phase-out, waste monitoring, and contractor compliance audits. Renewables transition: Controls supporting move to renewable/low-carbon energy, embedded in capital projects and SIPs. Nature & biodiversity: Green social prescribing partnerships and biodiversity enhancement plans (within SIPs), supported by engagement activity and external biodiversity audits. Travel & transport: Trust Travel Plan (2022–2027), cycle-to-work scheme, annual travel survey, and related monitoring through ISO 14001 structures. Climate adaptation & resilience: Climate risk assessments, emergency preparedness plans, and inclusion of adaptation measures in major projects, reviewed through governance routes. People & culture: Sustainability induction/training, staff engagement programmes and sustainability staff awards (“people as agents for change”).		Committees/oversight fora: Quality, Safety & Performance Committee, Strategic Development Committee, EMB/SLT Capital governance and specialist challenge: Capital Project Board / nVCC Project Board, Reviewable Design Data process, specialist engineering/sustainability consultants Clinical governance route: Clinical Sustainability MDT (review function ISO 14001:2015 External Audit (including surveillance audit passed October 2025) NWSSP Internal Audit Audit Wales Other independent checks noted: waste contractor compliance audits, external biodiversity audits	

Risk 06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values	Date of Risk	Current Risk Score
		April 2026	12
		Last Review Date	
		New Risk	

Executive Summary	This strategic risk brings together the cultural factors that enable the Trust to deliver its core purpose (including values and behaviours, systems and processes) and the external and internal factors that affect the supply, shape and capacity of the workforce at organisational and multi-disciplinary team level. A People Strategy is in place with work programmes focused on enabling us to become an employer of choice, with the Healthy and Engaged and People Development and Education steering groups, as set out below. Work programmes are underway to address feedback and mitigate the risk through development, support, wellbeing and other interventions, including effective strategic and operational workforce planning focused on recruitment, retention and people development. In addition, the Trust is seeking to maximise workforce capacity through a reduction in absence levels, supported by wellbeing interventions and the application of workforce policies in a way that minimises harm to staff and teams. In April 2026 EMB reviewed the Trust Staff Survey result alongside the feedback from Line of Sight and agreed to adjust the Cultural Milestone Plan, agreed on 26th March 2026, to focus on the following areas: • Executive recruitment • Leadership • Psychological safety • Supporting VCS to move to the new hospital

Associated Strategic Objectives	• Workforce sustainability (how we recruit, retain & develop our workforce capacity and capability) • Culture, values and behaviours / organisational development (belonging, inclusion, speaking up, leadership) • Staff wellbeing and engagement (reduce absence, improve staff experience) • Safe, high-quality care enabled by the workforce (because workforce culture/capacity directly affects patient and donor care)	Exec Lead	Director of People and OD
		Assurance Level	3
		Risk Appetite	Open

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	4	12	3	4	12	3	4		3	4	12	3	2	6



Associated Risks	Risk ID	Risk Title	Current Risk Score
	3865	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.	15
	3893	There is a risk to workforce sustainability and service development as a result of the absence of funding to appoint a Reporting Radiographer and Sonographer, leading to potential loss of staff with critical skills and failure to develop a radiographer led reporting service.	16

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	6.1	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	Quarter 2 report went to the Healthy and Engaged Steering Group on 28.10.2025. As at December 2025, compliance with the Anti-racist Wales e-learning package was 84.97% WBS reported on Q2 progress with their SEP actions to the Healthy and Engaged Steering Group. No update received from VCS.	OD Specialist	December.26
	6.2	Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	Quarter 2 report went to the Healthy and Engaged Steering Group on 28.10.2025. Actions have been completed regarding launching Work in	OD Specialist	December.2026

			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.		
	6.3	Embed positive values and behaviours across the Trust to create positive culture. Cultural Baseline Review	An initial Board Development session has taken place (23.10.25). There is a Chair's commitment to doing future work following this initial review. Further actions are being pulled together for consideration by the Board, including a Cultural Baseline to assess opportunities and challenges. Capability and capacity required to complete the work.	Interim Director of People and OD	December 25

6ey Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Strategy and organisational alignment: Trust strategies and enabling strategies (including the People Strategy) to set direction and align priorities. Leadership, behaviours and culture: values/behaviours framework and leadership development grounded in compassionate leadership. Workforce planning capability and governance: workforce planning methodology, training, dedicated infrastructure, and embedded reporting/oversight arrangements. Recruitment, attraction and employer brand: consistent recruitment and selection processes and employer	Control development required: further work is required to fully develop Communication and employee voice: communication infrastructure needs to be in place to support leadership messages and staff engagement, including employee voice	Executive Management Board (EMB) reporting People Development & Education Steering Group / People and Development Steering Groups Healthy and Engaged Steering Group (incl. wellbeing oversight) Routine monitoring through Senior Leadership Teams (SLTs) using workforce dashboards Recruitment metrics reporting (incl. NWSSP recruitment metrics) and divisional/strategic monitoring groups (e.g., Strategic Workforce Planning oversight) Reporting to EMB, Committees and the Trust Board (including cycles of business and committee reporting such as Supply & Shape/QSP	

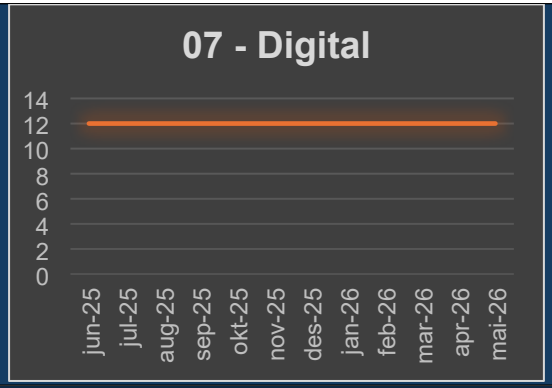
brand activity supported by recruitment metrics. Education and skills pipelines: education implementation planning and pathways to support new skills, new roles and development. Wellbeing and harm reduction: health and wellbeing infrastructure and embedding avoidable employee harm principles. Performance management and assurance: performance management frameworks and routine monitoring through governance forums. Service models and role clarity: clear service models and operational workforce plans aligned to service delivery. Inclusion and language standards: monitoring and improvement plans for Welsh Language Standards.		reporting) Internal Audit reports Internal and External Audit Welsh Government reporting via JET and IMTP	

Risk 07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical services, reduced quality and efficiency of care constrained decision-making, systems 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.	**Date Risk Raised** 1 April 2026 **Last Review Date** April 2026	**Current Risk Score** 12

Executive 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.

Associated Strategic Objectives	• Quality, safety and experience - the risk explicitly impacts patient/donor care quality and service disruption • Service delivery / clinical effectiveness - system failures and limited digital transformation affect continuity and efficiency of clinical services • Innovation / digital transformation - the risk is fundamentally about inability to implement and optimise digital systems, including safe adoption of AI/technology • Organisational sustainability / resilience - cyber incidents and fragile infrastructure create operational and reputational exposure	**Exec Lead**	Chief Digital Officer
		Responsible Committee	Quality, Safety and Experience
		Assurance Level	3
		Risk Appetite	Minimal

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	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.	16
	3922	There is risk to Multiple Domains as a result of the failure of the Blood Establishment Computer System, leading to compromised ability to supply blood to Wales.	15
	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
	3646	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
	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

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	07.01	Create the Trust Digital Reference Architecture to support C14 and others	National Target Architecture has been completed and is being formed into a set of business cases. Digital Design Authority has now meets regularly.	Chief Digital Officer	March 2026

			National Target Architecture programme has now been initiated and the Trust continue to actively engage in the business case development.		
	07.02	Prioritisation framework needs to be established for the Data and Insight Service. Prioritisation framework to be introduced by Portfolio Team.		Director if Place, Portfolio and Partnership	March 2026
	07.03	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.	DDAT Group have met three times and delivery board have met twice. The Trust has been represented in those meetings.	Chief Digital Officer	April 2026
	07.04	Complete digital diagnostic and the investment case for future investment in the digital service	Diagnostic is well advanced. Initial feedback was presented to the Digital Programme Board in January 2026	Chief Digital Officer and Director of Finance	March 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Trust Digital Strategy (published Oct '23). Digital governance reporting into Trust committees and programme boards. Active delivery/leveraging of key technologies (e.g., LIMS, IRS, BECS, EPMA). Training and education packages to build internal digital capability (Exec and Board included). Training and education packages for donors and patients. Ring-fenced digital investment in Trust budget (benchmark 4%). Build digital resource capacity and capability. Digital inclusion in the wider community.	Limited ability to minimise the impact of national programme delays (LIMS and RISP) on the Trust. Digital investment is below the 4% benchmark and there is no current plan to reach the required level. Impact assessment is needed for the national target architecture and how it aligns with local Velindre architecture.	Digital governance and delivery forums (e.g., Digital Programme Board; WBS/Velindre Futures), outcome/benefits tracking, staff/patient/donor feedback (incl. KLAS), mandatory training metrics, Digital IMTP and capital programme oversight, Digital Inclusion Plan activity/accreditation, and Divisional SMT/SLT reviews. Executive and committee reporting/oversight (EMB; SIRO reports; Strategic Development Committee; QSP/Quality, Safety & Performance; Audit/Performance Committee), cyber action plan reporting, and specialist governance bodies (e.g., IQSG; Caldicott Guardian/SIRO/DPO; Clinical & Scientific Strategy Board). Internal Audit (recurring across controls), plus external/independent oversight where applicable (e.g.,	

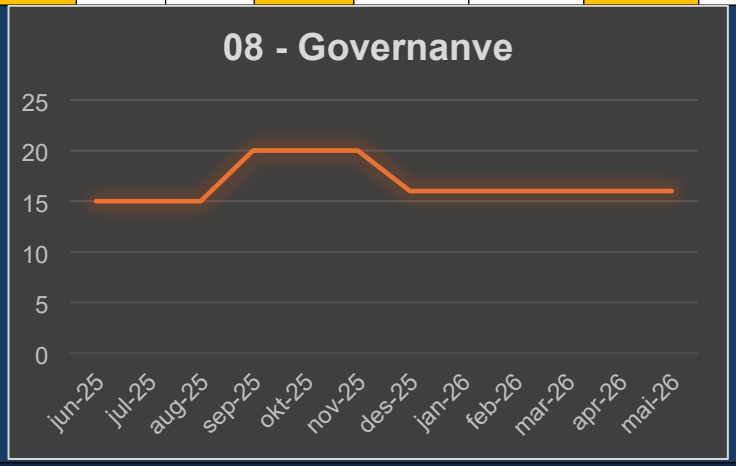
Prioritisation and change framework for managing service requests. Reduce/monitor unsupported applications and legacy systems. Trust digital governance. Lead/lag indicator reporting integrated into the wider performance framework. Cyber assurance controls in place. Digital transformation guided by an agreed digital architecture (Design Authority being established). AI strategy, policies and guidance for implementation and maintenance. Trust Information Governance arrangements.		Cyber Resilience Unit/WG IQPD as competent authority for NIS, Digital Communities Wales accreditation, External Audit of accounts, ICO/Welsh Government, national programme governance/DDaT leadership boards).	

Risk 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.	Date Risk Raised	Current Risk Score
		February 2025	12
		Last Review Date	
		April 2026	

Executive Summary	The Trust is working with Welsh Government and NWSSP to implement the recommendations of the review of NWSSP Accountability and Governance Arrangements. The Trust is working with an external expert advice provider 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.

Associated Strategic Objectives	Outstanding for quality, safety and experience Be recognised as 'outstanding' by external regulators • Be an organisation that consistently demonstrated compassionate leadership in everything it does • Listen to and learn from patients' and donors' experiences of care to drive continuous improvement	Exec Lead	Director of Corporate Governance
		Assurance Level	3
		Risk Appetite	Minimal
		Risk Appetite	Minimal

Scoring	Inherent Risk			Q2 – 25/26			Q3 – 25/26			Q4 – 25/26			Q1 – 26/27			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	5	15	4	5	20	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title			Current Risk Score
	3656	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.			16
		Action Detail	**Progress Notes**	**Action Lead**	**Target Date**
Action to Address Gaps	08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work.	Benchmarking completed and informing new Risk policy and Committee restructure. External governance specialists supporting development of governance improvement programme since March 2026.	Director of Corporate Governance	April 2026
	08.03	Review Trust Risk Policy	New policy, appetite statement and supporting procedures drafted. Being considered as part of wider governance improvement programme. Audit Committee consideration due in September 2026. Documentation being reviewed by external governance specialists.	Director of Corporate Governance	September -2026
	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	Governance improvement programme includes the following activities to deliver action: • New Corporate Governance Manual as a means for ongoing reference and information on how Trust governance works and the standards set. • New Board Committee structure including new Terms of Reference, Cycles of Business, ways of working • New map outlining the Trust's governance framework from 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.	Director of Corporate Governance	March 2027

			• Work to review the current hosting arrangements underway and will consider Welsh Government review (July 2025).		
	08.05	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Ongoing programme of training in place. Key briefing documents shared with Trust Board members and available for staff. New intranet space for training in development.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	September-26
	08.06	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies.	Policy on Policies developed and approved by QSP Committee in November 2025. Policy review report considered by QSP Committee twice a year.	Director of Corporate Governance	September-26
	08.07	Participate in WG implementation group re: NWSSP review of accountability and governance and implement recommendations in line with December 2025 statement.	Implementation group meeting on monthly basis. Recommendations re: NWSSP chair progressed. Recommendations re: clinical governance being considered by all parties.	Director of Corporate Governance	Nov.26
	08.09	New Board Development Programme delivered	12 month Board development and governance improvement programme underway for completion by March 2027.	Director of Corporate Governance	March 2027
	CLOSED ACTIONS				
	08.02	Develop new plan for phase 2 GAR programme.	GAR programme stood down and amalgamated into governance improvement programme since March 2026.	Director of Corporate Governance	CLOSED
Key Controls Established		**Key Gaps in Controls**	**Assurance**	**Key Gaps in Assurance**	

Trust Risk Register framework, policy, procedures and Risk Appetite Statement. Annual Assessment of Board Effectiveness Board Committee Effectiveness Arrangements Board Development Programme Quality of assurance provided to the Board External benchmarking on governance, assurance and risk to confirm best practice Cross-reference of Integrated Medium Term Plan objectives to strategic objective in the Board Assurance Framework	Risk Policy under review with aim of seeking Board approval in July 2026 Board development programme underway Governance improvement programme underway	Independent assurance through Internal Audit and Audit Wales work External oversight/escalation via Welsh Government Escalation & Intervention Arrangements including Public Accountability meetings. Governance oversight and monitoring through internal forums Specialist external advice when required	Approval by Audit Committee and Board regarding the new Framework Third line of defence in respect of C4 – Board Development Programme underway Approval of new Risk Policy and related documents

TRUST BOARD	
NEW OPERATING AND ACCOUNTABILITY ARRANGEMENTS 2026	
DATE OF MEETING	21/05/2026
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	Victoria Oxley, Director of Strategy, Planning and Performance (Interim)
PRESENTED BY	Victoria Oxley, Director of Strategy, Planning and Performance (Interim)
APPROVED BY	Carl James, Interim CEO
EXECUTIVE SUMMARY	Key points set out within this paper: 1. An overview of the new Operating and Accountability Framework approved by the NHS Wales Leadership Board on 17th February 2026 2. The new arrangements came into effect on 1st April 2026 and will replace the current JET and IQPD performance meetings 3. Welsh Government aims to simplify and standardise current accountability processes with a risk-based approach over 4 'pillar domains' 4. The Operating and Accountability Framework will also incorporate new escalation and de-escalation mechanisms with 'earned autonomy' leading to 'light touch' routine monitoring.

	5. Work will be undertaken in partnership with Welsh Government representatives to agree a core data set for VUNHST
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • Note the new Operating and Accountability Framework for 2026/27 • Discuss the implications for our internal performance and accountability processes

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Group	26/02/2026
Strategic Development Committee	05/05/2026
	(DD/MM/YYYY)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board noted the new arrangements for 2026/27 and the potential implications for the Trust's internal performance and accountability processes. SDC discussed the importance of a read through from this work and wider governance and performance reporting processes within the Trust, including the Board Assurance Framework and the Performance Management Framework. SDC also discussed that conversations are taking place in national peer groups (e.g. Medical Directors) to better understand and inform how organisations work with WG to shape the process moving forward. SDC highlighted the importance of fully engaging with this new process as there could be consequences regarding escalation and scrutiny if the Trust did not.

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

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

APPENDICES

1	New Operating and Accountability Interface – NHS Wales

ACRONYMS and INITIALISM	
IQPD	Integrated Quality Performance and Delivery
JET	Joint Executive Team
MAG	Ministerial Accountability Group

NHS P&I	NHS Performance and Improvement
WG	Welsh Government

1. SITUATION

1.1 This report sets out the new operating and accountability arrangements for NHS Wales which commenced on the 1st April 2026. This new framework was approved by the NHS Wales Leadership Board in February 2026.

1.2 These new arrangements align to the MAG Accountability Review recommendations and the MAG Productivity and Performance Review.

1.3 All NHS Wales organisations will be expected to operate under these new arrangements.

2. BACKGROUND

2.1 The new framework is attached as Appendix 1. The aim of the changes is to simplify the interface arrangements between NHS Wales organisations and WG and align the cadence of assurance meetings with the organisational levels of escalation.

2.2 This has resulted in the removal of the IQPD and JET meetings and instead, these will be replaced by an NHS Wales CEO led executive review meeting on a regularity related to organisational risk and escalation status. These arrangements will commence in Q1 of 2026/27 and a full review of the implementation of these changes is planned with the NHS Leadership Board in Q3 to ensure the desired outputs are being achieved.

2.3 It is important to note that the legal and statutory framework is not changing.

3. ASSESSMENT

3.1 Through these new arrangements WG will assess organisations against four pillar domains and a foundation domain:

- **Foundation domain: Leadership (Well led) -** Boards and senior leaders set clear purpose and strategy, role model the values and behaviours required for high quality care, nurture an open, fair culture, ensure strong integrated governance across quality, finance and operations, and drive continuous

improvement and system working. This domain will be assessed using a framework inclusive of self-assessment and evidence.

- **Pillar 1: Quality** - The safety, effectiveness and experience of care — including compliance with quality standards, learning from incidents, clinical outcomes, and reduction of unwarranted variation.
- **Pillar 2: Workforce** – a safe, sustainable and engaged workforce with the right capacity, capability and culture to deliver plans — encompassing recruitment, retention, sickness, wellbeing, turnover, and productivity enablers
- **Pillar 3: Finance** – In month and year to date financial position, medium term sustainability, savings delivery and use of resources, with credible, triangulated plans that balance quality, activity and workforce. Strategy and planning considerations sit here where they materially affect financial sustainability.
- **Pillar 4: Delivery/Performance** – delivery against nationally agreed priorities and the Performance Framework — including urgent and emergency care, planned care and cancer, diagnostics, mental health, and other access standards — supported by credible recovery plans and trajectories.

3.2 Each pillar will be evidenced through the single shared reporting pack and common dataset, with quarterly deep dives and a clear audit trail. Leadership (Well-led) will be evidenced through board evaluation, culture and speaking-up insights, external reviews and self-assessment against the well-led guidance.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 NHS Wales organisations will be expected to meet the following requirements to support these changes:

- Provide timely, accurate data and updates via the common reporting pack.
- Utilise the single reporting pack within Board papers and discussions.
- Maintain delivery plans (IMTP/annual plan) and corrective action plans aligned to escalation requirements.
- Participate in risk-based CEO/Executive Review Meetings with the NHS Wales CEO (cadence set by escalation level) to reinforce earned autonomy.

4.2 As VUNHST are currently at Level 1 (Routine Arrangements) Escalation Status it is anticipated that under these new arrangements this will align to the standard assurance processes. This should result in a 6 monthly CEO/Executive Review with NHS Wales CEO and monthly WG-NHS P&I oversight touchpoint meetings.

4.3 To enable an effective process for VUNHST under these new arrangements, work needs to take place in partnership with WG colleagues to agree an appropriate core data set. This needs to include appropriate benchmarking information from a national and international perspective.

4.4 Committee members need to be aware that consequences will be applied where performance or assurance falls short:

- **level based interventions** (enhanced monitoring, targeted intervention, special measures) per the WG framework are implemented.
- **formal notifications** at Level 1 and Level 2 (recorded letters of concern/performance notices) signalling accountable officer responsibility and expectations to recover.
- **Escalation of CEO accountability**: Where sustained non delivery persists, progression to Level 3/4/5 will carry progressively stronger consequences, including increased external review, limits on local flexibilities, and, at Level 5, use of statutory Ministerial intervention powers under the NHS (Wales) Act 2006.

5. IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
Choose an item</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒
• A beacon for research, development and innovation in our stated areas of priority ☒
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒
• A sustainable organisation that plays its part in creating a better future for people across the globe ☒</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>08 - Financial Sustainability and Long Term Value</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
</table>

	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). Quality and safety considerations form one of the central drivers to these changes.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	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:

Choose an item

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*	Not required - please outline why this is not required
	This is a WG initiative
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

A NEW OPERATING & ACCOUNTABILITY FRAMEWORK FOR NHS WALES

1. Introduction

The NHS Leadership Board and HSCEYG EDT identified several areas for change and consolidation to the interface and accountability arrangements of the NHS Wales system these aligned to the Ministerial Accountability Group (MAG) accountability review recommendations and MAG Productivity and performance review.

Change is needed to meet the overarching objectives of modernising and simplifying the accountability and operating frameworks in NHS Wales.

This paper makes several recommendations to meet those overarching objectives and seeks agreement from NHS Wales system leaders and Welsh Government (WG) officials.

The paper has considered the recommendations/objectives from the recent discussions and MAG reviews, and the following principles have informed the recommendations in this paper:

- Meetings at national level to be standardised (in line with MAG recommendations) with a clear purpose aligned to the escalation and intervention framework.
- The interface needs to be focussed with clarity on objectives, timelines, accountability, and precision of assurance.
- The current measurement system (process measures, inputs, outputs) doesn't drive change and is over complicated with too many priorities. Need to utilise the MAG recommendation of a single agreed performance and outcomes framework which is agreed and reported by all parties.
- Need to optimise use of NHS Leadership Board structure as a national oversight meeting to drive change and improvement.
- NHS Performance & Improvement (NHS P&I) is central to system improvement, oversight and assurance and should occupy a system role in providing an appropriate bridge between the system and Welsh Government.
- The Escalation & Intervention Framework, which was updated this year, needs to provide clarity in escalation and de-escalation criteria alongside the available support to organisations to drive system and organisational improvement.
- This framework will be supported by clear interventions from NHS P&I to support organisations alongside a clarity of the consequences of non-delivery of de-escalation criteria.
- Continue the movement to greater transparency, accountabilities need to be clear and drawn from IMTP framework and promote a culture of improvement, support and early intervention.

2. Oversight and Assurance

This document sets out a streamlined, risk-based approach to oversight and assurance for NHS Wales. It:

- **aligns** with the Welsh Government NHS Oversight and Escalation Framework (five escalation levels from routine arrangements to special measures).
- **integrates** the current NHS Wales Framework measures and domains (quality, workforce, finance, performance), ensuring consistent reporting and focus.
- **implements** selected recommendations and intent from the Ministerial Advisory Group (MAG) on performance and productivity (e.g. simplifying interfaces, strengthened clinical leadership and increasing transparency in monthly performance reporting).

Design Principles

- **Fewer interfaces, clearer lines:** Reduce the number of direct interfaces between Welsh Government and NHS organisations by using NHS P&I as the principal conduit.
- **One version of the truth:** A single, governed dataset and narrative shared across WG, NHS P&I and NHS organisations for assurance and performance reporting.
- **Risk-based and proportionate:** Cadence and intensity of engagement tied to escalation level and risk profile, in line with the WG framework.
- **Earned autonomy:** High-performing organisations gain lighter touch oversight, more freedoms and reduced meeting burden; weaker performance triggers closer support and intervention. (This mirrors good oversight practice common across UK systems.)
- **Productivity and outcomes focus:** Progress tracked routinely across quality, workforce, finance and performance pillars derived from the Planning, Quality, Performance and Outcomes Frameworks.
- **The Health Outcomes Framework:** Will provide the model through which measures and indicators of quality, safety, productivity, and equity will be aligned to the delivery of improved population health. Outcomes will be used consistently across Welsh Government, NHS P&I, and NHS organisations to guide improvement, monitor progress, focus escalation, and ensure that performance management drives meaningful change in health and wellbeing rather than activity alone.
- **Public accountability:** Clear annual public accountability meetings for each organisation.
- **Clinical Leadership:** Strengthened and aligned to service improvement.
- **Regional and Collective Accountability –** The principles within this paper will be applied to the three regional structures to support collective accountability and oversight.

3. Scope and Roles

3.1 Welsh Government (HSCEY Group)

- Sets strategy and policy which then align to ministerial priorities IMTP framework.

- Establish professional and clinical guidelines and service standards.
- The Offices of the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) provide national clinical leadership across Welsh Government and NHS Wales to ensure that policy intent translates into safe, effective, value based clinical practice. Through the CMO, CNO and their teams, they set clinical and professional standards, provide system level advice, and ensure a clear line of sight between ministerial priorities, clinical governance, quality, and population health outcomes. The CMO and CNO are the professional leads for NHS Wales and support the work of NHS P&I with clinical insight across quality, safety, productivity, equity, and outcomes to support proportionate escalation, targeted intervention, and sustained improvement across the system.
- Chairs a monthly **WG–NHS P&I Oversight Meeting** to receive a whole-system update against the 4 key pillars to inform progress, improvement and intervention criteria and outputs.
- Maintains links with scrutiny bodies (Audit Wales, Healthcare Inspectorate Wales) within the joint arrangements.
- Convenes appropriate and timely Tri-partite discussions to inform recommendations for escalation and deescalation.

3.2 NHS Performance & Improvement (NHS P&I)

- Acts as the **single operational assurance interface** with each NHS organisation.
- Consolidates data and narrative against the four pillars (quality, workforce, finance, performance).
- Operates a structured support offer (diagnostic, targeted support, improvement plans) matched to escalation level.
- Provides monthly system synthesis to Welsh Government, including risks, mitigations and recommended actions.

3.3 NHS Organisations (Health Boards, Trusts, SHAs)

- Provide timely, accurate data and updates via the common reporting pack.
- Utilises the single reporting pack within Board papers and discussions.
- Maintain delivery plans (IMTP/annual plan) and corrective action plans aligned to escalation requirements.
- Participate in risk-based **CEO/Executive Review Meetings** with the NHS Wales CEO (cadence set by escalation level) to reinforce earned autonomy.

4. Data and Reporting: “One Version of the Truth”

4.1 Shared Performance Pack

- **Content:** Core measures from the NHS Wales Performance Framework and Outcomes Framework - (including access, cancer, UEC, productivity/finance, quality indicators), plus organisation-specific risks and mitigations.

- **Ownership:** NHS P&I curates; organisations populate; Welsh Government and NHS Organisations utilise and report the same pack without alteration.
- **Frequency:** Monthly refresh; quarterly deep dives.
- **System Daily Reporting –** Utilises same data sets as Shared Performance Pack but is produced daily to inform system resilience and risk management.

4.2 Access for WG Policy Officials

- A **robust access mechanism** gives policy officials near-real-time data and board-level narratives to answer Ministerial and Senedd questions promptly.
- Access governed by information assurance protocols and role-based permissions; content sourced from the single dataset and evidence repository.
- This reduces duplication, improves responsiveness and supports transparency. (This approach is consistent with WG's drive to streamline oversight and reporting.)

5. Escalation Alignment

We adopt the **five escalation levels** and descriptions from the WG framework—routine arrangements (1) through to special measures (5)—and link these to a **meeting cadence** and **data/reporting requirements** proportionate to risk.

- **Levels reflect domains** (governance/leadership, performance/outcomes, finance, quality, strategy/planning, fragile services) and are applied per organisation and, where needed, per domain.
- **De-escalation criteria** are clear and mutually agreed and follow the framework (demonstrable sustained improvement and risk reduction).

6. Meetings and Interfaces (Reduced and Risk-based)

6.1 System-level

- **WG–NHS P&I Oversight Meeting (Monthly):** Whole-system update; escalation/de-escalation recommendations; cross-cutting risks (e.g., workforce, fragile services).
- **Public Accountability Meeting (Annual/Biannual per organisation):** Formal public session covering outcomes, finance, quality and delivery against priorities.

6.2 Organisation-level

- **CEO/Executive Review with NHS Wales CEO and team:** Cadence is tied to escalation level.
- **Whole Board Meeting with NHS Wales CEO and team –** organisations in Level 5
- **Targeted Support Clinics (as needed):** Time-limited improvement support aligned to the framework's "targeted support" provisions.
- **Individual Organisation or System Risks:** Time limited and aligned to agreed risk areas and performance profile

Existing IQPD/JET meetings are **removed** and replaced by the risk-based interface, with NHS P&I acting as the single operational interface.

The interface with other NHS organisations should align with this process – WAST, PHW, DHCW, and HEIW.

Note for consideration the hosting arrangements for NHS P&I.

6.3 Meeting Cadence by Escalation Level (Replacing IQPDs/JETs)

Risk-based cadence aligned to the **WG Oversight and Escalation Framework** levels.

Escalation Level (WG framework)	Description (summary)	CEO/Executive Review with NHS Wales CEO	WG–NHS P&I Oversight Touchpoint	Notes
Level 5 (Special Measures)	Very serious concerns; potential use of statutory Ministerial powers.	**Monthly**	**Monthly**	Intensive support; external review; strict consequences.
Level 4 (Targeted Intervention)	Serious concerns; time-limited targeted support.	**Every 2 months**	**Monthly**	Focused improvement plans; milestone reviews.
Level 3 (Enhanced Monitoring)	Serious concerns requiring close monitoring and proactive organisational response.	**Quarterly**	**Monthly**	Regular progress updates; data/evidence submissions.
Level 2 (Areas of Concern)	Early warning; prevent escalation through prompt corrective action.	**6-monthly**	**Monthly**	Formal notifications possible; targeted remedial actions.
Level 1 (Routine Arrangements)	Standard assurance; effective govern s	**6-monthly**	**Monthly (system)**	Light-touch; annual public accountability meeting.

Key change: IQPDs and JETs are **removed** and replaced with the above risk-based cadence, a common reporting pack, and the single operational interface via NHS P&I.

For Southeast and Southwest Wales, where Ministerial Direction has been given, regional meetings will be held between the health boards, Welsh Government and NHS Wales P&I on a six monthly basis to ensure collective accountability.

7. Earned Autonomy, Rewards and Consequences

7.1 Earned Autonomy (Rewards)

Organisations consistently meeting delivery expectations across **quality, workforce, finance and performance** will benefit from:

- **reduced meeting burden** (lower frequency and lighter touch).
- **flexibilities** in delivery (e.g., local pathway choice, discretionary improvement funding focus, streamlined approvals).
- **positive public narrative** at annual accountability meetings. (This mirrors best practice approaches used in other UK oversight regimes to incentivise performance.)

7.2 Consequences

Where performance or assurance falls short:

- **level-based interventions** (enhanced monitoring, targeted intervention, special measures) per the WG framework are implemented.
- **formal notifications** at Level 1 and Level 2 (recorded letters of concern/performance notices) signalling accountable officer responsibility and expectations to recover. (Consistent with the step-up model described in WG escalation arrangements.)
- **Escalation of CEO accountability:** Where sustained non-delivery persists, progression to Level 3/4/5 will carry progressively stronger consequences, including increased external review, limits on local flexibilities, and, at Level 5, use of statutory Ministerial intervention powers under the NHS (Wales) Act 2006 (as a last resort).

7.3 Accountability Mechanisms

In parallel, WG may review CEO accountability arrangements to ensure both **organisational** and **individual** accountability are clear, including formal warnings at Level 1 and Level 2 before further action if recovery does not occur (policy development required; legally compliant with existing statutory frameworks).

Consider a shift in escalation status decision making to align with revised arrangements.

DG/NHS Wales CEO to determine escalation status 1-3 with support from WG officials, with ministerial recommendations and decision at levels 4/5.

8. Role of NHS Performance and Improvement (NHS P&I)

Cabinet Secretary, in April 2025, stated that NHSP&I has a dual role to:

- Support NHS Wales to deliver better health services for patients and the public
- Support Welsh Government to hold NHS Wales to account for the provision of health services and delivery of statutory requirements.

The introduction of the role of Managing Director to provide leadership to NHS P&I is complete and he has the responsibility and accountability to act in redefining the approach and structure of the functions.

The functions of NHS P&I are being aligned to the accountability expectations set out in this paper.

The role of the clinical networks and national programmes alongside system leaders, will support the development of clinical leadership, system leadership and quality improvement.

In recognising the resources within NHS P&I the establishment of a support and intervention structure is being taken forward as part of this work.

The role of NHS P&I in system assurance will be defined to support the new interface with NHS organisations in development of the shared reporting pack and monthly monitoring.

9. Delivery Expectations and Tracking

To simplify and sharpen oversight, we will assess organisations against four pillar domains — Quality, Workforce, Finance, and Delivery/Performance — with a foundation domain of Leadership (Well-led) that sets the culture, behaviours and governance needed for sustainable improvement. This replaces the legacy set of escalation domains while remaining fully compatible with the Welsh Government's five escalation levels (routine arrangements to special measures). Escalation may apply to one or more pillars, and decisions will continue to follow the national framework and tripartite intelligence routes**.**

How this aligns with the current framework?

The national framework currently references domains such as finance, strategy and planning; performance and outcomes; quality of care, prevention; fragile services; governance; and leadership, capability and culture. These are now consolidated into the four pillars, with planning and governance embedded within Finance, Delivery/Performance and the Leadership foundation respectively, and fragile services managed through Quality and Delivery/Performance depending on the nature of risk**.**

Foundation domain: Leadership (Well-led)

Definition: Boards and senior leaders set clear purpose and strategy, role-model the values and behaviours required for high-quality care, nurture an open, fair culture, ensure strong integrated governance across quality, finance and operations, and drive

continuous improvement and system working. This domain will be assessed using a framework inclusive of self-assessment and evidence.

Leaders evidence: (i) clear shared direction and culture; (ii) effective governance and risk management; (iii) transparent use of data and insight; (iv) compassionate, inclusive people leadership; (v) visible improvement capability; and (vi) constructive system relationships that support delivery at pace.

Escalation focus: Concerns about leadership capacity, governance, culture or capability (including lack of credible recovery planning or weak assurance) will be recorded under this foundation domain and may trigger or amplify escalation in one or more pillars.

Pillar 1: Quality

Definition: The safety, effectiveness and experience of care — including compliance with quality standards, learning from incidents, clinical outcomes, and reduction of unwarranted variation.

Evidence base: National quality measures and statements, triangulated with the National Quality Management System, patient experience feedback and external assurance (Healthcare Inspectorate Wales, Audit Wales). Fragile or high-risk services (for example, maternity and neonatal) are captured here and, where relevant, in Delivery/Performance.

Expectations: Sustained compliance with agreed quality standards and trajectories; evidence of learning translating into improved outcomes and reduced harm.

Pillar 2: Workforce

Definition: A safe, sustainable and engaged workforce with the right capacity, capability and culture to deliver plans — encompassing recruitment, retention, sickness, wellbeing, turnover, and productivity enablers.

Evidence base: People-measures within the national oversight approach (for example, staffing, skill mix, rota fill, training compliance, wellbeing indicators), supported by qualitative insights from staff surveys and speaking-up data.

Expectations: Delivery of safe staffing plans and trajectories; improved stability and engagement; demonstrable impact of workforce actions on quality and operational performance.

Pillar 3: Finance

Definition: In-month and year-to-date financial position, medium-term sustainability, savings delivery and use of resources, with credible, triangulated plans that balance quality, activity and workforce. Strategy and planning considerations sit here where they materially affect financial sustainability.

Evidence base: Monthly monitoring returns, integrated performance and finance reports, and assurance over financial governance and control. Deeper review where there is a significant underlying deficit or gaps to plan.

Expectations: Sustained delivery against the agreed financial trajectory; strengthened financial controls; approved and deliverable medium-term plan demonstrating recurrent balance.

Pillar 4: Delivery/Performance

Definition: Delivery against nationally agreed priorities and the Performance Framework — including urgent and emergency care, planned care and cancer, diagnostics, mental health, and other access standards — supported by credible recovery plans and trajectories.

Evidence base: The single performance pack and published performance measures, trend analyses, risks and mitigations. Where quality or fragile-service risks are operational in nature (for example, patient flow, access backlogs), they will also be tracked here.

Expectations: Sustained delivery of agreed milestones and outcomes; variance managed within agreed tolerances; performance maintained without disproportionate negative impact on quality, workforce or finance.

9.1 Applying escalation within the pillars

- Levels: We continue to use five escalation levels, from routine arrangements (Level 1) through areas of concern, enhanced monitoring and targeted intervention to special measures (Level 5). Escalation can apply to one or multiple pillars and will be informed by proportionate, risk-based evidence.
- Tripartite and external assurance: Intelligence from Healthcare Inspectorate Wales, Audit Wales and other third parties will be considered, alongside organisational data and narratives.
- De-escalation: As per the framework, de-escalation will be agreed with clear criteria (typically one level at a time) and evidenced by sustained improvement.

9.2 Mapping from legacy domains to the new structure

- Quality of care ⟶ Quality pillar: Fragile services (for example, maternity and neonatal) monitored through Quality and Delivery/Performance as appropriate.
- Performance and outcomes ⟶ Delivery/Performance pillar: access, flow, recovery trajectories.
- Finance, strategy and planning ⟶ Finance pillar: with planning content embedded across Finance and Delivery/Performance according to impact.

- Governance; leadership, capability and culture ⟶ Leadership (Well-led): foundation domain.

9.3 Measurement and reporting

Each pillar will be evidenced through the single shared reporting pack and common dataset, with quarterly deep dives and a clear audit trail. Leadership (Well-led) will be evidenced through board evaluation, culture and speaking-up insights, external reviews and self-assessment against the well-led guidance.

1. **Diagnosis:** NHS P&I reviews trends, risks and variation using common pack.
2. **Support plan:** Organisation co-designs targeted actions.
3. **Review:** CEO/Executive risk-based meeting checks delivery and outcomes; WG–NHS P&I monthly oversight confirms escalation stance.
4. **De-escalation/Autonomy:** On sustained improvement, cadence reduces and flexibilities increase.

10. Information Governance and Transparency

- **Data assurance:** Single dataset governed by clear standards, definitions and audit trail to ensure accuracy and comparability. (Supports the “one version of the truth” principle.)
- **Publication:** Annual public accountability meetings will publish a concise performance summary and progress against ministerial priorities.
- **Privacy and security:** Role-based access for WG officials; compliance with legal and statutory duties.

11. Conclusion and next steps

EDT/ Leadership Board is asked to consider the changes set out in this paper which respond to the discussions at NHS Leadership Board and in MAG recommendations.

Agree that we implement the changes from 1st April 2026.

TRUST BOARD	
Reviewing the Board Committee Structure Update	
DATE OF MEETING	21 May 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	Non Gwilym, Interim Director of Corporate Governance
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Carl James, Interim CEO
EXECUTIVE SUMMARY	This paper provides a further update on the work undertaken since the Trust Board's meeting in March 2026 to review and restructure Board Committee arrangements. It outlines the progress made in developing the proposed revised committee structure, reflects feedback from numerous discussions and sets out the next steps required to strengthen assurance, clarify oversight, and ensure the Board's governance framework is aligned to the Trust's strategic priorities and future operating context. The paper also sets out a revised implementation timetable, with the new Board Committee structure now proposed to take effect from July 2026.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the proposal and **AGREE** the revised date for implementation.

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 The Trust Board has considered the key principles outlined in this paper at various forums including the January Private Board meeting and the February Board Development meeting in February 2026. The output of those discussions has informed the development of this paper.	
7 LEVELS OF ASSURANCE	
n/a	
APPENDICES	
n/a	

1. Background and Context

At its meeting in March 2026, the Trust Board agreed a plan to review and restructure its committee arrangements.

Since the Trust Board meeting:

- Committee Chairs and Executive leads have been identified for the new structure;
- Chairs and Executive leads have met with Line of Sight and the Corporate Governance team to consider the scope of the new committees and their proposed ways of working;
- Terms of Reference are being drafted;
- A review of the Corporate Governance Team's current ways of supporting and working with committees is underway, with further work continuing to ensure the team is appropriately aligned to support the effective implementation of the revised committee structure.

Given the value of this work and the depth and quality of the discussions undertaken to date, additional time is required to fully consider the feedback received and ensure it is thoughtfully reflected in the final proposals. This will help to ensure that the resulting arrangements are robust, effective and well designed to support the Trust's future needs.

On this basis, the implementation plan has been reviewed and the Trust Board is asked to consider a revised implementation timetable, with the new Board Committee structure now proposed to take effect from 31 July 2026.

Week	Milestone	By when?
1	Baseline committee mapping completed	End of February
2	Review Terms of Reference (ToR) and assurance flows completed - 121 Committee Chairs - Draft new ToR and Cycles of Business - Follow-up meetings with Chairs - Group discussion	End of June
3	- Complete QIA/EQIA	End of June
4	- Board approval – new Committee Terms of Reference, changes to Standing Orders	30 July 2026
5	New committee structure Go-Live adopting ToR and Cycles of Business	From 31 July 2026
6	6 months initial review	End of March 2027
7	Full post-implementation effectiveness review	12 months

7. Recommendation

The Trust Board is asked to **NOTE** the proposal and **AGREE** the revised timetable for implementation.

1. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (BAF)	08 – Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A Quality Impact Assessment is in development and will be presented to the Trust Board in May.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not yet completed (Include further detail below why)
	An assessment against the socio-economic duty will be completed as the work progresses.

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:
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.
	A review of the team structure to support the proposed structure is underway and will be presented to the Board in May 2026.

EQUALITY IMPACT ASSESSMENT	An Equality Impact Assessment is in development.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) The new structure will be developed in alignment with the scope of the Trust's statutory duties as outlined in the Model Standing Orders.

2. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	All relevant risks are outlined in BAF 08.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD	
Streamlined Approach for the Culture Milestone Plan	
DATE OF MEETING	21/05/2026
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	Sarah Jenkins, Executive Director of and Organisational Development (Interim)
PRESENTED BY	Sarah Jenkins, Executive Director of and Organisational Development (Interim)
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	This paper seeks Board approval for a refinement to the implementation approach of the Trust's three-year Culture Milestone Plan, originally approved by Trust Board in March 2026. The proposed changes do not alter the Plan's strategic ambition to embed a compassionate, inclusive and high-performing organisational culture and to support the work we are already doing; rather, they aim to ensure delivery is focused, streamlined, achievable and aligned to current organisational priorities and capacity. The paper proposes a refined delivery approach with key priority areas that better integrates culture activity within existing governance, operational, and transformation programmes. This approach is designed to improve organisational coherence, reduce duplication, and enable clearer prioritisation of activity, while

	ensuring sustainable use of organisational capacity.
RECOMMENDATION / ACTIONS	The Board is asked to: 1. APPROVE the proposed refinement to the implementation approach for the Culture Milestone Plan; and 2. APPROVE the streamlining to focus on the key priorities set out. • Our Governance and Leadership work with Line of Sight • Executive team recruitment • Supporting Velindre Cancer Service to move • Building on actions already taken, such as Speaking Up Safely, embedding these and assessing their impact. • Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES, with psychological safety at the core); and • Wider leadership development.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	27/04/2026
Strategic Development Committee	05/05/2026
Quality, Safety and Performance Committee	07/05/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Feedback on discussion of the Culture & Inclusion paper has through the governance process has highlighted the value of the Staff Survey results, shared in March 2026, in guiding our culture work. We have had the opportunity since then to review more detailed evidence behind these results and triangulate with our other Discovery work. In addition, recognising the scale of change progressing across of our organisation, to ensure we acknowledge the capacity and wellbeing of our staff, it is recommended we focus on specific priorities to enable a more streamlined approach. These priorities are:

1. Our Governance and Leadership work with Line of Sight
2. Executive team recruitment
3. Supporting Velindre Cancer Service to move
4. Measures to support an open culture, such as Speaking Up Safely

5. Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES and building psychological safety)
6. Wider leadership development

It is acknowledged that the decision should be taken back to the Trust Board to agree the recommendations.

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR

Select Current Level of Assurance

Compassionate Leadership	3
Psychological and Physical Wellbeing	3
Diversity and Inclusion	3
Values and Behaviours	3
Employee Voice	2

APPENDICES

	None

1. SITUATION

1.1 To seek Board approval for a refinement to the implementation approach for the Trust's three-year Culture Milestone Plan, approved by the Board in March 2026.

1.2 The proposed refinement does not alter the strategic intent, ambition or core principles of the agreed plan. Rather, it seeks to build on the work we have already been doing to help embed across the organisation and be proportionate in its approach.

2. BACKGROUND

2.1 In March 2026, the Board approved a three-year Culture Milestone Plan to support the continued development of a compassionate, inclusive and high-performing organisational culture across the Trust.
Since approval, early implementation planning and alignment discussions across corporate and operational teams have provided greater clarity regarding:

- The scale of concurrent strategic and transformation activity across the Trust;
- Organisational interdependencies and delivery sequencing;

- Cumulative programme demand on leaders and teams; and
- Opportunities to streamline and integrate culture activity more directly within existing operational and transformation programmes for example the nVCC hospital move.

  This consideration has taken place alongside encouraging staff survey outcomes (2025), which indicate a strong cultural foundation across a number of key themes and provide assurance regarding the overall direction of travel.

3. PROPOSED REFINEMENT OF FOCUS

3.1 Trust Board is asked to approve the focus on specific priorities for now, in light of the matters above:

1. Our Governance and Leadership work with Line of Sight
2. Executive team recruitment
3. Supporting Velindre Cancer Service to move
4. Building on actions already taken, such as Speaking Up Safely, embedding these and assessing their impact.
5.
6. Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES, with psychological safety at the core); and
7. Wider leadership development.

3.2.1 It remains the position that the Staff Survey will be our main measure of cultural impact. Once an OD partner is identified, a review of potentially wider culture measures will be scoped. The Board is advised that this is now also being considered on a national level.

3.3 The proposed refinement is intended to ensure culture continues to operate as an enabler of organisational performance and strategic delivery, rather than as a parallel programme of work. This should deliver benefits of improved organisational focus and reduced initiative burden across teams.

4. RECOMMENDATIONS

4.1 The Board is asked to:

4.1.1 APPROVE the proposed refinement to the implementation approach for the Culture Milestone Plan; and

4.1.2 APPROVE the streamlining to focus on the key priorities set out in paragraph 3.1 above.

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*	06 -Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐
QUALITY IMPACT ASSESSMENT	**Choose an item**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text

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*	Not required - please outline why this is not required *This is an assurance report, not a proposal for change.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

3. 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	Yes - please complete sections below
WHAT IS THE RISK?	BAF 06. That our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive culture in line with our organisational values.
WHAT IS THE CURRENT RISK SCORE	New risk statement April 2026, score under review.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*All aspects of this work will impact positively on this risk.*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	7th May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Quality, Safety & Performance Committee Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Annie Evans, Deputy Director of Nursing, Quality & Experience on behalf of Gillian Knight, Executive Director of Nursing, AHPs & Health Scientists
REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on 7th May 2026.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its review in March 2024, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 7TH MAY 2026

3.1 Triangulated themes

The following triangulated themes were identified:

- **Workforce pressures and sustainability risks** - Recurring concerns across programmes and operational reporting regarding workforce capacity, recruitment, and readiness to support future service models.

- **Financial and commissioning uncertainty** - Ongoing challenges relating to funding flows, commissioning arrangements and recurrent savings delivery, with increasing financial risk identified ahead of service transformation.

- **Improving governance grip and ownership** - Evidence of strengthened divisional ownership and governance processes, alongside continued need to improve risk articulation, action tracking and clarity of assurance.

- **System readiness and interdependencies (nVCC, TRAMS, infrastructure)** - Key dependencies across major programmes and infrastructure developments, with associated risks to delivery timelines and operational readiness requiring ongoing oversight.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the May 2026 QSP Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-papers/quality-safety-performance-2026/quality-safety-amp-performance-committee-07-05-2026/?ts=1778154744942

3.3 Summary of Committee Highlights

The following areas were highlighted for reporting to the Trust Board by the Committee:

ALERT / ESCALATE	**Trust Risk Register** The Committee noted the position regarding the development of a replacement risk management system and highlighted the lack of clarity on whether this will be progressed on an all-Wales basis. The Committee agreed that this requires further clarification and visibility at Trust Board level, given the potential implications for consistency and alignment across organisations.
ADVISE	**Trust Risk Register** The Committee received the Trust Risk Register update, noting changes to the register during the reporting period. Discussion focused on the trajectory of a number of risks, with concerns raised regarding the realism of target risk reduction dates and the ability to clearly demonstrate progress against mitigating actions. Particular attention was given to risks relating to SACT and Radiotherapy, with a request for improved triangulation across directorate, divisional and corporate levels to support clearer oversight. The Committee emphasised the need for greater clarity on how risks are progressing towards target scores and strengthened assurance on the effectiveness of mitigating actions.

	Board Assurance Framework The Committee received the updated Board Assurance Framework (BAF), noting progress in aligning the framework with the Trust's strategic objectives. It was acknowledged that the BAF remains a work in progress, with further refinement required to improve clarity and usability. The Committee highlighted a number of areas for development, including ensuring that target dates are current and realistic, strengthening the articulation of gaps in controls, and reinstating elements such as the 'three lines of defence' to support assurance. The Committee also emphasised the need to ensure a balanced representation of risks across all services to provide a comprehensive organisational view. Overall, the Committee supported the direction of travel, and noted that further development is required to strengthen the framework ahead of future iterations. **NHS Wales Shared Services Partnership** **Transforming Access to Medicines (TrAMs) Update** The Committee received an update on the TrAMs programme, noting progress across all workstreams, including completion of the Southeast Radiopharmacy build and advancement of the Full Business Case for the Southeast Hub. The Committee discussed programme timelines in detail, highlighting concerns regarding potential delays to the Southeast Hub, with indicative timelines extending beyond original planning assumptions. The need for greater transparency in reporting timelines, associated risks and system impacts was discussed. Workforce risks were also noted, particularly in relation to recruitment, training and transition of staff. The Committee emphasised the importance of clearly articulating these risks and impacts in future reports to support effective oversight and forward planning.
ASSURE	**Presentation - Dementia and Vulnerable Persons Provision and Infection Prevention and Control Considerations - new Velindre Cancer Centre (nVCC)** The Committee received a presentation on the approach to inclusive design for the new Velindre Cancer Centre (nVCC), with a focus on dementia and vulnerable patient provision. It was noted that extensive engagement with patients, carers, community groups and staff has directly informed the design, resulting in a patient-centred approach incorporating dementia-friendly principles, improved wayfinding,

access to nature, and enhanced privacy and dignity. Key features included inclusive facilities (e.g. adult changing, multi-faith and tailored patient areas) and strong staff involvement in the design process. The Committee acknowledged the challenges of balancing competing needs across different patient groups and was assured that the design is aligned with best practice, noting the need to review outcomes against patient experience once operational.

The focus then turned to infection prevention and control, where the Committee received an overview of how the nVCC design supports compliance with Welsh standards and minimises risk for a highly vulnerable patient cohort. It was highlighted that infection control considerations have been embedded throughout the design, including ventilation, water safety, decontamination processes and environmental cleanliness, supported by specialist input and multidisciplinary governance arrangements. Enhanced resilience measures, including a negative pressure facility, have been incorporated.

The Committee was assured that robust arrangements are in place, whilst noting that some practical and emerging challenges will require ongoing monitoring as the project progresses towards operational delivery.

Culture and Inclusion Report

The Committee received an update on culture and inclusion, noting progress in establishing the foundations of the Trust's cultural framework, including development of the cultural baseline, milestones and initial engagement activity to inform action planning.

The Committee recognised positive developments in staff engagement, including strong participation in recent "Ask Anything" sessions, and renewed executive commitment to support the 'Croeso' Induction programme and to strengthen communications with staff. It was noted that work is ongoing to develop divisional and organisational plans following the staff survey, with a focus on co-production with staff.

However, the Committee acknowledged that the programme remains at an early stage of maturity, with limited progression in assurance ratings to date, and emphasised the need for clearer delivery plans and improved measurable outcomes in order to support a movement in assurance levels.

Finance Report for the period ended 31st March 2026

The Committee received the Month 12 Finance Report and noted that the Trust achieved all statutory financial duties and delivered a small year-end underspend, maintaining financial balance. A balanced plan

has been set for the current financial year; however, the Committee recognised the increasing financial challenge ahead, including reliance on non-recurrent savings, underlying cost pressures within services and system-wide funding constraints.

The Committee was assured on current financial performance but emphasised the need for continued close monitoring of financial risks and a sustained focus on improving recurrent savings and longer-term financial resilience.

Quarter 4 Integrated Quality and Safety Report

The Committee received the Quarter 4 Integrated Quality and Safety Report, noting an overall positive position across patient and donor experience, infection control and regulatory compliance, alongside clear evidence of improved ownership and governance at divisional level. Continued improvements were noted in areas such as patient feedback, IPC compliance and action tracking, supported by strengthened leadership and more robust processes within services.

The Committee discussed a number of areas in detail, including complaints handling, incident reporting, pressure ulcer management, and information governance. The Committee also noted ongoing work to strengthen mortality review processes, and to refine the regulatory action tracking and triangulation with risk.

Particular assurance was taken from the strengthened divisional ownership of quality and safety, the progress in closing historic actions, and the proactive approach to learning and improvement. However, the Committee emphasised the need to maintain focus on embedding these improvements, ensuring sustainability, and continuing to strengthen data quality and learning systems.

Overall, the Committee was assured on the progress being made, noting that further maturity and consistency is required across some areas.

Performance Management Framework

SACT/Radiotherapy
The Committee noted that a dedicated workshop is scheduled to provide a more detailed review of performance, pathways and targets. Members were invited to submit queries in advance of the workshop to support improved understanding and oversight.

Welsh Blood Service (WBS)
The Committee discussed the presentation of performance metrics, particularly in relation to serious adverse events. It was highlighted that current incident grading terminology does not always accurately reflect

	the context, and the absence of defined national targets makes the interpretation of the data within the PMF challenging. . It was agreed that further refinement is required to improve clarity and interpretation at Board level. ***Estates, Infrastructure & Sustainability*** The Committee noted progress in relation to fire safety training compliance and was advised of a clear trajectory to achieve compliance by August, subject to staff uptake. This will continue to be monitored. Overall, the Committee noted ongoing issues regarding data quality, accuracy and presentation within the PMF, and welcomed the acknowledgement that this is a priority area for improvement to ensure the framework supports effective oversight and decision-making. **NWSSP Introduction to Medicines Value Unit** The Committee received an introduction to the Medicines Value Unit (MVU), noting its role as a national function providing analytical and clinical intelligence to support consistent, evidence-based decision making on medicines use across NHS Wales. It was clarified that the MVU operates in an advisory capacity and works alongside existing procurement and clinical governance arrangements. Members noted limited prior awareness of the Unit and sought further clarity on its scope, integration with Trust services and role in addressing operational challenges, including timely access to medicines. It was agreed that further detail would be explored outside of Committee, with a more developed update to be brought back prior to assigning a level of assurance.
INFORM	**NHS Wales Shared Services Partnership** **Clinical Pharmacy Technical Services Update** The Committee received an update on Clinical Pharmacy Technical Services, noting a stable position with no new regulatory issues, complaints or changes to service provision. Ongoing activity includes support to health boards through product supply, delivery of national vaccination programmes, and development of contingency medicine stockpiles. The Committee was advised that services continue to meet performance requirements and regulatory standards, with appropriate assurance in place, including ongoing compliance monitoring and support to the nVCC Radiopharmacy commissioning process.

	Trust Policies for Approval The Committee approved the following policies: • QS03 Handling Concerns Policy • QS12 Safeguarding and Public Protection Policy • QS08 Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust • IG09 Information Governance and Information Security Policy • IG07 Acceptable Internet Use Policy • IG03 Email and Instant Messaging Use Policy
APPENDICES	Quality and Safety Quarter 4 Report

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on 7th May 2026.

Velindre University NHS Trust
Quality and Safety Report
Quarter 4 2025-2026

(1st January 2026 – 31st March 2026)

WHAT IS QUALITY?

The Health & Social Care (Quality Engagement) (Wales) Act 2020 was implemented from 1st April 2023. This law includes the Duty of Quality and defines quality as the following:

'Continuously, reliably and sustainably meeting the needs of the population we serve'.

This is not limited to the effectiveness of health services; the safety of health services; and positive experience of service users.
The 12 Quality Standards are used across the trust which help deliver against the 6 quality domains:

Trust Approach

The Trust maintains a communication network primarily consisting of staff members from various teams across the organization. This network includes our Divisional Quality Hubs, Integrated Quality & Safety Group, Quality, Safety & Performance team, and Executive Management Board, all of which offer assurance to the Trust Board and the people of Wales regarding the Trust's dedication to fulfilling the Duty of Quality.

The Trust infrastructure is supported by a range of digital tools and systems to assist with monitoring, collaborating and reporting on the services the Trust supplies across Wales.

With this infrastructure, quality information can be shared effectively and timely. This can also help identify best practices, risks, areas of improvement or just for reporting purposes.

1. INTRODUCTION AND EXECUTIVE SUMMARY

The Trust's Q4 integrated quality & safety report provides analysis of key outcomes, activity, learning and improvement during Q4 and, where possible, provides themes, trends and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintain a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care

Quality & Safety Indicators Overview

Q4 2025/26 | Q4 2024/25

Q4 2025/26	Q4 2024/25
9 Putting Things Right Formal Complaints	2024-25: 10
77.8% Putting Things Right Compliance	2024-25: 50%
33 Early Resolution Complaints	2024-25: 35
3 New Redress	2024-25: 3
7 New Inquests	2024-25: 6
0 Ombudsman cases	2024-25: 0
718 Incidents	2024-25: 565
3 Duty of Candour Incidents	2024-25: 7
3 Nationally Reportable Incidents	2024-25: 2
1 New Claim	2024-25: 2
4 Safeguarding Duty to Report	2024-25: 6
2 Complaints Reopened	2024-25: 2
98% Welsh Blood Service satisfaction	2024-25: 98%
95% Velindre Cancer Service satisfaction	2024-25: 94%

1. INTRODUCTION AND EXECUTIVE SUMMARY

Analysis of concerns data for quarter 4 2025/26 has demonstrated an increase in total complaints received by the Trust, and a reduction in complaints regarding themes identified in previous quarters for both divisions. This demonstrates success resulting from targeted improvement work regarding communication with patients & donors, appointment management, clinical assessment/treatment and attitude & behaviour.

Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain positive. A total of 1038 people completed VCS patient feedback surveys Quarter 4. This is an increase of 1.6% from Q3 2025/26 (1022). This equates to a patient feedback rate of 9.4% of the 11,096 patients that attended Velindre Cancer Service. Welsh Blood Service feedback responses fell from 12% to 6%, this is due to issues with access to the Civica application on the feedback tablets used during blood collections.

Work has continued to explore further opportunities to gather patient and donor feedback for learning and improvement. A Trust wide Patient and Donor Experience working group has developed an improvement plan with staff across WBS and VCS. The priority of the group is to explore how to improve capability and capacity to gather feedback.

Compliance with Putting Things Right timescales for complaints response has increased since quarter 3 from 71.4% to 77.8%. This is above the national PTR target of 75%.

A continued trend since December 2023, providing positive assurance of complaints handling.

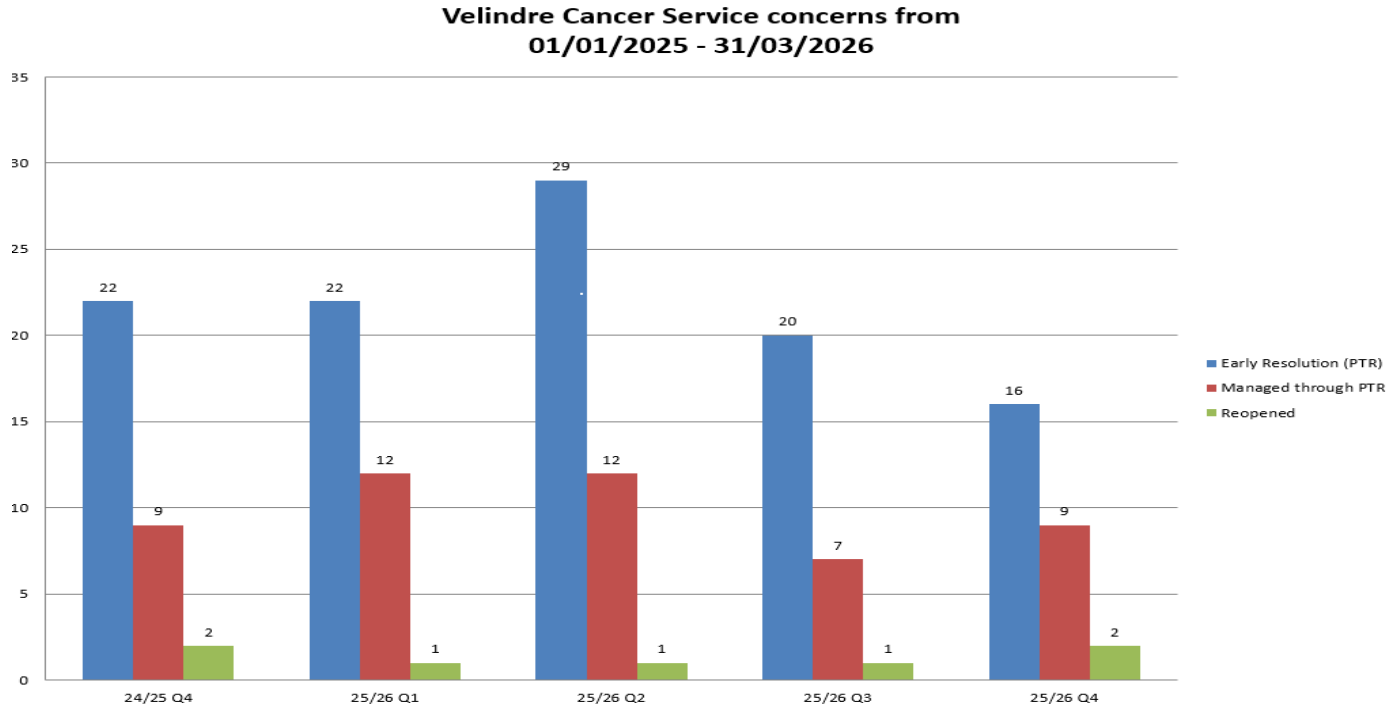
Three incidents at Velindre Cancer Service triggered the Duty of Candour.

The Trust continues to comply with legislative safeguarding responsibilities and reporting.

Hospital Associated Infection rates remain low.

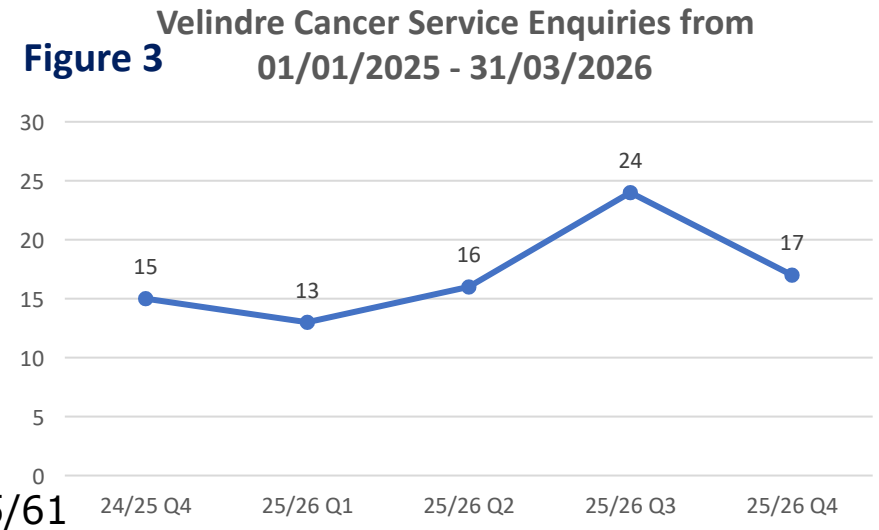
2.1 COMPLAINTS – VELINDRE CANCER SERVICE

Figure 2



Enquiries

Figure 3



Out of **11,096** patients who attended Velindre Cancer Service, **0.23%** raised a complaint.

Complaints

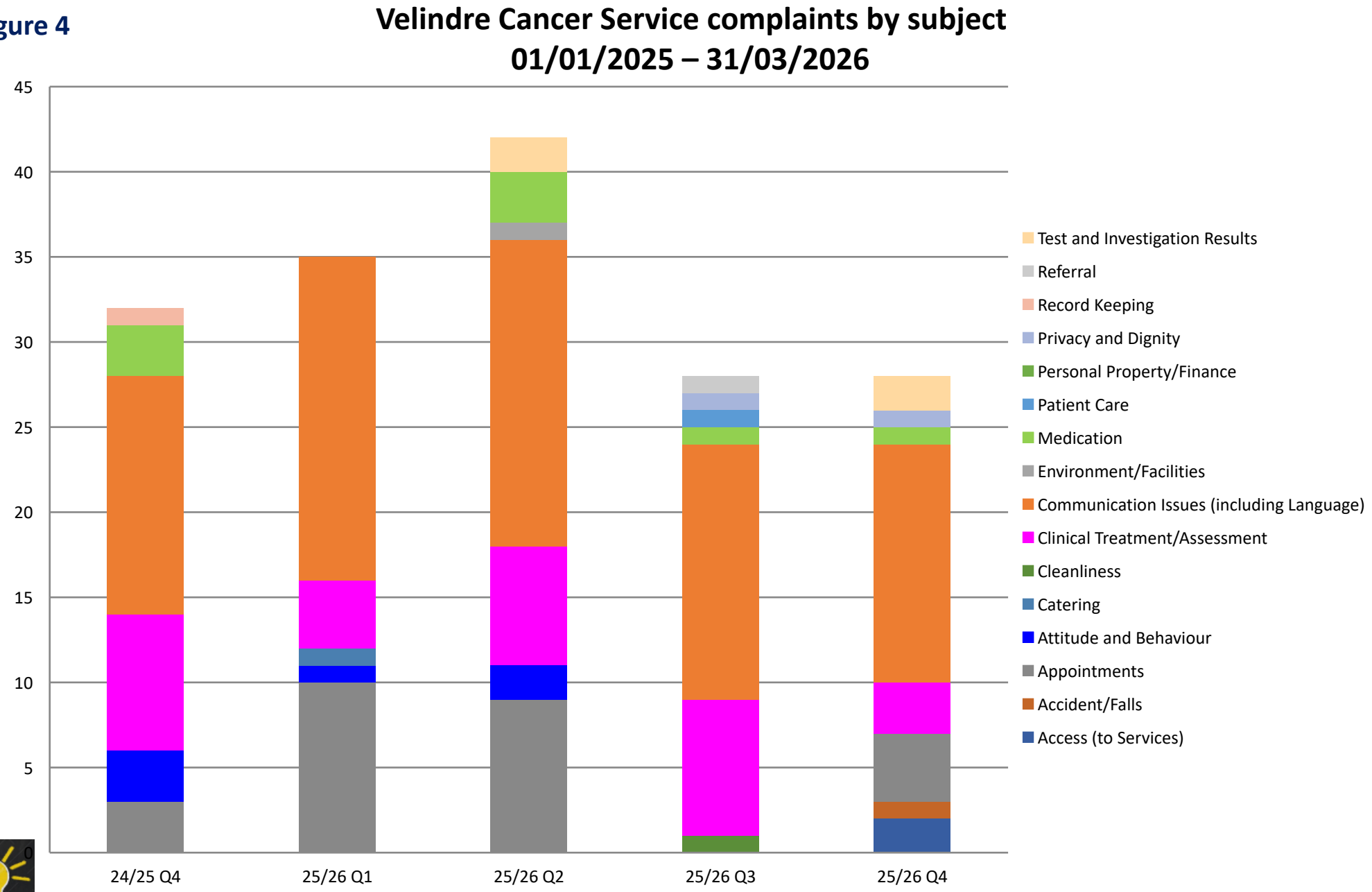
25 Total New Complaints raised

16 complaints managed as Early Resolution

9 complaints managed formally

2 complaint reopened

Figure 4


Velindre Cancer Service complaints by subject
01/01/2025 – 31/03/2026
45
40
35
30
25
20
15
10
5
0
24/25 Q4
25/26 Q1
25/26 Q2
25/26 Q3
25/26 Q4
Test and Investigation Results
Referral
Record Keeping
Privacy and Dignity
Personal Property/Finance
Patient Care
Medication
Environment/Facilities
Communication Issues (including Language)
Clinical Treatment/Assessment
Cleanliness
Catering
Attitude and Behaviour
Appointments
Accident/Falls
Access (to Services)

2.1 COMPLAINTS – VELINDRE CANCER SERVICE CONT.

ANALYSIS

The number of concerns raised in Q4 has overall remained stable – with a slight increase seen in formal investigations and slight reduction in concerns managed by Early Resolutions.

Following the improvements undertaken in SACT Bookings Team and secondment of a SACT Scheduling and Performance Manager role last year, a significant reduction was seen in the number of concerns related to appointments in Q3. This quarter has seen an increasing trend again in the number of concerns related to appointments, with staffing challenges (vacancies and sickness), including vacancy in senior roles within the SACT bookings team a contributing factor.

A new Team leader has now been appointed and started 1st April, and a successful recruitment round for booking staff was undertaken in March.

There has been a continued reduction in “Communication” concerns that relate to the communication surrounding the patients clinical care e.g., understanding of diagnosis, planned treatment, or monitoring plan. Q4 had 14 concerns and in Q3 there were 18.
Demonstrating learning and improvement regarding communication around clinical care.

A smaller number of concerns are also related to ‘clinical treatment and assessment’, and ‘Test & Investigations’, such as delays in treatment decisions, questions about investigations, or queries about past treatment. While fewer in volume, these concerns carry higher significance and emphasise the need for clear documentation and timely review of clinical information.

No clinical harm has been identified in any of the concerns raised.

LEARNING AND IMPROVEMENTS IDENTIFIED FROM VELINDRE CANCER SERVICE CONCERNS

A new PCDEA clinic (Nurse-Led Consent, Patient Education and Pre-SACT Assessment Clinic), which is planned to launch in mid-April will initially focus on lung and breast disease sites and will operate as a nurse-led service for patients attending prior to cycle one Systemic Anti Cancer Therapy (SACT).

This model aims to streamline the current pathway, where patients attend a medical-led new-patient clinic and then return separately for pre-cycle-one assessment and education. Under the new approach, patients will still see the consultant or medical team as new patients, but their pre-cycle-one appointment will take place within the nurse-led clinic, where they will receive their pre-SACT assessment, chemotherapy education, and complete consent.

This is expected to reduce the number of patients requiring medical-led introduction appointments and improve overall flow and patient experience.

A selection of Cancer Support Workers have been enrolled on to a Macmillan - Supporting Cancer Care Programme. The training programme is designed to deepen their knowledge and understanding when supporting people with cancer.

VCS team have been leading on 'Call for Concern' implementation nationally. The Acute Physical Deterioration Implementation (APDI) have proposed using VCS materials to help standardise Call 4 Concern branding nationally.

VCS 'Patient and carer dignity group' meetings recommenced in January led by the Supportive Care team

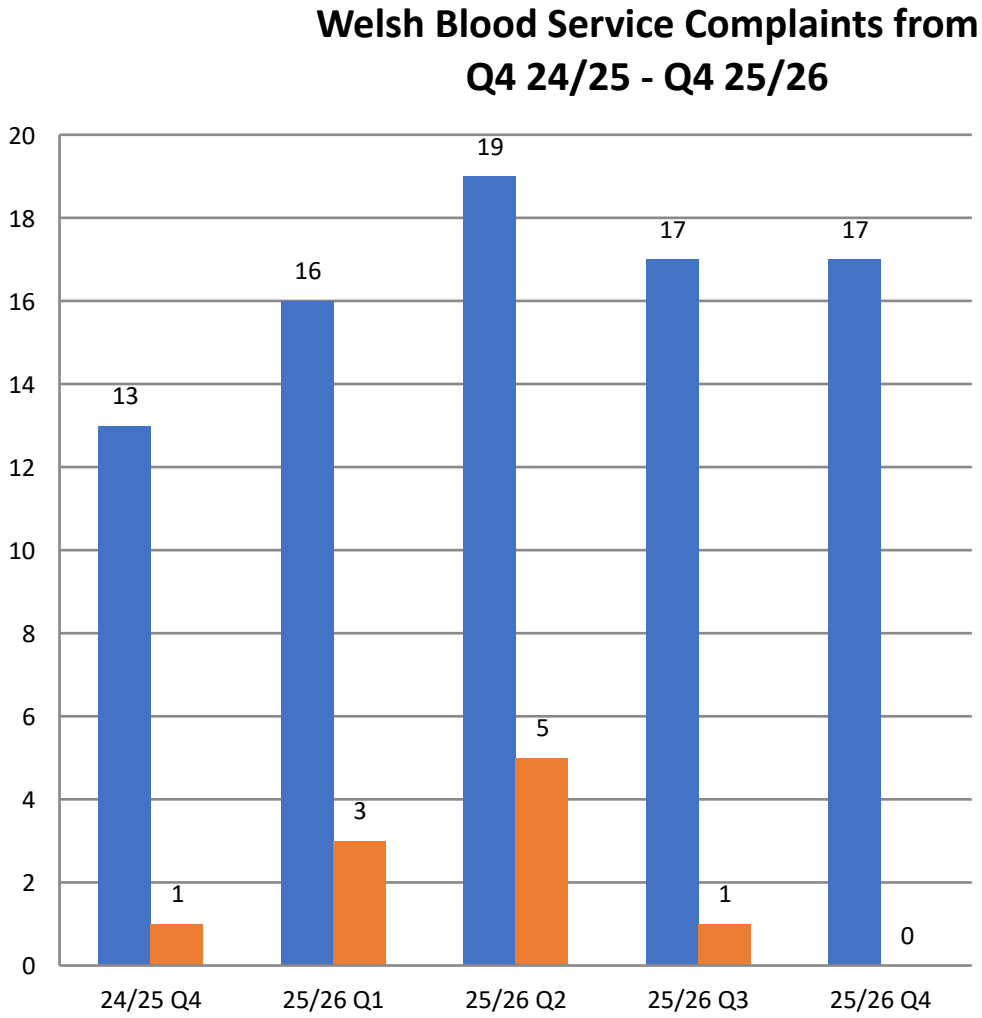
In February the Nevill Hall SACT unit (V@NHRU) reopened, with capacity to deliver SACT to approximately 20 patients a day. This has been very positively received by patients.

A new Radiotherapy Palliative clinic has commenced in V@NHRU, where patients can have their new patient appointment and CT planning scan at V@NHRU. This is a positive step towards care closer to home.

Denosumab trial is ready to role out to more patient enabling more patients to deliver Denosumab at home. This plan will save up to 2500 attendances per year.

2.2 COMPLAINTS – WELSH BLOOD SERVICE

Figure 5



17
Total New Complaints raised

17
Resolved through Early Resolution

0
Formal PTR

0
reopened

0.08% of 21,010 registered donors raised a complaint

2.2 COMPLAINTS – WELSH BLOOD SERVICE CONT.

ANALYSIS

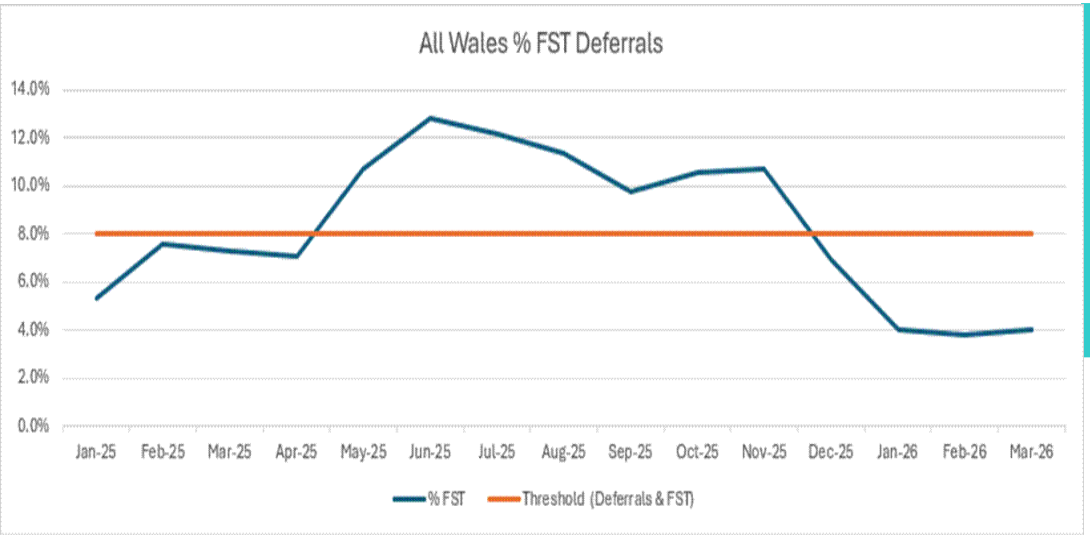
The main themes and opportunities for improvement related to **appointments, communication issues, clinical assessment/ treatment, Access to Service and Attitude & Behaviour** mainly within donor collection teams. These concerns continue to be spread across a variety of teams and locations.

LEARNING AND OUTCOMES

Since, clinics introduced secondary point of care testing using a venous sample to provide a more accurate Haemoglobin measurement in December the WBS has not received further concerns relating to this theme. This is a testament to the hard work and dedication by the Clinical Services Team.

Failed Screen Test Deferral Rates and Point of Care Testing:

The All-Wales Failed Screen Test deferral rate continued its downward trajectory, reducing to 4% in January, compared with 6.9% in December, demonstrating ongoing improvement and the sustained effectiveness of venous sampling in supporting safe and appropriate donor selection.



The Donor Contact Centre Team Leaders have implemented a secondary eProgesa search for all staff to identify and update duplicate records.

The Clinical Governance Lead Nurse working towards the following to address concerns related to donors having visited/residency in Chagas/TCruzi risk areas:

- Develop and circulate a Quality & Assurance guidance booklet for all WBS Registered Nurses to support consistent understanding and communication regarding Chagas related deferrals.
- Audit of donors from Central and South American countries who have been deferred since Chagas testing was discontinued.
- Present audit findings at the Clinical Consultant and Lead Nurse meeting on 18/02/2026.

Outcome of nurse meeting:

✓ Establish a working group to explore the implications of potentially reintroducing Chagas testing, including costs, resource requirements, and wider operational or clinical impacts.

✓ Discuss topic at the WBS RN forum to support a standardised approach across Wales.

Heat map for the National Patient Experience Survey at VCS

Figure 6 **1038** patients (9.4% of 11,096 patients) provided feedback through the Patient Experience Survey showing a continued steady increase from previous Quarters.

Directorate	Responses	3 - Was the time you waited:	4 - Did you feel well cared for?	5 - Were you treated with dignity and respect?	7 - Were you able to communicate in your preferred language?	8 - Did you feel that you were listened to?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Were things explained to you in a way you could understand?	11 - How would you rate your overall experience?	Overall
		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Acute, inpatient & palliative medicine	235	90	98	99	100	97	96	96	96	96
Radiation services	153	95	98	99	100	98	96	99	97	98
SST Services	326	81	93	96	99	93	93	94	92	93
Systemic Therapies	324	94	97	99	99	97	94	94	96	96
	Overall	**89**	**96**	**98**	**99**	**96**	**95**	**95**	**95**	**95**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	

Directorate	Response %
Acute, Inpatient & Palliative Medicine	22.6%
Radiation Services	14.7%
SST Services	31.4%
Systemic Therapies	31.3%

Although SST Services is below the benchmark for waiting times at 81%, this is an increase to the previous quarter, which was 76%.

3.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

95% were happy with their experience

11% Felt the time they waited was longer than expected

96% Felt well cared for

4% included that the question wasn't answered and the main feedbackk was due to appointments and waiting times.

98% felt they were treated with dignity and respect

1046 patients in total completed a feedback survey - 7% increase from Q3 2025/26

5% Felt their care was not always explained in a way they understood

Figure 7

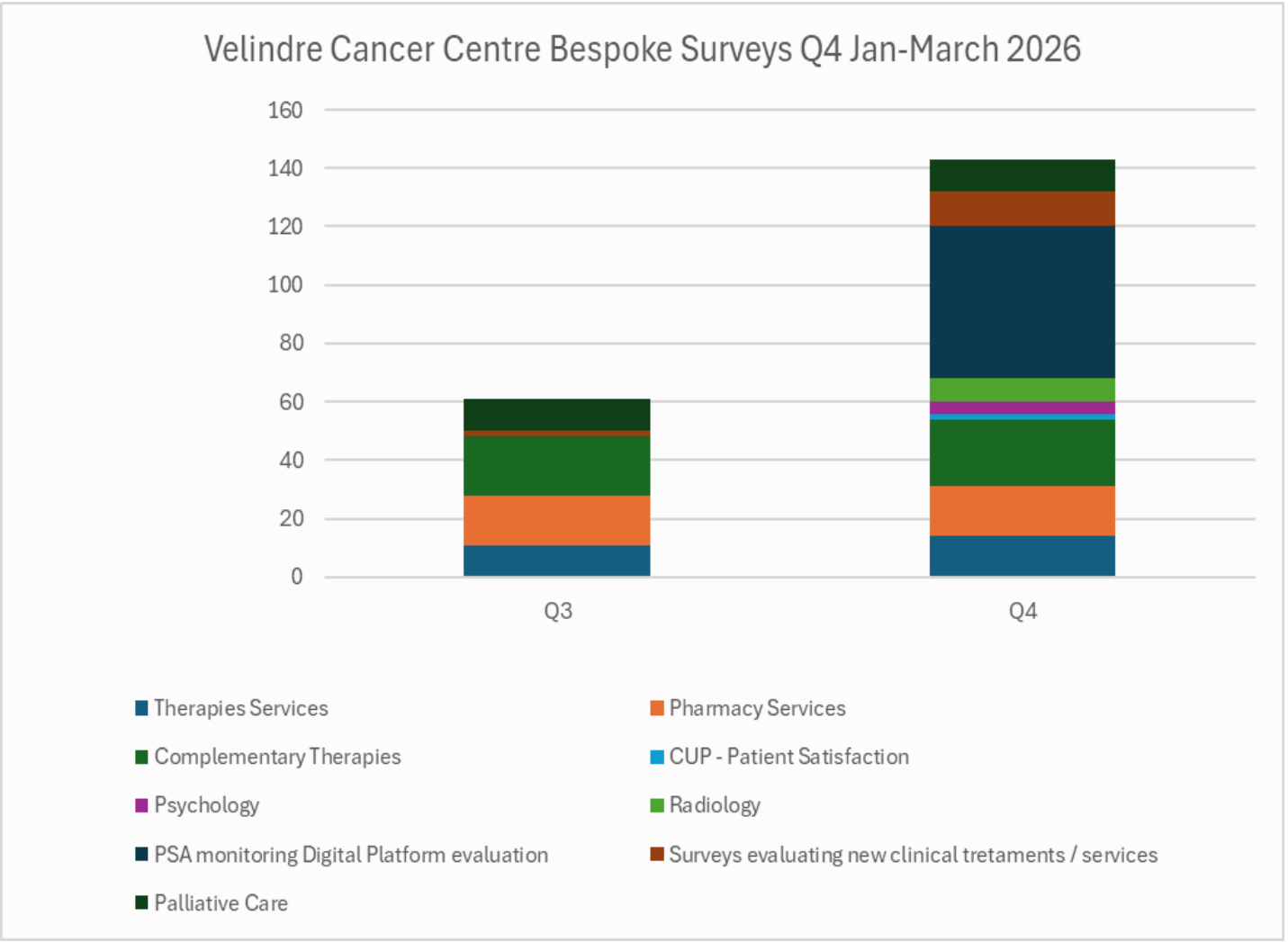


Figure 7 represents surveys and questionnaires that have been created through the CIVICA platform to evaluate and seek feedback on particular services or aspects of care / treatment at VCS. **139** patients undertook a bespoke survey in Q4, a significant increase from 51 in Q3. This demonstrates a ambition from individual teams to improve and develop their services, as well as evaluate new services, test and learn their impact and ensure continuous refinement.

The results of these surveys will be fed back through divisional quality & safety meetings in future reports.

There is a continued focus on increasing patient feedback within Velindre Cancer Service. Working in collaboration with Patient and Carer Partnership Board and the Patient Engagement Lead.

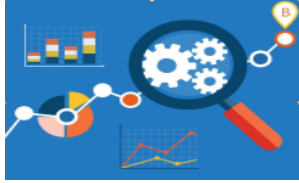
3.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

You Said	Together We Have
• Patients did not feel that the new heat pads being used on the SACT units to assist in cannulation were as effective as using buckets of warm water	• Explained to patients that due to health and safety, and infection control considerations **when** using warm buckets of water, practice has recently changed.
• Patient has reported that the hospital gowns at Radiotherapy are too small. The patient felt exposed at the back.	• The team has welcomed this feedback and we are trialling a different system for gowns.

We asked
You said
Together we have

Patient Stories

3 Patient Stories have been recorded and shared through Directorate Quality, Safety, Risk and Patient Experience Meetings - 1 regarding experiences with appointment letters, another sharing their experience of a medication error, and another sharing their challenges and experience through complex treatment



Wall of Thanks

The care I received on Rowan today was absolutely second to none.

Thank you for everything you do for us all. You truly are heroes! Every single one of you

To all the hardworking and caring people in the OPD reception team, thanks for the wonderful times shared this year

To all you lovely people on Reception, thank you for your kindness and your lovely smiling faces every day I attended.

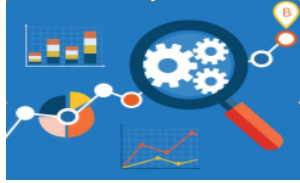
Just remember, that for everyone difficult person, there are 99 that appreciate you

Your guidance and encouragement helped her so much and gave her so much strength. We are deeply grateful for the compassion you showed throughout

A special thank you to Jayne and Debbie who have gone above and beyond to help me on my visit to Velindre. I cannot thank you enough, it means everything to have a cheeky welcome. Both bent over backward to be helpful

Thank you for your care and support throughout this journey. I could not have got through it without you

Although I was very scared, your team made me feel safe, supported, and cared for



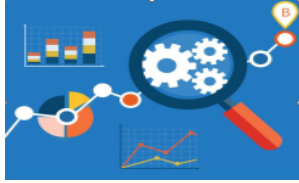
Q3 Engagement Highlights – Head of Patient Engagement

- Close of Cardiff and Vale UHB Improving Cancer Journey project – stakeholder event
- Attendance at Inspired to Soar – Seen Heard Valued engagement event to hear experience of ethnic minority communities and cancer treatment
- Attendance at Llais Women's Health Public Forum
- Attendance at Merthyr Voluntary Action Children, Young People and Family Forum
- Introduction of CONVO British Sign Language Video Relay Service which provides 24/7 access for patients and the public.

1st Trust sponsored research protocol reviewed by PCPB

Introduction of CONVO British Sign Language Video Relay Service

3.2 VELINDRE CANCER SERVICE – PATIENT ENGAGEMENT



Topic	Type	Purpose	Outcome
Call 4 Concern	Engagement and Co-production	To ensure VCS process and information materials are accessible, etc.	Draft information materials, prototype for future areas of work. Easy Read materials.
2 Young Ambassadors Opportunities and Newsletters	Engagement and Communication	Youth Engagement	Opportunity for engagement with patients and staff
Oncology Academy Communication Focus Group	Engagement and Co-production	To hear lived experience to feed into development of course materials. The focus was on sensitive or difficult communication experiences.	Incorporated into Postgraduate module in Advanced Communication and Psychological Skills.
2 Patient and Carer Partnership Board Meetings	Engagement	Engagement/Input into topics.	See previous slide.
2 Patient Story at Educational Events	Story	Sharing of Lived Experience to students	Educational
Patient Engagement in Trust Sponsored Research	Engagement and Co-production	To ensure there is robust patient engagement into Trust initiated research.	Draft process and feedback into first trial.
Use of AI in Outpatient Clinic Administration	Engagement and Co-production	Patient Voice	Review of patient information and consent materials.
Radiology Patient Engagement	Engagement and Co-production	Patient Voice	Review of patient information and consent materials. Naming Convention for new VCC
Victory for Velindre Welsh Baccalaureate Dragons Den	Youth Engagement	Education, support for schools, etc	Raising awareness of cancer, Velindre, supporting curriculum

3.2 VELINDRE CANCER SERVICE – PATIENT ENGAGEMENT

Topics	Type	Output
Increasing diversity within volunteers and boards members	Engagement	Development of stakeholder list and targeted plan to inform stake holders of opportunities etc.
Trust Pharmacy, medicines and Prescribing Practice Strategy	Engagement and Co-production	To inform development of strategy principles.
Velindre Cancer Chairty	Engagement and Co-production	Information materials for 'Leaving a gift in your Will' and free Wills initiative.
VCC Radiology Department Quality Standard and Patient Engagement plan	Engagement and Co-production	Review of patient information. Naming convention in nVCC.
Patient Representation on VCS key meetings/Trust Committees	Engagement	Ongoing discussions with Trust chair, Chief Executive and Chief Operating Officer.
IMPULSE Research Study	Engagement and Co-production	Engagement into Trial protocol, information and consent.

3.3 WELSH BLOOD SERVICE – DONOR EXPERIENCE

The Welsh Blood Service values all donor feedback received in helping to understand both successes and further opportunities to improve. We capture, analyse and trend our donor experience feedback and share it, along with actions taken in response, with our donors, their families and staff inline with the requirements of the Duty of Quality. There are the results of the Civica Surveys and digital on-session feedback forms. Number are lower for quarter 4 due to issues with the Civica application.

98%
Were overall satisfied with their care

100%
Said things were explained in a way they could understand

6% (1,272)
Of 21.010 donors provided feedback

100%
Said they were listened to

100%
Said they were treated with dignity and respect

Service Group	Responses	2 - Was the time you waited:	3 - Did you feel well cared for?	4 - Were you treated with dignity and respect?	6 - Were you able to communicate in your preferred language?	7 - Did you feel that you were listened to?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Were things explained to you in a way you could understand?	10 - How would you rate your overall experience?	Overall
		Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	
WBS	1272	95	99	100	98	100	100	100	98	99
	Overall	**95**	**99**	**100**	**98**	**100**	**100**	**100**	**98**	**99**
	Benchmarks	85	85	85	85	85	85	85	85	0

Wall of Thanks

East A - "Friendly staff at every step from arrival to getting my club orange biscuit."

East B - "Staff were friendly and informative. The whole process felt very relaxed, and I felt very well looked after."

East C - "It seemed like a very happy working atmosphere which made my experience a good one."

West - "Adrian, Rod and Kathy were very professional and caring thank you."

Reception - "Very clean and very pleasant staff."

Bangor - "I enjoyed my time here dealing with knowledgeable and super friendly staff."

Apheresis - "The Apheresis staff in Talbot Green are amazing, they're a credit to themselves and the WBS they're genuinely lovely people and brilliant at their jobs."

East C - "It seemed like a very happy working atmosphere which made my experience a good one."

3.4 WELSH BLOOD SERVICE – DONOR ENGAGEMENT

Welsh Blood Service undertakes a monthly email survey to improve donor retention and evaluate donor satisfaction from initial contact to post-donation experience. Survey results are reviewed, and the overall satisfaction score is reported to Welsh Government.

Q3 Satisfaction Scores for those who had successfully donated		Q3 Satisfaction Scores for all those who had attended a donation	
92.9% (2,577) Overall, Donor Satisfaction		89.5% (2,813) Overall, Donor Satisfaction	
Bangor (208) 93.3%	Wrexham (382) 93.2%	Bangor (234) 89.3%	Wrexham (415) 89.2%
East (1,399) 92.1%	West (588) 94.7%	East (1,530) 88.5%	West (634) 92.3%

Q4 Satisfaction Scores for those who had successfully donated		Q4 Satisfaction Scores for all those who had attended a donation	
93.6% (2,014) Overall, Donor Satisfaction		91.3% (1,995) Overall, Donor Satisfaction	
Bangor (147) 96.6%	Wrexham (293) 93.5%	Bangor (159) 93.1%	Wrexham (315) 89.8%
East (1,034) 91.8%	West (408) 97.1%	East (1,089) 89.5%	West (432) 96.1%

3.4 WELSH BLOOD SERVICE – DONOR ENGAGEMENT CONT.

Response Summary – About the respondents

2,014 Completed Responses

95.7% would donate again

92.6% Net Score

17-86 Age range

933 Male (46.8%)

159 Bangor (8.0%)

315 Wrexham (15.8%)

432 West (21.7%)

58 Average Age

1,062 Female (53.2%)

366 East A (18.3%)

367 East B (18.4%)

356 East C (17.8%)

National Satisfaction Scores (for successfully completed donations)

Satisfaction Scores of 9 or 10

93.6% National Satisfaction

Bangor 96.6%

Wrexham 93.5%

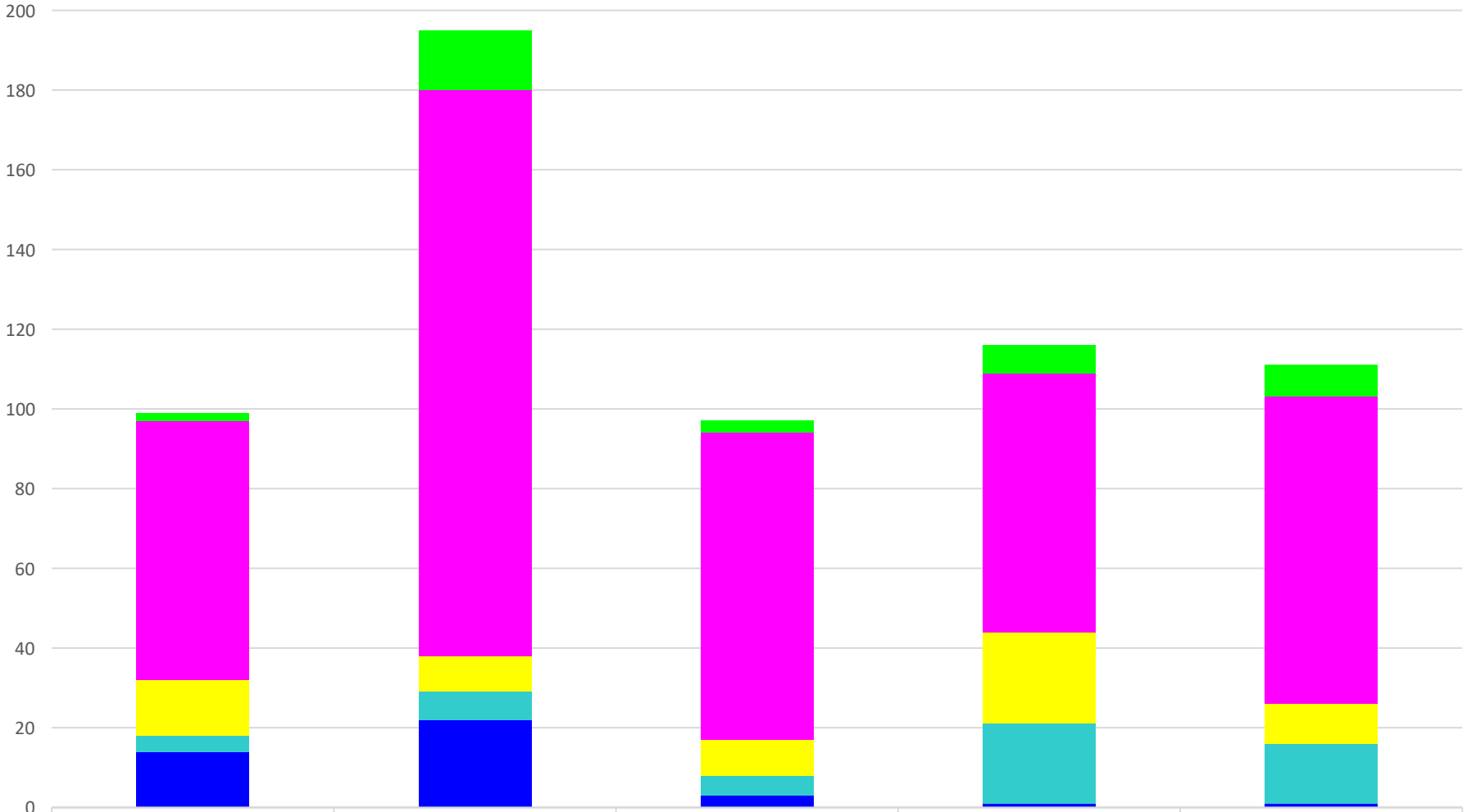
East 91.8%

West 97.1%

3.5 TRUST OVERVIEW – COMPLIMENTS

Figure 8

Compliments Received Trust-wide (Top 5 Locations)



	24/25 Q1	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4
Clinical Nurse Specialists	2	15	3	7	8
VCC Radiotherapy Department	65	142	77	65	77
Radiology Department (XRAY)	14	9	9	23	10
Outpatients Department	4	7	5	20	15
Velindre Cancer Service	14	22	3	1	1

3.5 TRUST OVERVIEW – COMPLIMENTS CONT.

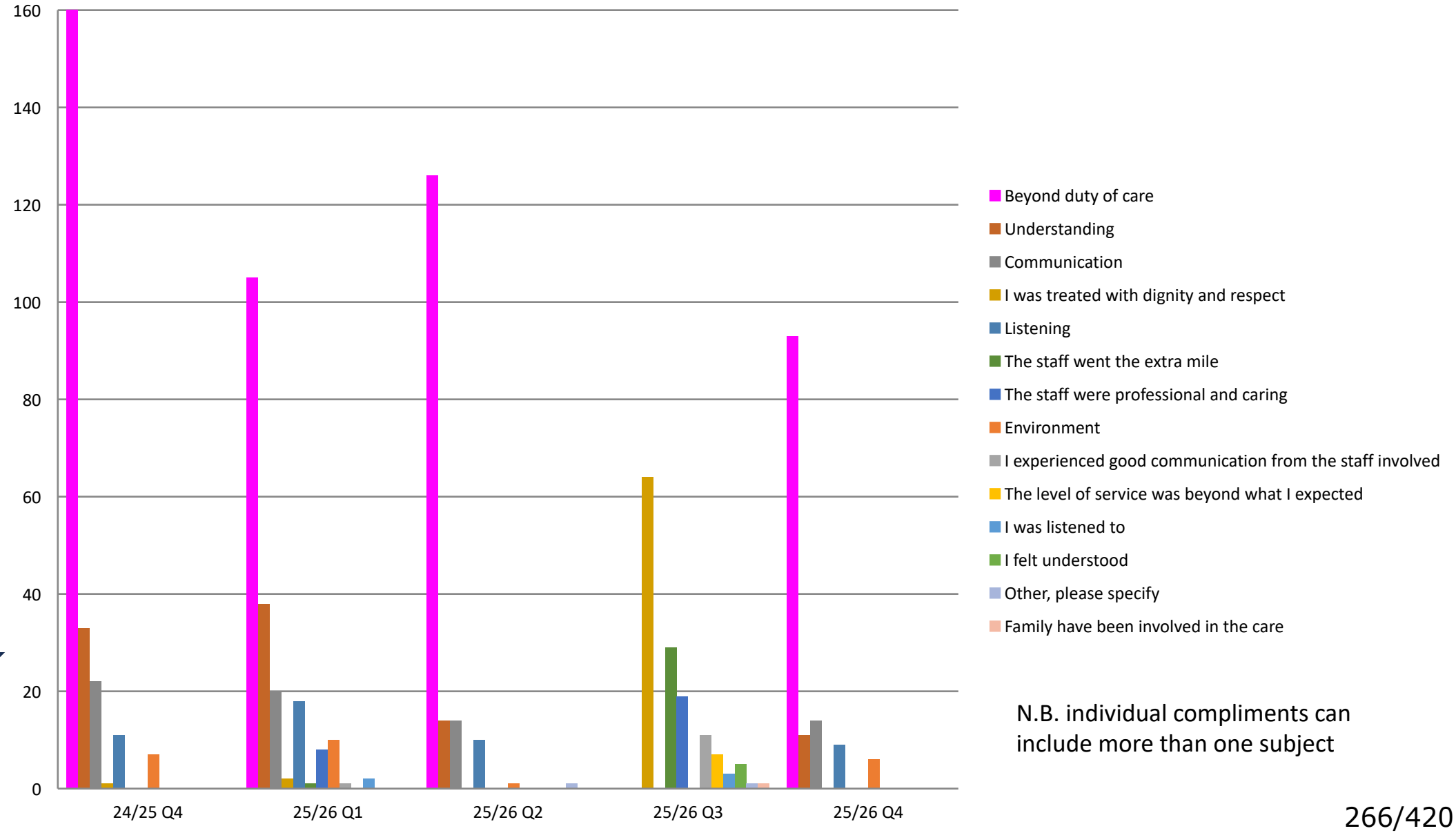
Figure 9

Compliments Received by Subject (Q4 2024-25 to Q4 2025-26)

126 Compliments were recorded on Datix

120 were recorded for Velindre Cancer Service

6 were recorded for Welsh Blood Service



N.B. individual compliments can include more than one subject

3.6 TRUST OVERVIEW – Digital Patient Reported Outcome Measures (PROMS)

The digital PROMS platform is in use across 4 VCS teams (lung, neuro-oncology, Cancer of Unknown Primary and prostate). Since implementation in September 2025, over 1600 sets of PROMS or Digital Health Assessments have been received, with more than 6,500 patients enrolled onto the system. **[WHAT HAVE WE DONE WITH THIS?]**

Work is ongoing to understand the true service response rate as a proportion of patients do not have valid contact details and therefore cannot receive digital health assessment requests. The team is also working to restart PROM collection in Colorectal which was paused shortly after go-live due to issues with the configuration that resulted in discharged patients being contacted. This issue was logged with the necessary bodies and all affected patients contacted to apologise.

A stand-alone tool for assessing Prostate patient urinary symptoms is going live in Q1 26/27.
Pathways under development include Bladder, Neuroendocrine Tumours (NETS), Anal cancer and Virtual Assessed Patients (VAP). The use of digital health assessments to support teams that contact patients routinely by phone with symptom checklists will be a focus for the coming year.

4.1 INCIDENTS – DUTY OF CANDOUR

54 Incidents were initially reported as having caused potential moderate harm

Following review, 3 Incidents Triggered the Duty of Candour

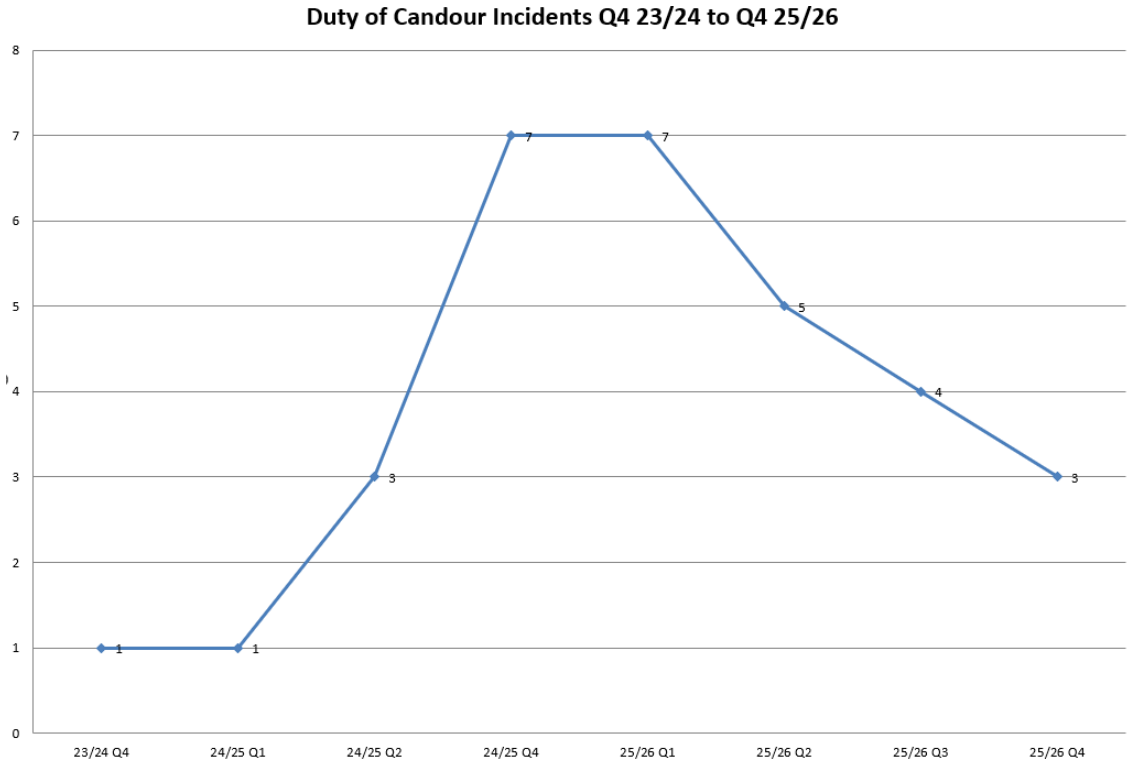
2 incidents triggered national reporting

Figure 11

Reporter's initial harm assessment	Manager's interim harm assessment	Number of Incidents Regraded
Severe	Moderate	1
Severe	None	1
Severe	Low	5
Catastrophic / Death	None	1
Catastrophic / Death	Low	1
Catastrophic / Death	Catastrophic / Death	1
Moderate	None	11
Moderate	Low	24
Moderate	Moderate	2
Moderate	Severe	1
Moderate	Blank	6
Low	Moderate	1

Harm Assessment Grading of Incidents
Following initial management review with appropriate clinical review, the incident grading was revised as demonstrated in Figure 11 .
Support is provided by Datix leads to reporters regarding appropriate grading of incidents.

Figure 12



ANALYSIS

As shown in Figure 12, the Trust has seen a continued decrease in the number of incidents triggering the Duty of Candour since Q1.

4.2 INCIDENTS – DUTY OF CANDOUR CONT.

4 Speedy Cascades circulated

11 Rapid Review Meetings

Themes and learning identified from significant incidents (potential moderate or above harm)

- Escalation, management and transfer of unwell VCS patients
- Accuracy of completion of All Wales Transfusion Record (AWTR) to ensure risks recognised.
- Triage assessment and advice provided by VCS Treatment Helpline
- Follow up of patients with prostate cancer requiring radiotherapy.

Learning and Improvements

A review of First Floor Ward and Ambulatory/Assessment Unit nursing documentation is underway.

Supportive treatment (iron / magnesium / blood infusions) bookings will now be undertaken by the Ambulatory Care Co-ordinator instead of the SACT bookings team. In addition, work is being undertaken to review the Ambulatory bookings process, and a move to a more digital solution to move away from e-mails.

'Druggles' have been commenced at Ward MDT's: These are a five minute presentation including a hot topic (ideally suggested by a member of the MDT), anonymised error of the week (to provide feedback in real time and share learning from the error) and the results from the weekly prescribing audit. The aims of the druggles are to increase communication between the MDT, to educate staff on specific topics relating to medicines, to highlight areas for improvement and to encourage discussion.

4.2 INCIDENTS – DUTY OF CANDOUR CONT.

1 Learning From Event Reviews (LFER) submitted

4 Duty of Candour investigations concluded

Themes and learning identified from significant incidents (potential moderate or above harm)

- Incorrect transcription of blood results with reliance on a manual procedure vulnerable to human error
- The absence of robust, standardised processes for the management of post-treatment follow-up for prostate cancer patients
- Radiotherapy planning processes to ensure the correct number of appointments are booked
- Lack of robust procedures for escalation and management of unwell patients within Velindre Cancer Centre

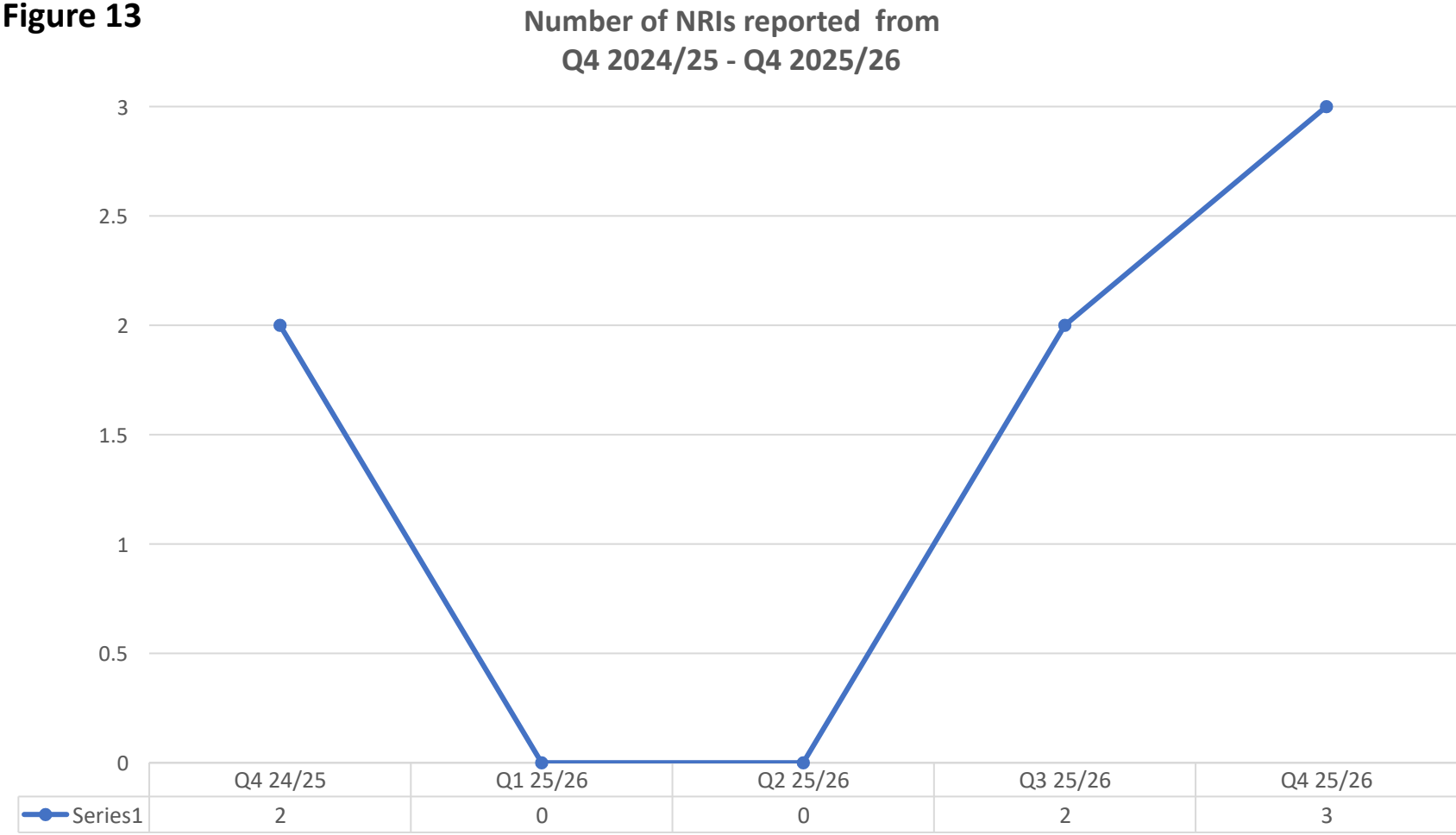
Learning and Improvements

- The requirement to improve medical cover within first floor ward has been recognised through incident learning and feedback. From February 2026 there will be a resident doctor, increasing continuity of care.
- As part of our Dietetic Service improvement plan, new procedure and guidance has been written for outpatient consultations – both face to face and via telephone, with the intention of improving patient experience by reducing hospital visits, and increasing capacity
- The use of email to communicate clinical information between clinicians, physics and radiographers in the has been reduced through use of ARIA carepaths and journal notes. These also form a record of decisions/changes/updates made at each stage of pathway
- **'Assessment Criteria for Inter-Hospital Transfer from Velindre Cancer Centre Using Own Transport' -** Standalone document developed initially, however, it will eventually form part of a wider VCC Transfer SOP, ensuring that there is clear guidance and criteria for safe, and timely decision making.

4.3 NATIONAL REPORTABLE INCIDENTS (NRI) TRUST WIDE

3 Nationally Reportable Incidents

Figure 13



Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

Death:
A service user dies and the NHS care did or may have contributed to the death.

4.4 IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS (IR(ME)R) REPORTABLE INCIDENTS

Radiotherapy Physics led investigations:

3 notifications due to known issues with imaging equipment.

1 notification due to a machine fault on La8 (Elekta) which resulted in additional verification images being acquired and affected multiple patients.

1 notification due to an Multileaf Collimators (MLC) error which resulted in additional verification images being acquired and affected multiple patients.

1 notification related to poor quality images acquired using a specific imaging preset selected for patients with artificial hip(s) on the Ethos linacs which affected multiple patients.

None of these incidents are clinically significant but did meet the SAUE Criteria for reporting to HIW.

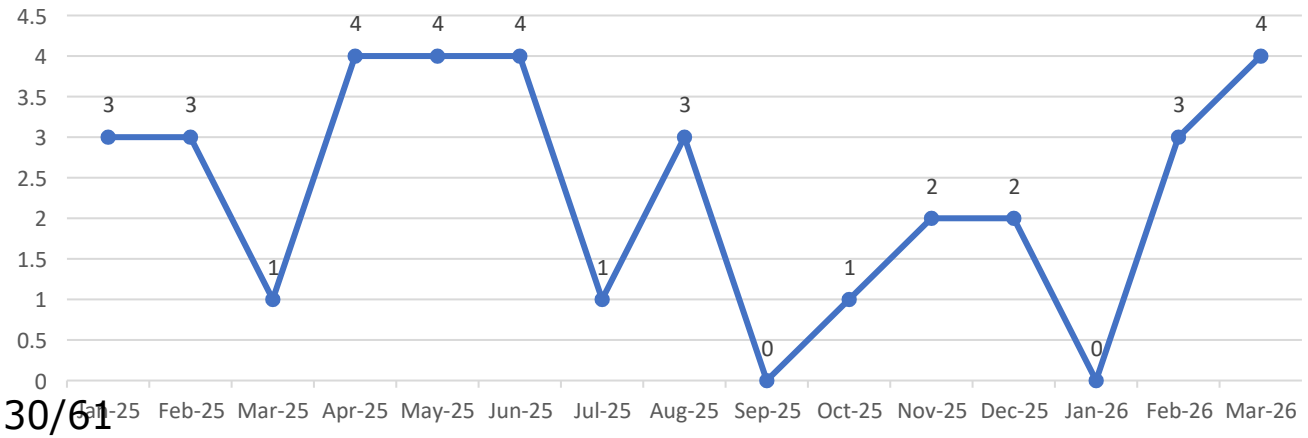
Radiotherapy Service-led investigations:

1 notification for a patient received **3** or more imaging exposures in a single fraction – due to a combination of equipment fault and incorrect manual application of couch correction movements. This incident is not clinically significant.

Seven in total Significant Accidental or Unintended Exposures (SAUE) under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R were reported to Health Inspectorate Wales (HIW).

Figure 14

Significant Accidental or Unintended Exposures reported under IR(ME)R



The fault with specific imaging equipment is long standing with established mitigations, which have been discussed in depth with the UK Health Security Agency (UKHSA).

4.5 VELINDRE CANCER SERVICE – INCIDENTS

Figure 15

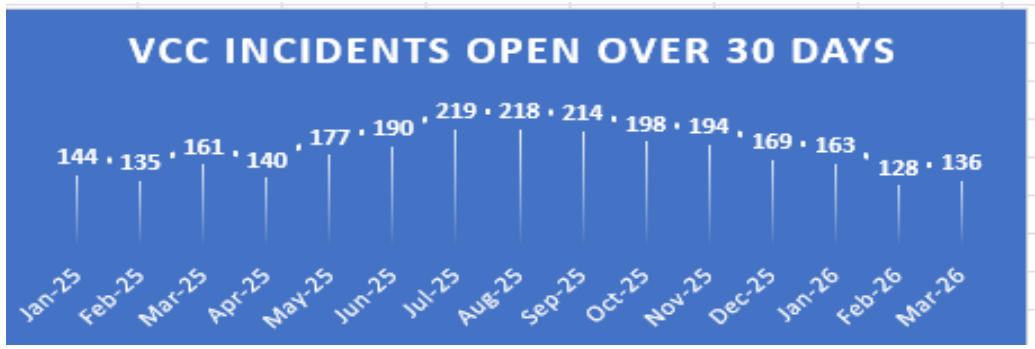


Figure 15 shows a decrease in the number of incidents open over 30 days across the Cancer Service. Work is ongoing with departments to continue to improve, including regular reports and incident management training and education. Heads of Nursing and General Managers started in Quarter 3 and are providing robust oversight and ownership. An acceptable level of no more than 25% of new incidents open over 30 days has been set in Quarter 4 with a mechanism for escalation.

Figure 16

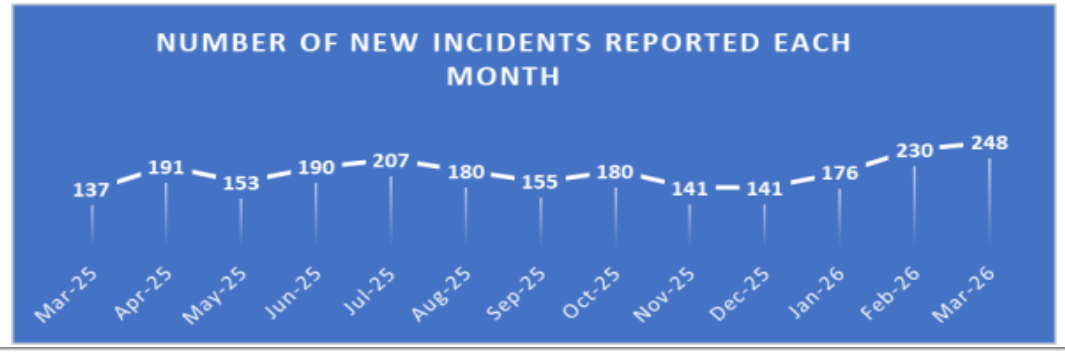


Figure 16 shows fluctuation in the number of incidents reported each month. 654 incidents were reported in quarter 4 which equates to **4.2%** of patients that attended Velindre Cancer Service. There has been a steady increase, in incident reporting this could be attributed to an improved reporting culture. However, this will be monitored to identify any specific trends over time.

Figure 17

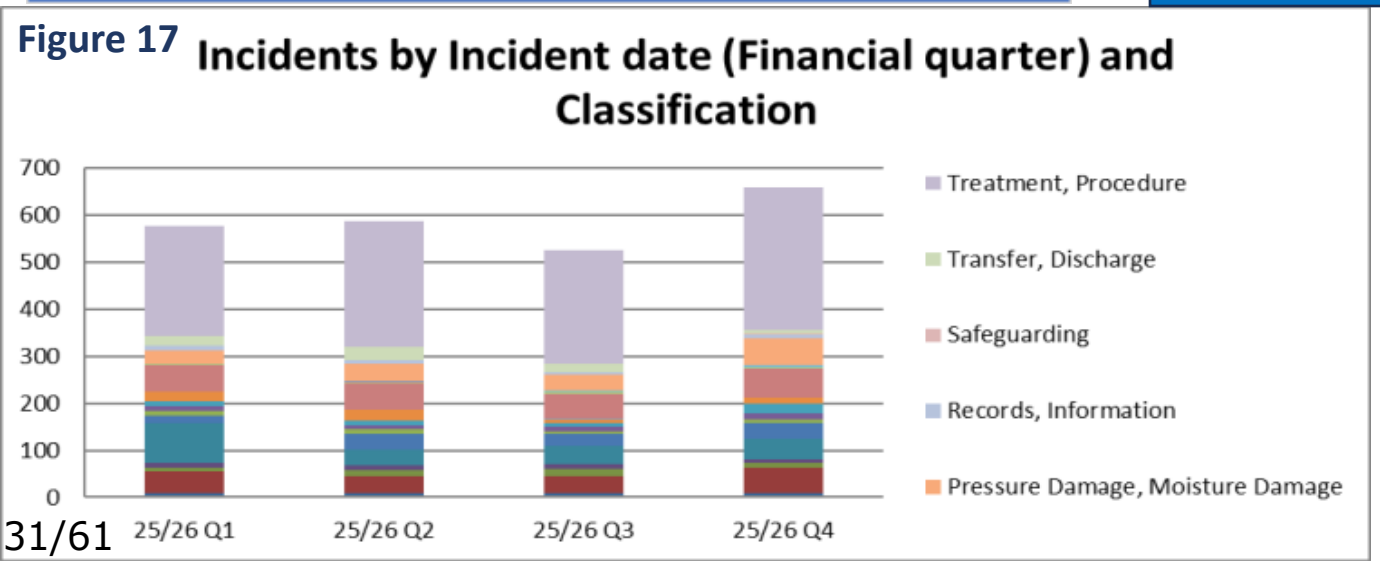
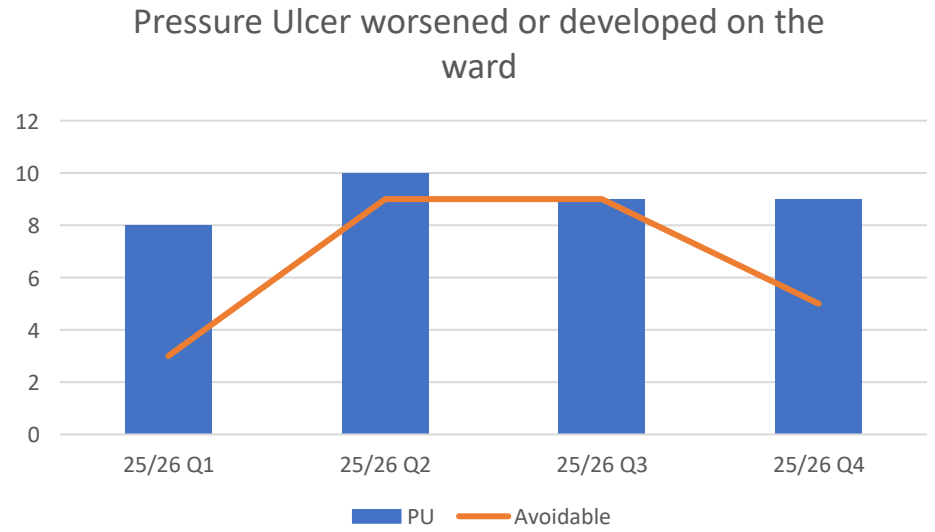


Figure 17 identifies that the highest number of incidents related to **'Treatment and Procedure'** which is in keeping with previous reporting periods. The majority of these relate to no harm and near miss incidents associated with Radiotherapy and is a Trust requirement to record on the Datix system.

4.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Figure 18



Whilst **Figures 18** does show a continued high level of pressure damage that developed or worsened during an inpatient admission to Velindre Cancer Service, encouragingly a reduction was seen in reported incidents during February and March with . All cases have been investigated and discussed in monthly Pressure Ulcer Learning Panels and in quarter 4. No acquired or worsened pressure damage was above a grade 2, though 5 cases have been found to be avoidable. Improving the prevention and management of pressure damage is a priority for VCS in quarter 1 2026/2027.

Key updates and Improvements in Q4:

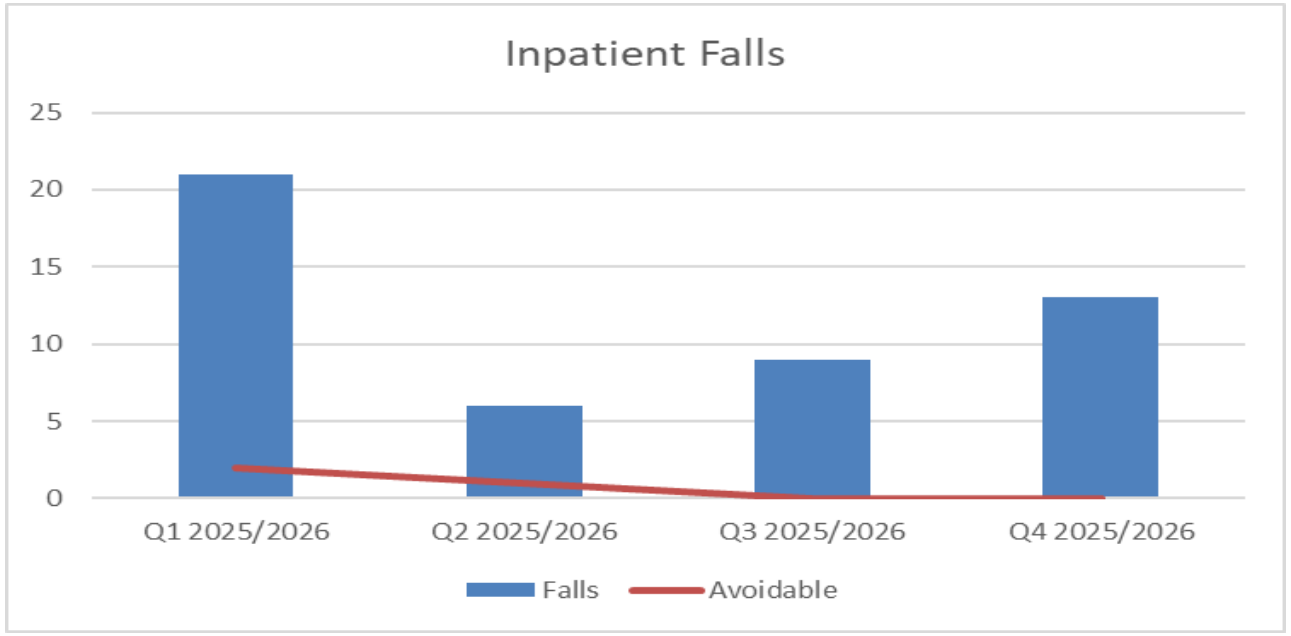
- Procurement of new mattresses that were delivered in March
- Implementation of a new mattress framework in align with All Wales guidance which has been shared with all ward teams to support appropriate equipment allocation
- Training compliance has improved. Several members of staff have attended Cardiff & Vale sessions on mattress selection and pressure damage catagorisation.
- Champions have been identified within each unit, Work is underway to finalise the roles and responsibilities associated with the champion role
- A pressure prevention care plan is now implemented for all patients identified as being at high risk of skin damage or deterioration

Future Developments to be undertaken in Q1 2026/2027:

- Velindre cancer Service are exploring opportunities to establish a Service Level Agreement with Cardiff and the Vale Tissue Viability Services. This would aim to enhance support related to nursing resource, documentation standards, research collaboration, and overall service quality.

4.5 VELINDRE CANCER SERVICE – INCIDENTS CONT.

Figure 19



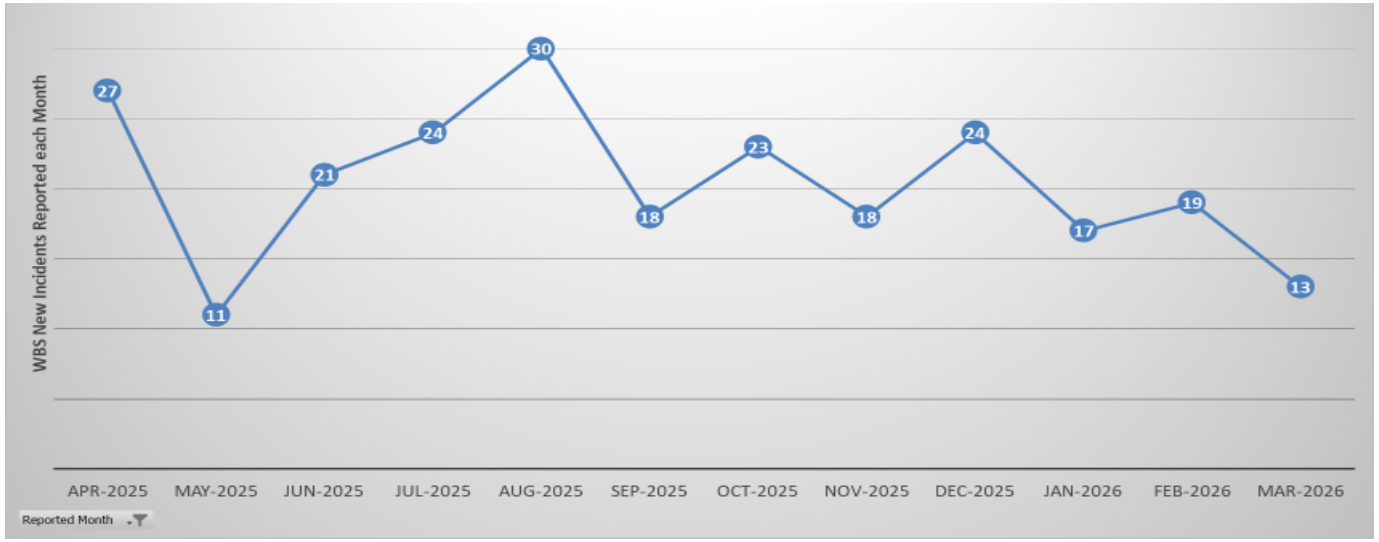
Positively, there have been no avoidable falls at Velindre cancer Service in the last six months. During Quarter 4 one fall resulted in a patient injuring her ankle, a thorough review was undertaken and the fall was considered unavoidable. No harm was sustained in any of the other falls during Quarter 4. Although avoidable falls have remained low overall, emerging themes highlight the need to strengthen the use of the investigation tool and address gaps in falls-prevention training to ensure consistency and improve learning across teams.

Falls training package has been identified on ESR, however this is being reviewed to ensure its suitability for Velindre Cancer Service and in line with Velindre Cancer Services Falls policy.

4.6 WELSH BLOOD SERVICE – INCIDENTS

Incidents which may result in harm to patients, donors or staff are reported in Datix Cymru

Figure 20



ANALYSIS

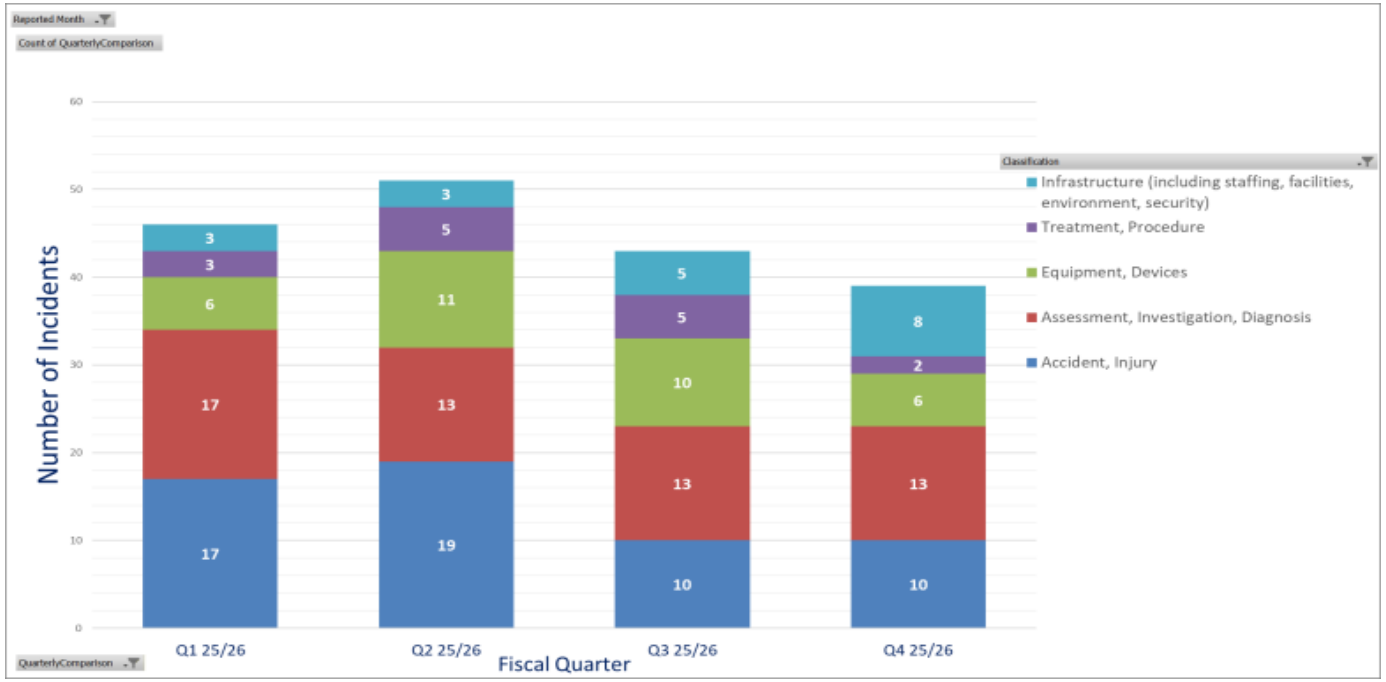
Figure 20 shows a decrease in the average number of incidents reported during Quarter 4 compared to Q3; there are a small number of events, over a wide range of classifications and no specific contributory factors . There has been a decrease, in incident reporting it is not clear the reason. Overall, the number of reports remains low, with no significant trends identified; monitoring of reports for trends is continuous.

OVERDUE ACTIVITY

The number of incidents exceeding the 30-day target date for closure (KPI.35) has decreased **significantly during Q4: January n=13, February n=5 and March n=5. The Q4** average was **n=8 compared to n=15 in Q3**. This improvement may have been driven by a greater focus on data included in the Trust's Performance Management Framework (PMF).

The number of **overdue actions has peaked at n=30 in February, with the monthly average increasing from n=20 (Q3) to n=22(Q4)**. This performance is again attributable to a number of actions being assigned within specific areas (most notably RCI Laboratory), combined with a limited resource to complete those actions.

Figure 21 Incidents by theme (top 5) – Quarterly comparison



ANALYSIS

As seen in Figure **21**, the most frequently reported themes in **Q4** are consistent with previous quarters.
All events were assessed as low/no harm and have been subject to investigation; no significant trends/themes have been identified.

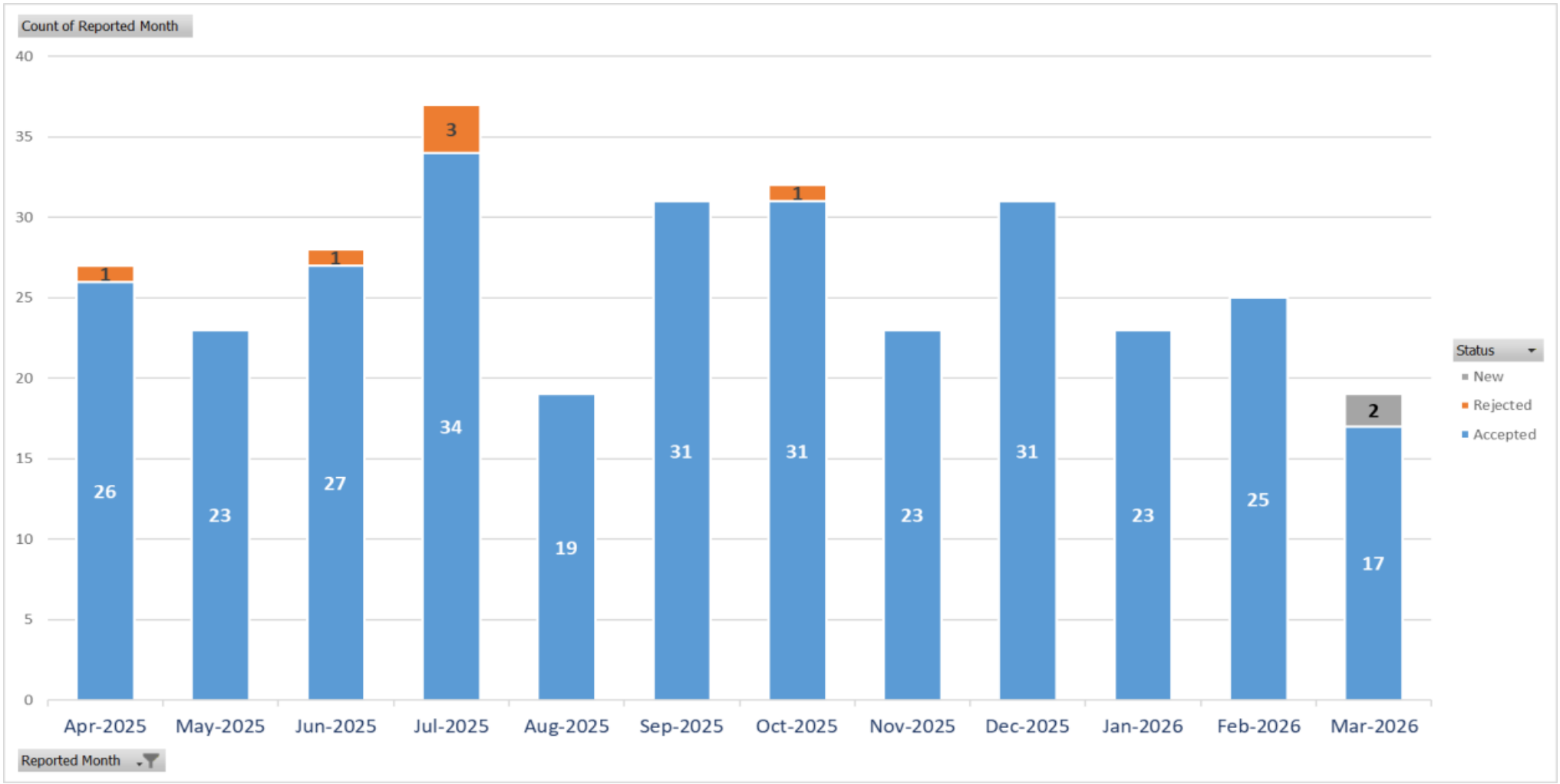
- 'Assessment, investigation, diagnosis' (n=13): Three of these are SABRE reportable events (see slides 38 and 39) and four relate to information provided by the donor after they had donated. In these four cases there was no deviation from process; the donor had not provided sufficient information at the time of donation to enable staff to make a decision to defer the donor
- A greater number of 'infrastructure' events have been reported this quarter (n=8), however, no trends have been identified.

*More information on accidental injury and information governance (IG) can be found in the Health & Safety and IG sections of the report.

Good Manufacturing Practice (GMP) Incidents are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS), in line with regulatory standards.

Figure 22

GMP Incidents reported via Q Pulse



4.6 WELSH BLOOD SERVICE – INCIDENTS CONT.

ANALYSIS

Figure 22 shows **67** GMP incidents were reported in **Q4** (2025-26) which is fewer than the previous quarter, n= 86

The highest number of reports continues to relate to **laboratory errors (n=24) which is significantly fewer than the previous quarter (n=35)**

8/24 laboratory errors are associated with the previously reported trend in manual transcription errors within antibody screening reports (RCI Laboratory). These errors are related to process complexity, coupled with manual data transcription.

The Red Cell Immunohematology (RCI) Laboratory processes for linking and reporting have been independently reviewed this quarter, along with a detailed analysis of RCI Laboratory incidents occurring between July 2025 and January 2026, and a second assurance/effectivity review of mitigating actions that are already in place.

LEARNING AND OUTCOMES

49% (20/41) of incidents reported by RCI Laboratory (between July 2025 and January 2026) **are reporting and transcription errors**, including some that were externally reportable to MHRA.

Monthly analysis of data shows that some mitigating actions have moved forward in assurance level, but **reporting errors continued to reoccur and the overall number of these incidents has stayed broadly the same.**

Root causes are linked to **system-level design limitations** rather than staff performance or isolated workflow issues, and therefore long-term risk reduction is unlikely to come from training or small workflow changes alone. However, a series of practical improvements have been proposed by staff, to aid risk reduction.
The risk aligns with risk nos. 2774 and 3643 on the Trust Risk Register.

Further improvement will require system-level redesign, enhanced digital integration, and controls that reduce dependence on manual transcription and prolonged concentration. The introduction of an all-Wales Laboratory Information Management System (LIMS) is expected to significantly reduce this type of error

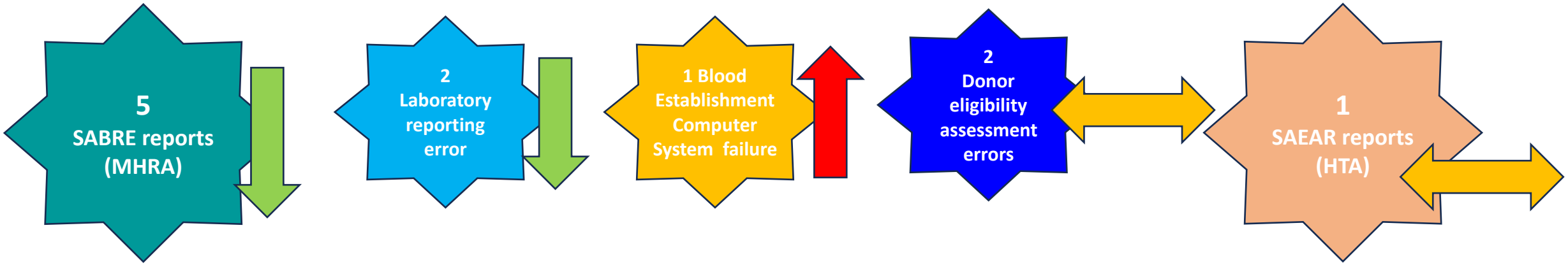
5.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE)

ANALYSIS

Five adverse events were reported to MHRA via the Serious Adverse Blood Reactions & Events (SABRE) portal in **Q4** compared with 7 in **Q3**.

All events were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the divisional Integrated Quality and Safety Hub before submission to the Regulatory body.

One serious adverse events (SAEAR) was reported to the Human Tissues Authority (HTA) in Q4.



4.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE) CONT.

ANALYSIS

Themes identified from SABRE events

There have been **no failures to defer donors due to medication since Q2.** The two donor selection errors reported this quarter relate to a donors not being deferred after receiving an animal bite:

- On both occasions the need to defer a donor was missed at their previous assessment, despite the donors declaring they had been bitten.
- One error is attributable to ambiguity within the relevant donor eligibility question.
- For the second error, it is unclear whether the donor stated they had been bitten outside of the UK as no country is documented.

The frequency of error compared to the number of donors assessed remains small, but each event presents a risk to patient safety if the risk is not identified and managed effectively.

Learning and improvements

The existing animal bite question will be separated into two questions to distinguish between bites from a non-human primate, and bites from other mammals.

Automatic electronic deferrals will be introduced within the Donor Record Management System for animal bites, and staff will be advised to enter the country in which a donor sustained a bite.

These incidents are included as learning scenarios during the Clinical RN meetings and lessons learnt continue to be disseminated across all Blood Donation teams for inclusion in daily briefing discussions.

WBS continue to engage with an external provider to develop a digital tool that supports correct decision making. Trialling this tool was delayed due to staff changes and the recent eProgesa computer system outage. Initial validation has been successful and the trial is now scheduled to begin in May.

4.6 WELSH BLOOD SERVICE – EXTERNALLY REPORTED INCIDENTS (SABRE) CONT.

ANALYSIS

Themes identified from SABRE events

The theme of manual transcription errors in within the laboratory reporting process has continued this quarter.

The manual nature of the reporting process is cause for error from time to time and root cause is known to be process/system related.

Whilst errors of this nature make up 49% of all errors reported by the RCI Laboratory t**he overall rate of error is estimated to be 1-2% of reports issued.**

Learning and improvements

Detailed analysis of RCI Laboratory incidents occurring between July 2025 and January 2026, along with a review of the effectivity of mitigating actions already in place, has concluded that **further improvement will require system-level redesign, enhanced digital integration, and controls that reduce dependence on manual transcription and prolonged concentration**

The introduction of an all-Wales Laboratory Information Management System (LIMS) is expected to significantly reduce this type of error.

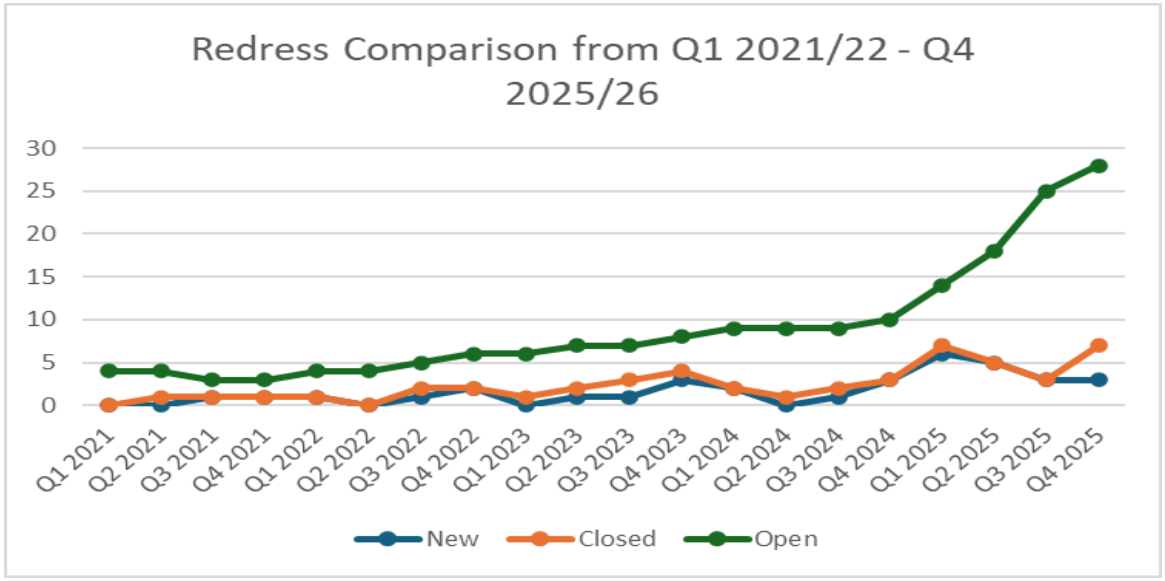
It is accepted that until a fully automated process can be introduced errors are likely to happen occasionally.

(Refer to Trust Risk Register – risk nos. 2774 and 3643)

5. REDRESS

ACTIVITY

Figure 23



The data opposite does not include potential claims, which have seen a rise in the number of potential claims received

3 Reimbursement approvals received from Welsh Risk Pool

As demonstrated in Figure 23, Q4 continues to see a rise in Redress matters. The increase in Redress cases has arisen following the introduction of the Duty of Candour and aligns with the Duty of Candour principles and the Listening to People Process.

3 New Redress cases opened

0 Offer made

0 Qualifying liability admitted

4 Cases closed

21 cases remain under investigation

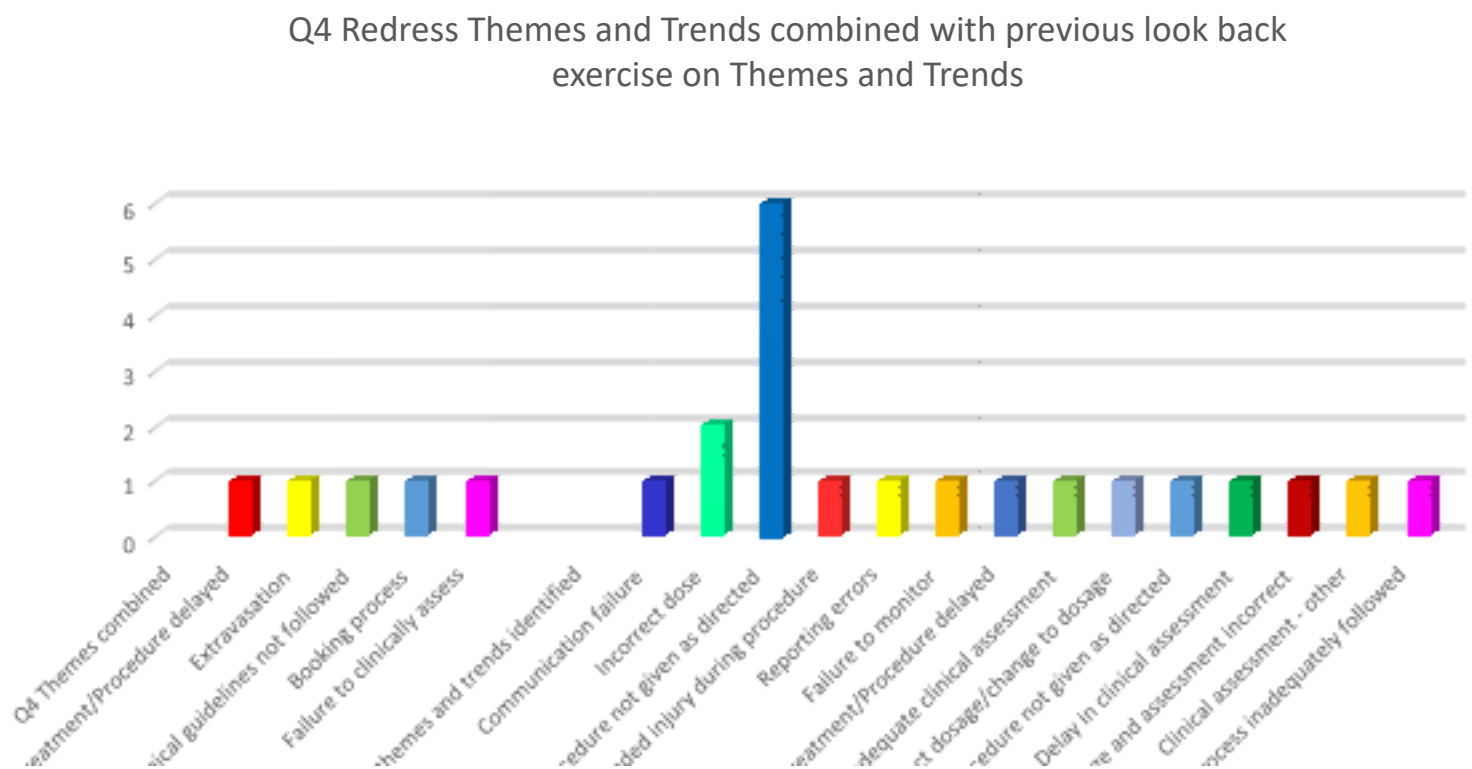
7 cases remain open after 12 months

1 Learning from Events Report submitted to Welsh Risk Pool

5. REDRESS CONT.

Themes identified as the highest recurrence relate to treatment/procedure, either identified as given wrongly or inappropriately, delayed or not given as directed, including the failure to discontinue treatment.

Figure 24



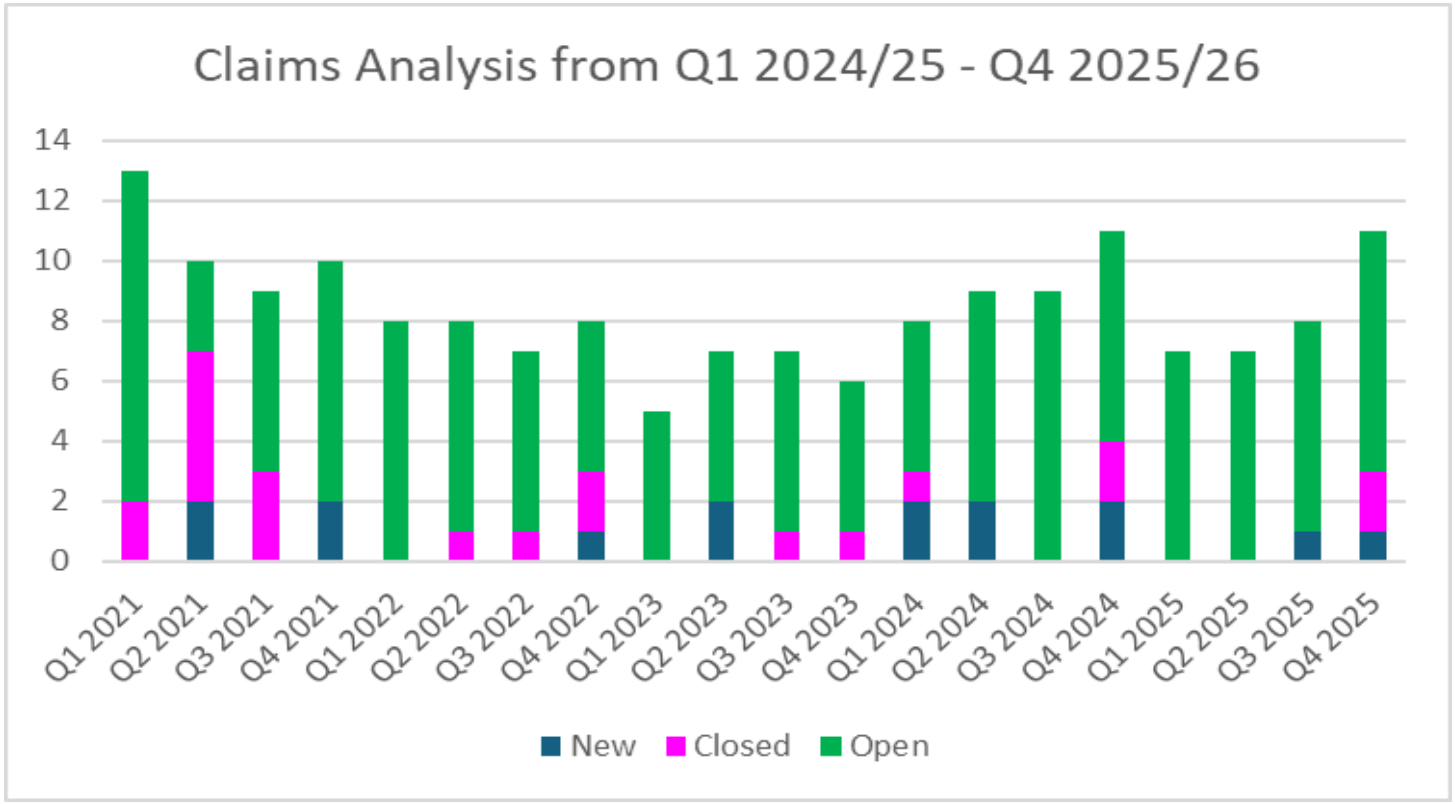
Although the cases remain varied overall, no broader themes or trends have emerged from this quarter's activity; the look-back exercise of themes and trends over the years have identified one theme appearing more than once, concerning instances where treatment or procedures may not have been followed as directed.

6. CLAIMS

Claims activity remains stable this quarter, in contrast to rising trends in Redress and Inquests.

Previous reports have captured potential claims. However, for the purpose of this report only confirmed cases have been captured

Figure 25



1 New claim received

8 claims remain ongoing

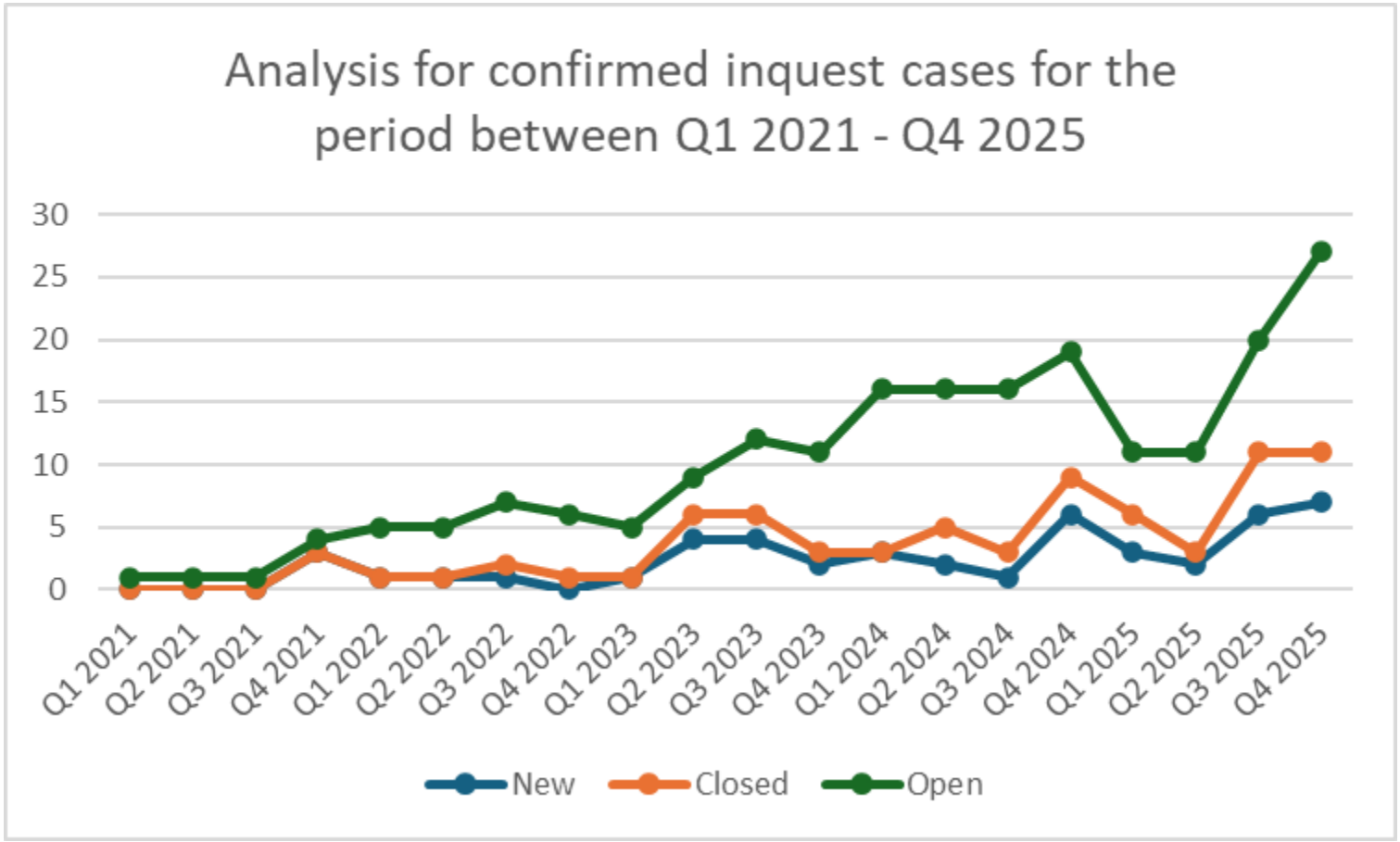
2 claims closed – denial of liability issued

7. INQUESTS

Figure 26 shows there has been a rise in inquests being opened during the reporting period, no trends, themes, risks or issues have been identified relating to the new inquests.

The Trust continues to see a rise in inquest activity. Please note that only confirmed cases are shown in the graph opposite. This does not include potential inquests nor coronial enquiries that are dealt with on the same basis as a confirmed inquest.

Figure 26



8. CLAIMS, REDRESS AND INQUESTS LEARNING

Inquest hearing outcome

Missed opportunity to reduce dose of chemotherapy in line with national guidance, clinical review, and patient request, resulting in patient being admitted to Velindre Cancer Service. The Coroner concluded that the patient died as a result of the adverse effects of the unreduced dose of chemotherapy administered in October 2023.

Key Learning Themes identified

Root identification :
The required reduction in chemotherapy dose was not documented in the clinical records, and the dose was not amended at the time the decision was made in clinic, resulting in the dose remaining unchanged when it was prescribed two weeks later.

Learning :

- Actions included the development of a VCC-wide action plan, monitoring through QSMG and IQSG
  Updating booking and documentation processes, and ongoing review of incidents for themes identified in the report.
- The need for consistent and complete outpatient clinic documentation, adherence to VCC SACT Prescribing Guidelines
- Improved recording of toxicities
- Strengthening documentation and multidisciplinary support in sarcoma clinics
- Updated and timely guideline review and recognition of the reliance placed on pharmacy and SACT nursing checks.

Redress – Learning from Event Key Points

Incident Overview

A supportive treatment, requested in May 2025, was not arranged due to an incorrect booking, lack of communication with the patient, and delayed monitoring, which resulted in an unplanned emergency admission. Whilst no physical harm was found to have occurred, the patient had suffered psychological impact for which a qualifying liability was identified.

Organisational Learning undertaken and shared through VCS Quality, Safety, Risk, and Experience

- The development of a clear Ambulatory Care Standard Operating Procedure
- Updating booking rules
- Undertaking a demand and capacity review - Recruitment of a booking coordinator
- Improved monitoring and follow up between SACT cycles
- Enhancing reliability in patient communication, and greater oversight of complex manual booking processes.

9. MORTALITY

Figure 27

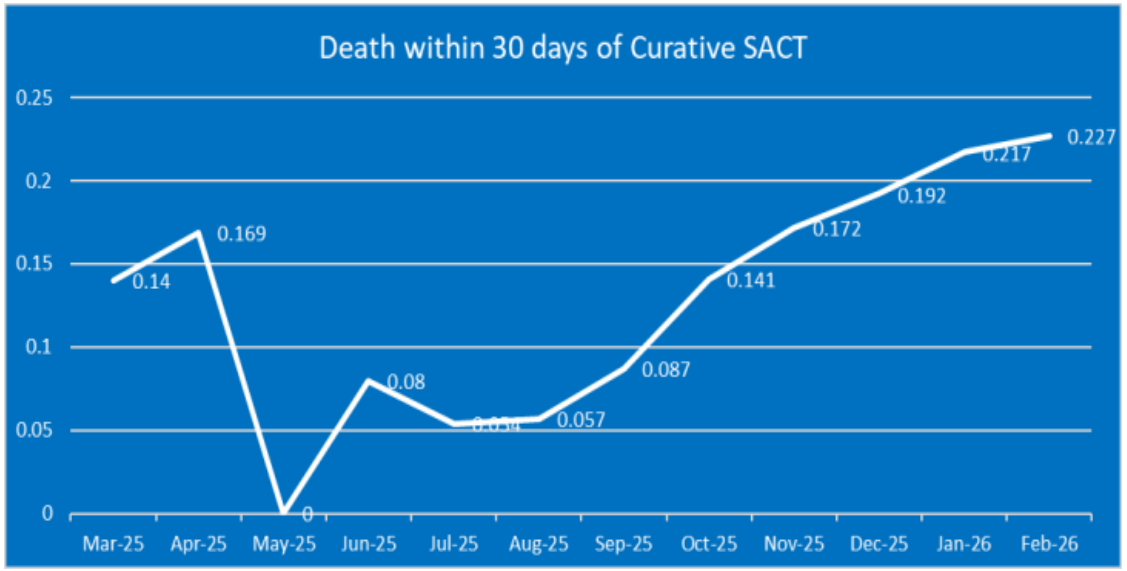


Figure 28

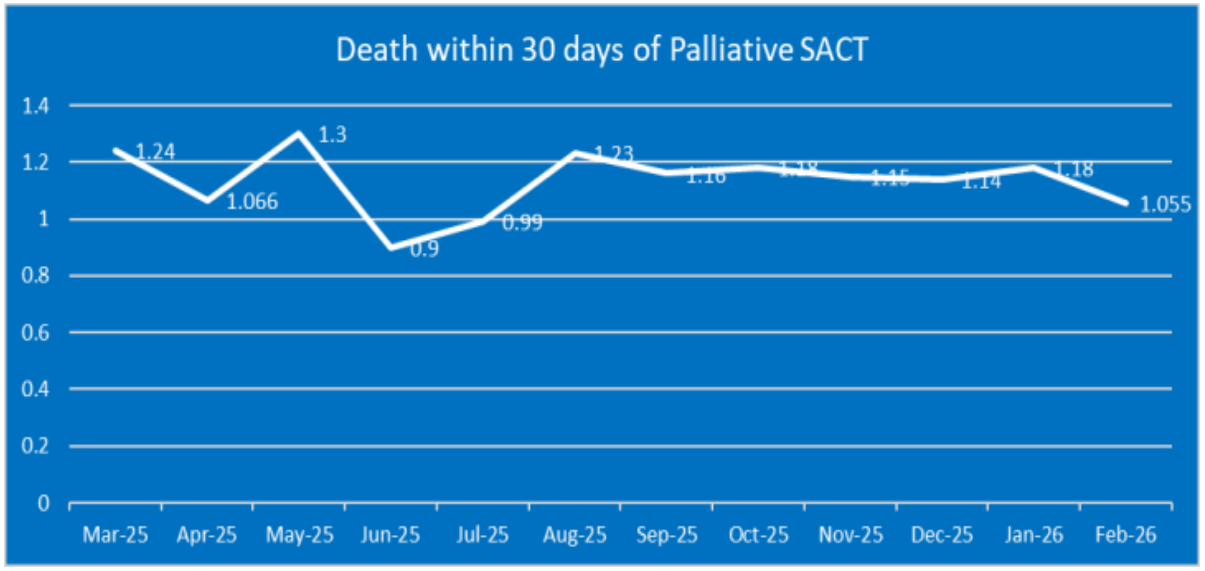
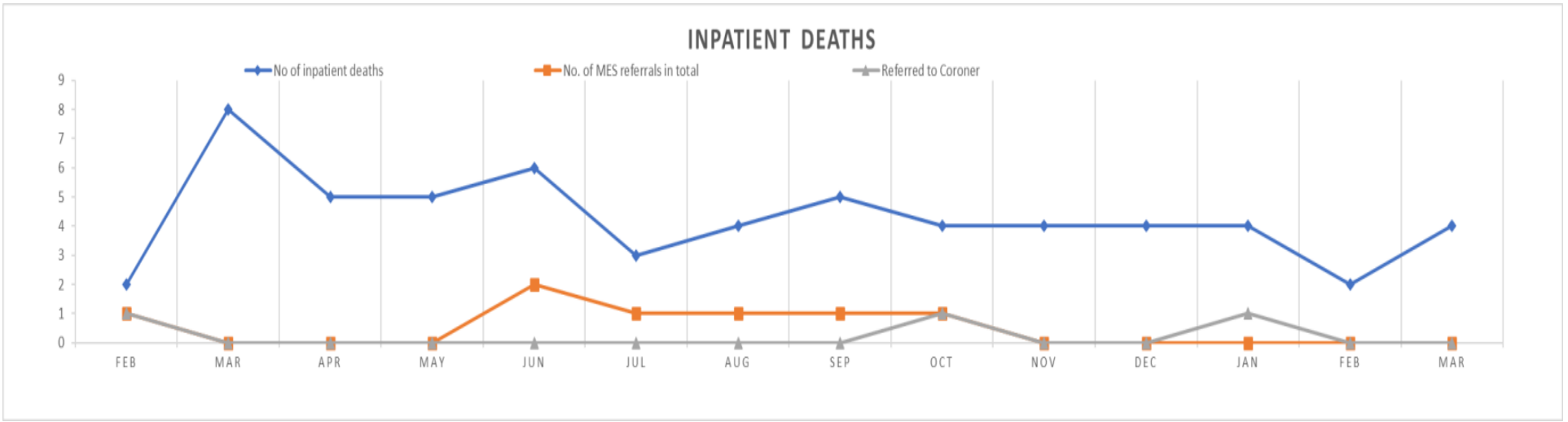


Figure 29



Figures 27 and 28 only show data up to February 2026. This is due to that the March data would not be completed at the point of generating.

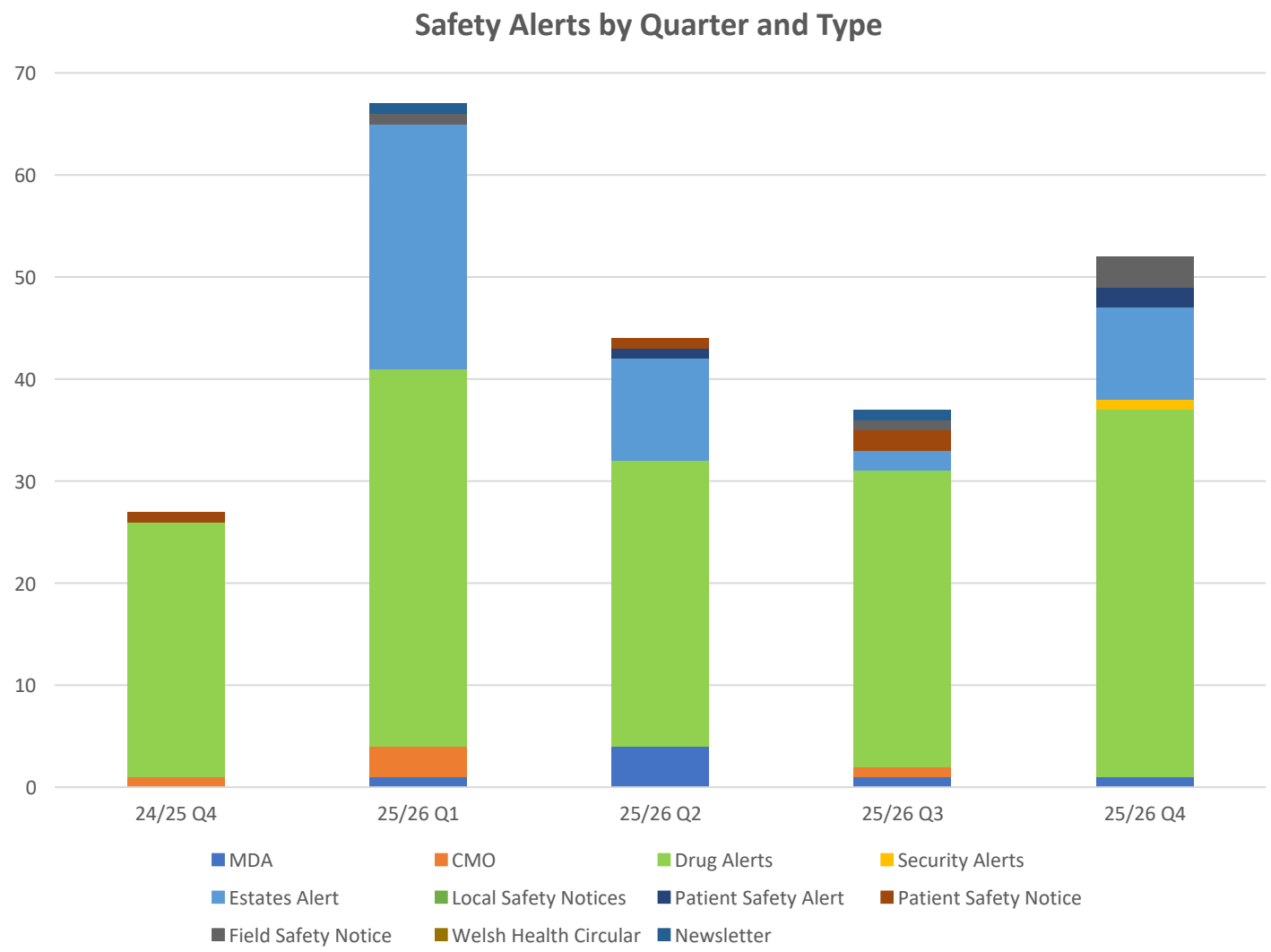
9. MORTALITY CONT.

ANALYSIS

- SACT mortality data is collected and reported monthly. Although there is no available benchmark for curative or palliative SACT, a 2% 30-day mortality rate from the 2008 National Confidential Enquiry into Patient Outcome and Death report is commonly used, and VCS remains below it.
- All SSTs now review deaths within 30 days of SACT, 30 days of palliative radiotherapy, and 90 days of radical radiotherapy .
- Radiotherapy data validity issues prevent full reporting - the Data and Insight team are working on a solution for this. However, 30- and 90-day radiotherapy mortality data continues to be captured and reviewed by the mortality team and SSTs.
- All inpatient deaths were reviewed within the VCS Inpatient Mortality Review Meetings and independently by the MES. Currently there isn't an action log from the mortality review meetings, which would suggest that we aren't closing the loop on any learning. Directorates are working with VCS Quality and Safety team to develop a process for this, utilising DATIX.
- The Cancer Service is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCS and feeding back findings and identifying learning.
- Figure 27 shows a gradual increase in Q3 and Q4. A review of curative deaths will be undertaken. Due to the small numbers of patients, percentages are disproportionately affected by low numbers of individuals who have died.
- An overarching service wide mortality and audit meeting is planned for September 2026 – this will aim to strengthen the mortality governance structure. This will ensure learning is shared across the division, quality improvement projects appropriately identified and supported, and the outcomes more meaningful.

10. SAFETY ALERTS

Figure 30



ANALYSIS

52 Safety alerts were issued to the Trust; this is significantly higher compared to Q3.
Drug/pharmaceutical alerts continue to be the highest number of alerts received in the Trust. The drug alerts relate to medicine recalls and stock issue notifications from suppliers.

THEMES AND OUTCOMES

Medication recalls and defects were the most common medication-related safety alerts issued to the Trust. Any of these alerts that were applicable to the Trust were actioned.

POSITIVE ASSURANCE

All Safety Alerts received were addressed within timescales and appropriate action taken. All safety are inputted into the implementation module on Datix, which is then cascaded to the appropriate department within the divisions, and they can provide compliance to the alert. If further action is required, action plan are discussed and updated regularly.

11. INFORMATION GOVERNANCE

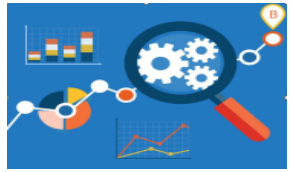


Figure 31

Introduction – Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links information rights, data quality management, records management, information management, information sharing, information security (including cyber security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability, security and confidentiality and the collection, storage and dissemination of information.

Incidents and Investigations – Total number of incidents for the quarter **plus** a 2 year run graph displaying the themes and trends.

Root Cause Analysis – Where the cause of the incident is not immediately clear, the Head of IG will conduct a more in depth investigation.

Reported to the ICO – It is a legal requirement to report certain types of incident to the ICO (where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals). RCA will also be conducted as a matter of course.

Subject Access Requests – The legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.

Data Protection Impact Assessments – It is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement.

Training Attainment – The minimum standard for compliance in NHS Wales is 85%, the compliance (%) is reported as at 1st January annually and may affect CAG status.

Incidents – 1st January – 31st March 2026

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation			
					Low Risk / No Harm	Root Cause Analysis	Total	DATIX Open	DATIX Closed	Total	IG Complete
Corporate Services	4	0	4	0	3	1	4	2	2	4	4
VCS	13	0	13	1	11	2	13	6	7	13	13
HTW	0	0	0	0	0	0	0	0	0	0	0
WBS	6	0	6	0	5	1	6	4	2	6	5
TCS/NVCC	0	0	0	0	0	0	0	0	0	0	0
NWSSP	16	0	16	1	15	1	16	3	13	16	14
Total Trust	**39**	**0**	**39**	**2**	**34**	**5**	**39**	**15**	**24**	**39**	**36**

Figure 32

Analysis Table for Incidents – 1st January – 31st March 2026

Reason	Number of incidents	VCS	Corporate	WBS	NWSSP	Total
Communication with Patients	1	1	0	0	0	1
Equipment Issues* Corporate and WBS incident the same.	3	1	1	1	0	3
Destruction of Records	1	0	0	0	1	1
Lost Records	1	1	0	0	0	1
Misdirection	17	4	1	3	9	17
Unauthorised Access	1	0	0	0	1	1
Unauthorised Disclosure of Records	15	6	2	2	5	15
Total Trust	**39**	**13**	**4**	**6**	**16**	**39**

Figure 33

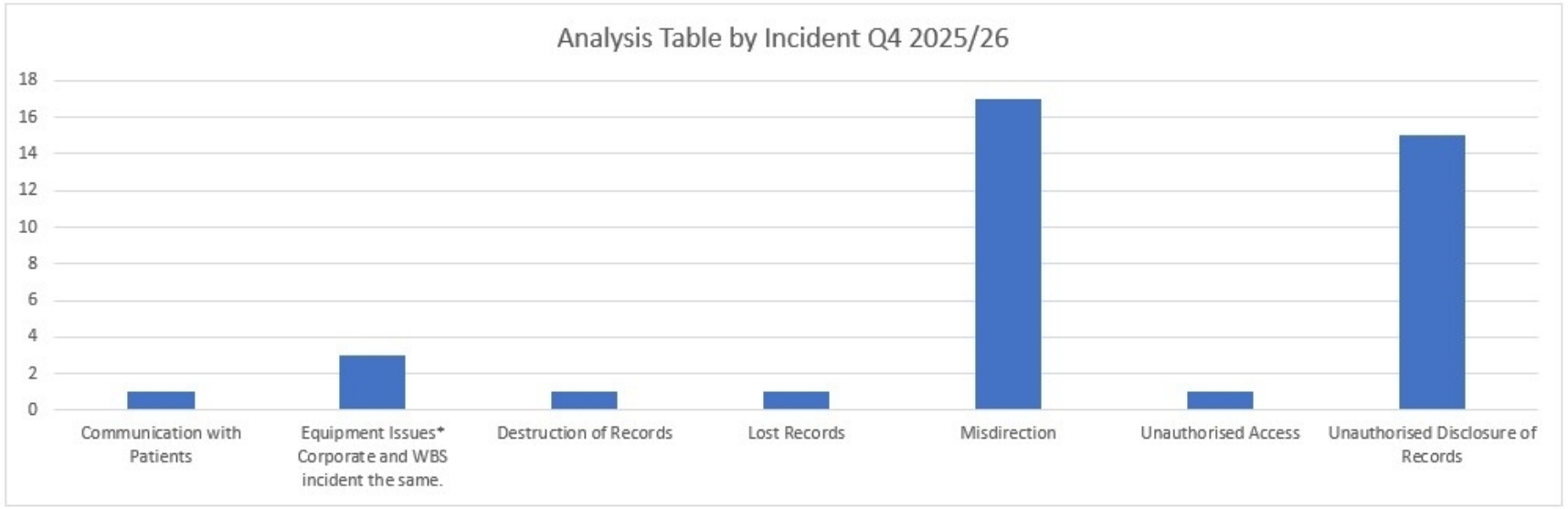


Figure 34

VCS (Medical Records) Subject Access Requests – 1st January – 31st March 2026

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Cancelled	Total	Percentage compliance
January	30	8	26	0	0	30	100%
February	32	5	25	0	0	32	100%
March	34	17	17	0	0	34	100%

Figure 35

Corporate (Non-Medical Records) Subject Access Requests – 1st January – 31st March 2026

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	0	0	N/A
February	3	1*	100%
March	0	0	N/A

* x1 request extended due to complexity

Figure 36

WBS (Donor Records) Subject Access Requests – 1st January – 31st March 2026

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	2	2	100%
February	12	12	100%
March	14	14	100%

Figure 37

NWSSP Subject Access Requests – 1st January – 31st March 2026

Month	Number of requests	Requests in Progress	Completed in Statutory timeframe	Requests breached	Total	Percentage compliance
January	0	n/a	n/a	n/a	0	100%
February	1	0	1	0	1	100%
March	0	n/a	n/a	n/a	0	100%

2025/26 Trust DPIA/Legitimate Interest Assessment Activity

Figure 38

2025/26 Trust DPIA/Legitimate Interest Assessment Activity

Quarter	DPIA's Commenced	VCS	WBS	Corporate	TCS	RD&I	NWSSP (includes LIA)	Completed in Quarter (for entire Calendar year including DPIA commenced in previous quarters)
Q1 2025/26	33	9	7	6	3	2	6	16 (Includes 1 All-Wales and 4 NWSSP)
Q2 2025/26	30	8	7	8	0	0	7	23 (Includes 4 NWSSP)
Q3 2025/26	34	14	3	8	0	0	9	16 (Includes 3 NWSSP)
Q4 2025/26	26	16	4	6	0	0	6	30 (Includes 15 NWSSP)
Total	123	47	21	28	3	2	28	85

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

2025/26 All-Wales DPIA Activity

Quarter	DPIA's Commenced	Completed in Quarter	Ongoing
Q4 2024/25	16	0	16
Q1 2025/26	TBC	TBC	TBC

*Full analysis and progress presented to IQSG/SIRO monthly and IM for IG quarterly

Figure 39

Training Statistics by Division for the Trust – 1st January – 31st March 2026

% Compliance Standards	% attainment
Standard	85%

Division	% attainment		
	January	February	March
Corporate	87.50%	88.45%	87.32%
HTW	95.83%	92.00%	100.00%
NVCC	85.71%	91.67%	92.11%
NWSSP	92.55%	89.73%	89.53%
RD&I	90.41%	90.14%	90.00%
VCS	89.99%	91.61%	91.60%
WBS	93.43%	93.64%	92.58%
Trust Overall	90.49%	91.61%	91.30%

Figure 40

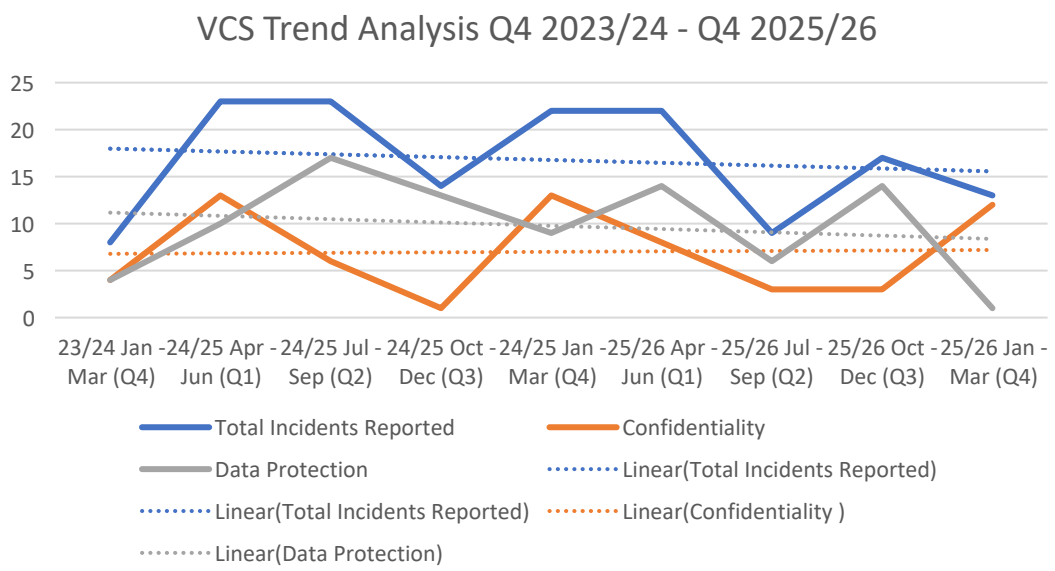


Figure 41

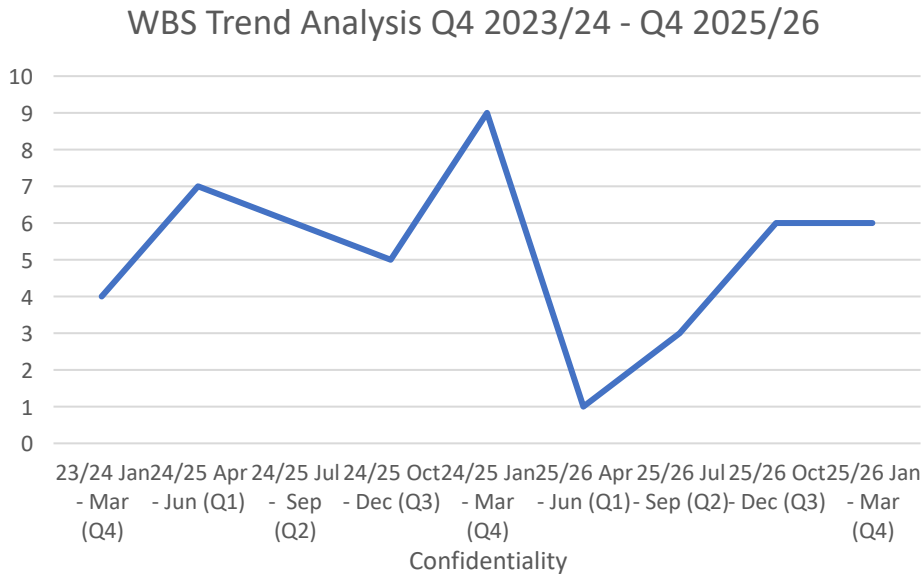
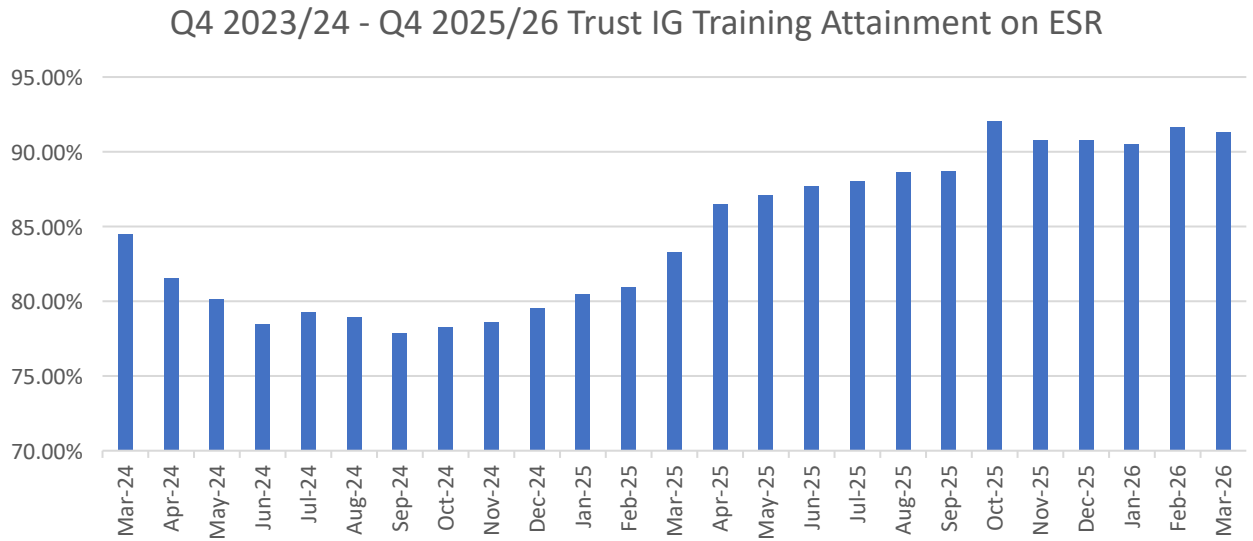


Figure 42



Assurance and Analysis

Positive assurance

1. **Training:**
   a. Training continues to be delivered via ESR/inductions and specific workshops, the last 3 months have seen training attainment maintained over 90%, but it is crucial that the high of 92% in Oct 25 is regained, Divisions are requested to support attainment to 95% (expectations exceeded) as that is what is required over the border in NHS England
   b. IG Training compliance at 31st March 2026 for the Trust is 91.30% (minimum standard is 85%)
2. **Email** –The new AI Policy was published in the Quarter with guidance about to be published early in Q1 2026/27
3. **SAR compliance** – Remains steady across the Trust – 100%
4. **DPIA's** – Across the Trust (includes all divisions and hosted bodies) 15 DPIA's and 9 DPA's were approved in Q4 2025/26, a decrease of 1 DPIA and increase of 6 DPA's against Q3 2025/26. In contrast 8 DPIA's have been approved at time of writing (13 Apr 26) for Q1 2026/27.

5. **NDR** – WG decided to implement a Deputy CMO led group, 1st meeting planned for 24th April 2026. All other activity on hold due to impending elections on 7th May 26.

Risks to compliance with Legislation, Policies, Procedures and Standards and mitigation activity

1. **Compliance Risk** – Risk of non-compliance with minimum M&S standards for IG and Cyber Security training on ESR significantly mitigated.
2. **TAF Risk** – DPO continues to review TAF 05 with CDO, recent work took place in Q4 2025/26
3. **Overall IG Risk** – Cyber risk is elevated and remains overriding risk in line with the current threat environment. Latest incident (Stryker – Iranian State Sponsored) took place on 11th March 2026
4. **Training Risk Mitigation** – There is a cultural issue regarding confidentiality in the Trust that requires further work during Q1 2026/27
5. **Investigations** – IG has conducted several in depth but connected investigations which are confidential in their nature, reports have been shared with those who have a business need to know.

Analysis, themes and learning

1. **Incidents** – Overriding themes in Q4 remains consistent with Q3; unauthorised access/disclosure and misdirection. All incidents remain avoidable. The confidentiality issue identified above requires significant work. A Board Dev session in Q1 2026/27 is planned.
2. **ICO Reported incidents** – The ICO were informed of 7 IG incidents in Q4 2025, 6 of which due to sensitivity are not reported in DATIX, CEO/Chair and SIRO aware. DPO continues to have regular dialogue with the ICO in relation to those cases. The ICO were also informed of 1 Cyber/NIS incident in March 2026 related to E-Progesa which is well documented in WBS, assessment of data loss and any impact remains ongoing in April 2026.
3. **Training** – Training compliance in Q4 remains consistent in that compliance meets the minimum requirement for the Trust (85%).
4. **DPIA** – Remains the main methodology to assess compliance with *data protection by design and default* and address risk and information rights.
5. **Triangulation** – Training compliance correlates with incidents. Points 1&3 above demonstrates that increased training and awareness can reduce incidents.

Safe	Timely	Effective	Efficient	Equitable	Person Centred
Evidence that Staff recognise their responsibilities in respect of Legislation, Codes of Practice and Trust Policy.	All incidents, reports and SAR's are submitted and/or responded to within required timescales	All IG incident reports have been completed appropriately and where feedback is received it is acted upon.	IG support is accessed at the correct point in any process (data protection by design and default) and where needed for incident management	The principles of Caldicott, Confidentiality and Data Protection are based on the European Convention on Human Rights and Article 8 of the Human Rights Act 1998	Evidence that the Caldicott and data protection principles have been adhered to in all reports made across the Trust. A fair approach has been taken in relation to allegations of any wrongdoing by members of Staff

Healthcare Associated Infections

Figure 43

HCAI Review to end March 2026						
Month	C. *difficile*	Bacteraemia cases				
		MRSA	MSSA	*E. coli*	*P. aeruginosa*	Klebsiella species
	2024-25 total no. of cases = 5	2024-25 total no. of cases = 0	2024-25 total no. of cases = 3	2024-25 total no. of cases = 11	2024-25 total no. of cases = 0	2024-25 total no. of cases = 8
Q1	ZERO	ZERO	1	4	ZERO	ZERO
Q2	1	ZERO	2	4	ZERO	ZERO
Q3	2	ZERO	1	4	2	ZERO
Q4	2	ZERO	ZERO	3	ZERO	2
Total:	**5**	**0**	**4**	**15**	**2**	**2**

Velindre acquired HCAI Review to end March 2026						
Month	C. *difficile*	Bacteraemia cases				
		MRSA	MSSA	*E. coli*	*P. aeruginosa*	Klebsiella species
	2024-25 total no. of cases = 3	2024-25 total no. of cases = 0	2024-25 total no. of cases = 0	2024-25 total no. of cases =1	2024-25 total no. of cases = 0	2024-25 total no. of cases = 1
Q1	ZERO	ZERO	ZERO	1	ZERO	ZERO
Q2	ZERO	ZERO	ZERO	2	ZERO	ZERO
Q3	ZERO	ZERO	ZERO	ZERO	ZERO	ZERO
Q4	1	ZERO	ZERO	2	ZERO	ZERO
Total:	1	0	0	5	0	0

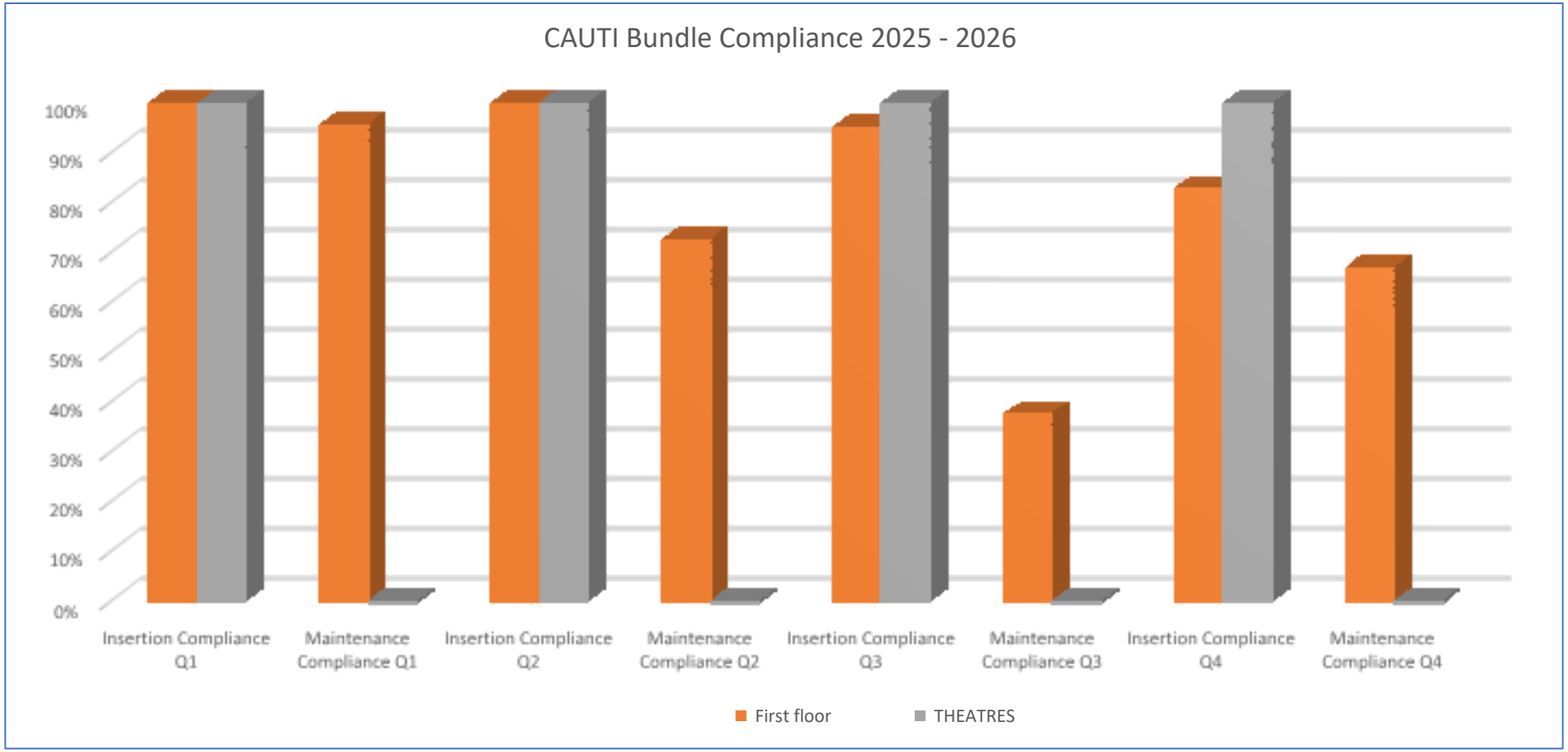
Assurance

Healthcare Acquired Infections – There were 3 infections deemed Velindre acquired. The C difficile RCA identified learning around antimicrobial prescribing and timeliness of isolation/specimen taking. RCAs are underway for the E. coli infections.

As part of the All Wales Clostridioides *difficile* Collaborative work, the Infection Prevention and Control (IPC) and Quality Team are leading a programme of work within the Cancer Centre to improve awareness and education around *C. difficile*. This includes promoting best practice in the correct management and handling of specimens. This initiative aligns with and supports the wider programme of work being delivered by the IPC Team.

Compliance to CAUTI Urinary Catheter Bundles:
Insertion compliance remains high but there have been some issues identified with maintenance compliance bundle being completed on Welsh Nursing Record. The digital team is working with IPC and ward staff to rectify this training issue. There have been no infections related to urinary catheters in Q4 2026.

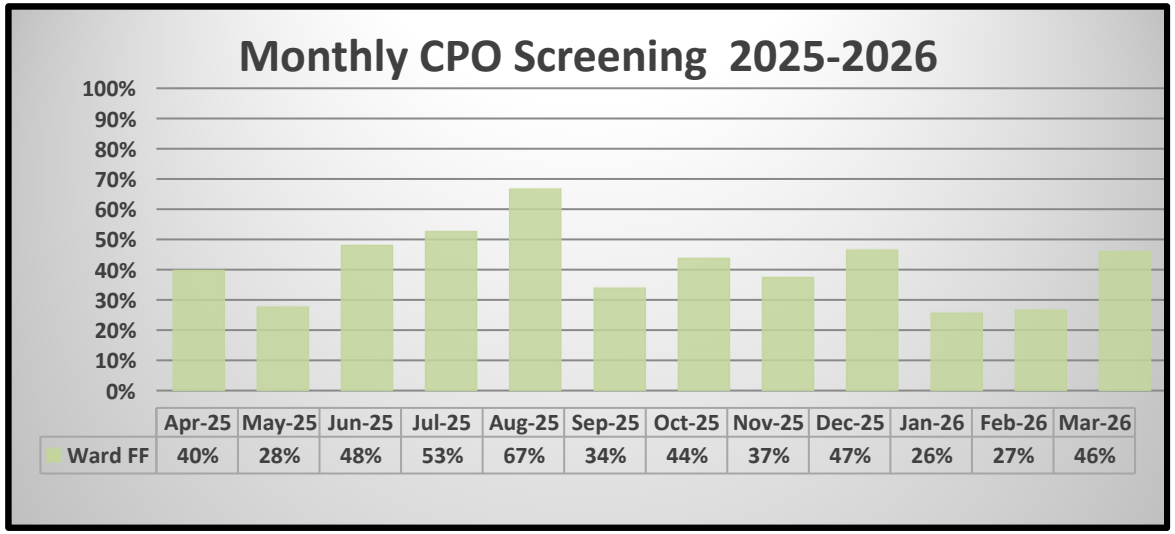
Figure 44



Compliance with screening for Carbapenemase Producing Organisms (CPO)

With emerging MDRO's (multi drug resistant organisms) and numbers increasing across Wales, in line with the national policy we need to undertake routine CPO screening on all admitted patients within a specific time frame. The IPCT have worked closely with the ward manager and key staff within the team to emphasise the importance of this swab.

Figure 45

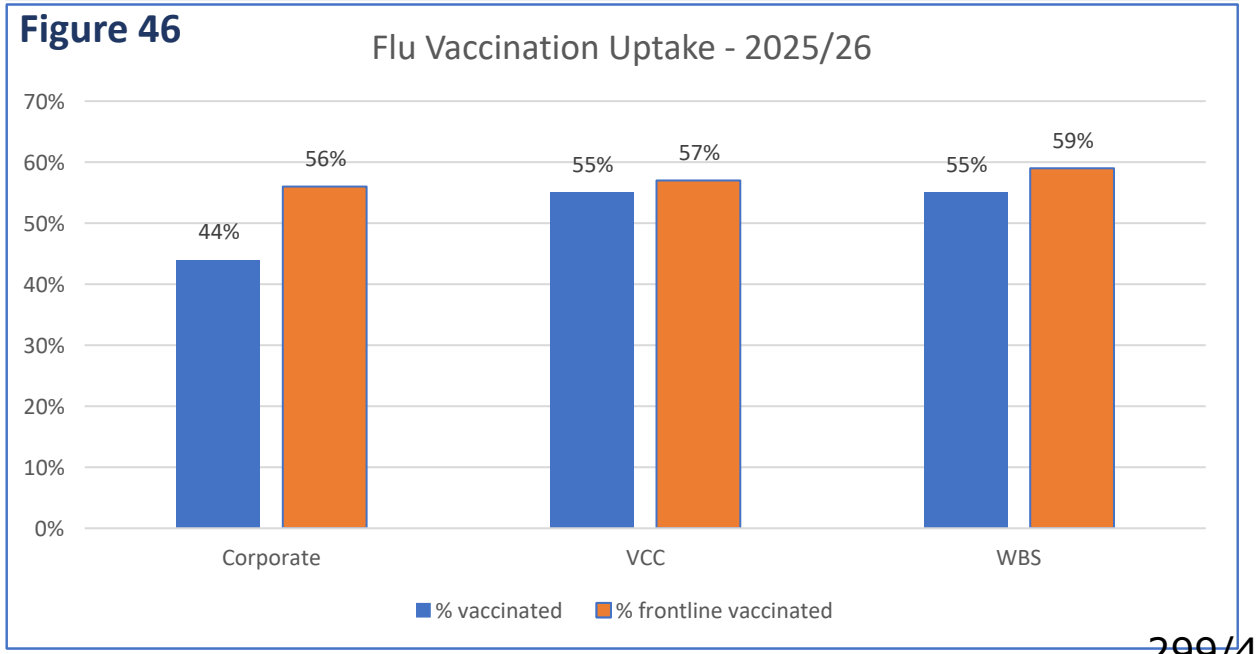


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Ward FF	40%	28%	48%	53%	67%	34%	44%	37%	47%	26%	27%	46%

Influenza

Staff vaccination campaign began 8th September 2025 and ran until 31st March 2026. Update data:

Figure 46



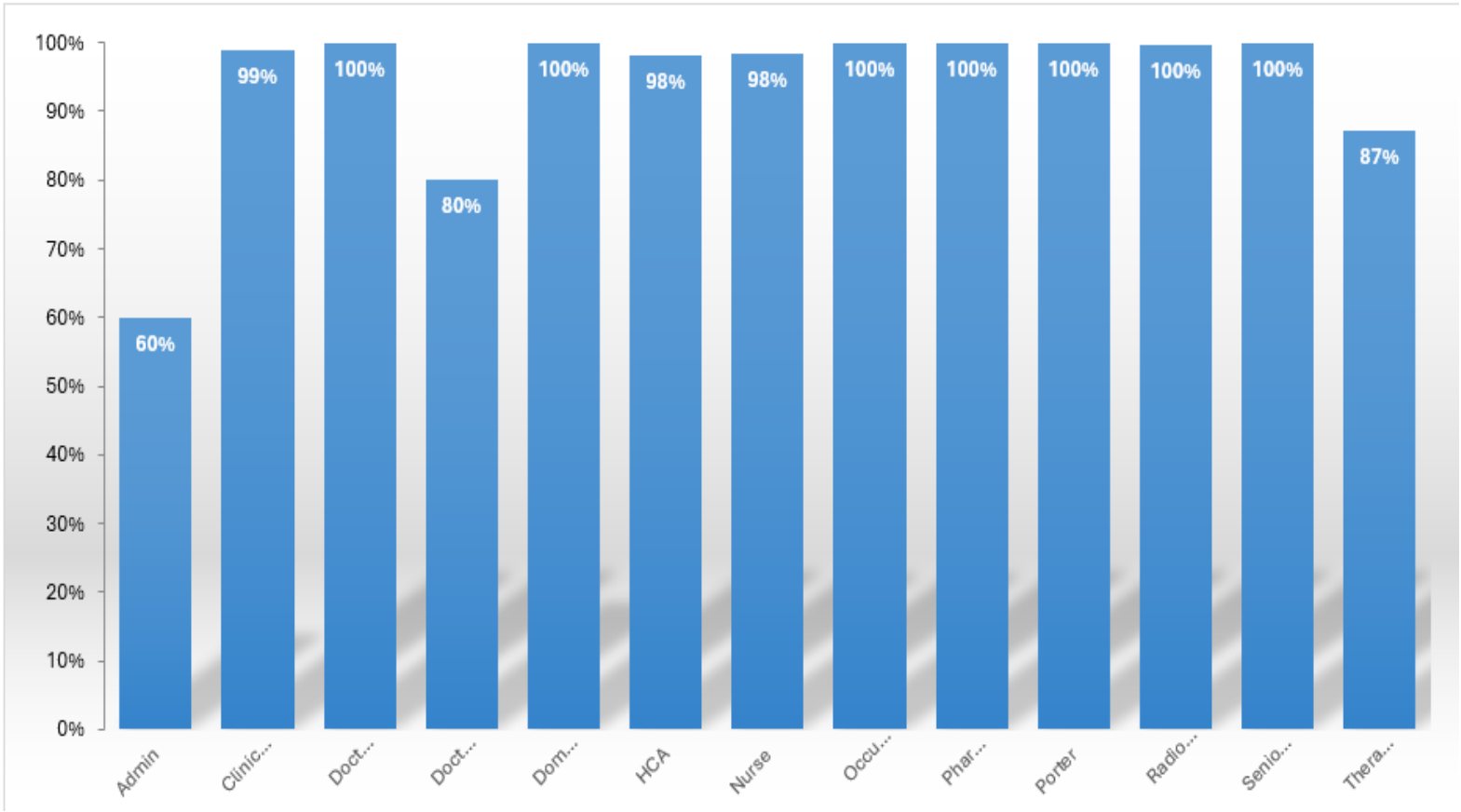
12. INFECTION PREVENTION AND CONTROL CONT.

Hand Hygiene compliance

Hand Hygiene audits continue to be undertaken across the Trust. The IPC Team continue to undertake spot checks to validate hand hygiene practice. Any non-compliance is discussed at time of audit and education provided.

Figure 47

Hand Hygiene compliance **by staff group** – April 2025 to March 2026, 96%

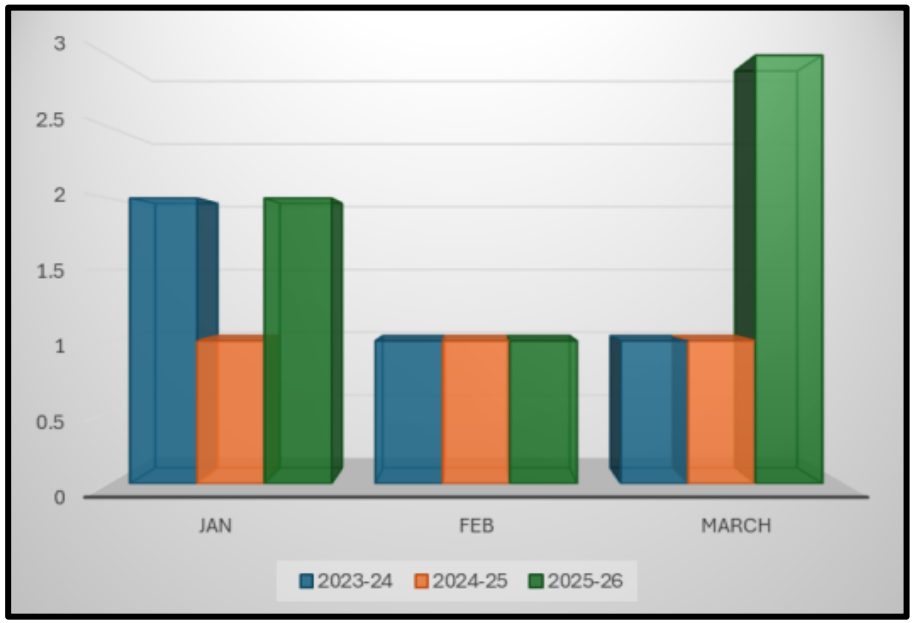


Overall compliance Q4 – **95%**

Figure 48

Deprivation of Liberty Safeguards

DoLS Activity Q4

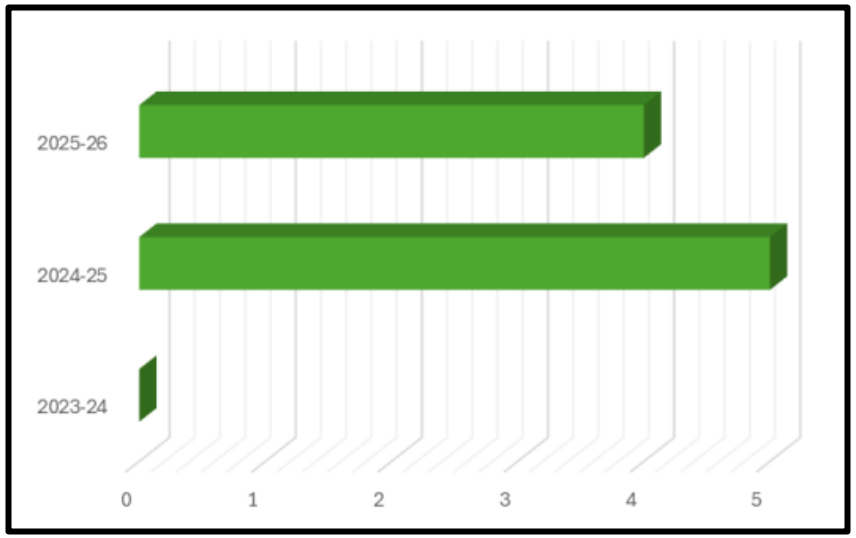


Safeguarding and Public Protection Activity

6 applications for Deprivation of Liberty Safeguards (DoLs) were made during Quarter 4, which is an increase from Quarter 3 (0). DoLS information was redistributed and staff resources reviewed to ensure they were up to date.

Figure 49

Safeguarding Activity Quarter 4



4 Duty to Reports were shared with Local Authorities during this quarter. 3 Reports were generated by VCS and 1 report by WBS.

1 VCS report, submitted in February 2026, related to the increase of avoidable pressure areas noted at Pressure Ulcer learning panel. Following review of the measures already in place and the improvement plan the Local Authority were satisfied that the Trust was taking immediate action to resolve the issue. Therefore, the threshold for s126 adult at risk enquiries was not met and no further action was required.

14. HEALTH & SAFETY

Outcome

Progress made on P1 (leadership & accountability) within H&S management system.

Incident reporting consistent; good PMF inclusion but timeliness issues remain.

Early development of audit programme and legal register underway.

Initial steps taken to improve WBS incident accessibility.

COSHH training planning in progress.

Theme

Need to shift from reactive → preventative controls

Training gaps (manual handling, sharps, COSHH)

Inconsistent local ownership (P1)

Environment/equipment safety needs strengthening

Reporting culture & timeliness require improvement

Continued focus on staff wellbeing (V&A)

Trends

Predominantly low harm incidents.

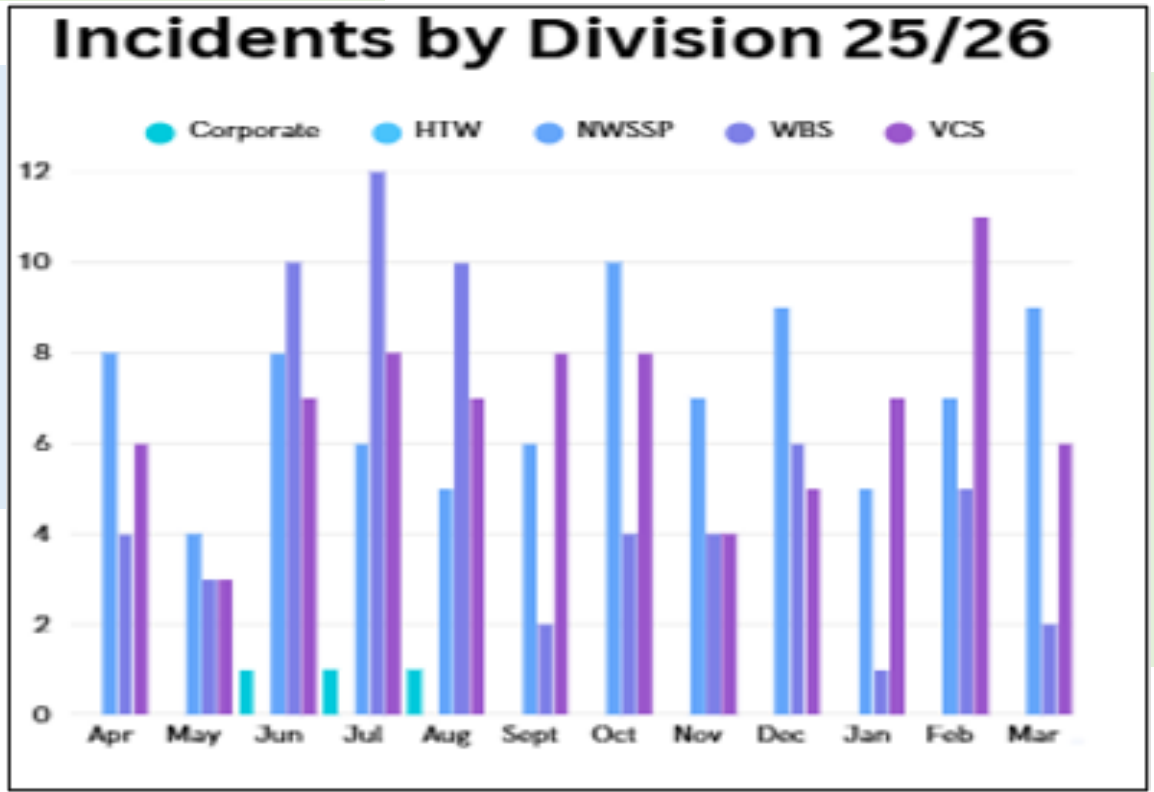
Staff most frequently affected.

Key risks: manual handling, sharps, slips/trips.

Ongoing violence & aggression towards staff.

Equipment & environmental issues recurring.

Delays in incident reporting.



Focus

Strengthen leadership & accountability (P1)

Improve incident reporting accessibility, quality & timeliness

Develop annual audit programme aligned to risk

Progress legal register

Roll out COSHH training

15. EXTERNAL INSPECTIONS AND ASSURANCE

Quality and Safety Governance Audit – Internal Audit

2025/26

Purpose

To review operational quality and safety governance arrangements in order to provide assurance that issues fundamental to the quality and safety of services are managed, monitored and escalated.

NWSSP Internal Audit completed a review of the implementation of the agreed management actions from the 2024/25 audit of Duty of Quality that was issued in May 2025.

The review was completed in line with the 2025/26 Internal Audit Plan for Velindre University NHS Trust (the 'Trust'). In the original report Internal Audit issued a reasonable assurance opinion and identified seven key areas with medium priority findings and management agreed actions to address risks associated with their findings. The Audit, Risk and Assurance Committee has monitored the progress made in implementing the management actions, via the internal audit tracker.

Overview

With this being a follow-up of previous actions, an assurance rating is not provided and is presented as an advisory review. From the seven original agreed management actions, the following was concluded based on the position reported to the March 2026 Audit Committee:

• Two agreed actions have been fully completed with appropriate supporting evidence. One requires revisiting following the conclusion of the VCS restructuring process.

• One issue relating to the inclusion of SMART objectives within the Quality & Safety objectives for 2025/26 was reported as complete but has been re-raised at this review as it remains relevant to the 2026/27 Quality & Safety objectives.

• One agreed action has been recorded as completed in full in AMaT, however requires additional evidence to demonstrate the completeness of actions and the effectiveness of oversight.

• One of three actions recorded as 'partially complete' or 'in progress' had passed their implementation date but there was an absence of effective measures to reschedule overdue actions or to assess the associated risks.

One management action has been agreed as follows:

Review the Trust 2026/27 Quality Priorities and ensure that
they include:

- Identification of a clear baseline or starting point;
- Definition of measurable outcomes, including specific metrics (e.g. percentage compliance), timeframes (e.g. over three-month period), sample sizes;
- Use of precise and clearly defined targets for improvement, avoiding vague terms such as "strengthen" or "improve"; and
- A focus on intended outcomes and impact, rather than solely on activities.
- SMART actions

The Quality Priorities will be submitted for Trust Board approval.

TRUST BOARD

TRUST SEAL REPORT: 21 MARCH – 14 MAY 2026

DATE OF MEETING	21 May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	FOR NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Non Gwilym, Director of Corporate Governance (interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (interim)
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(21st March – 14th May 2026)**.
RECOMMENDATION / ACTIONS	The Trust Board is requested to **NOTE** the contents of the Trust Board Seal Register included below as **Appendix 1.**
GOVERNANCE ROUTE	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1 – Seal Register	

1. SITUATION/ BACKGROUND

1.1 The content of the Trust Board Seal Register has been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(21st March – 14th May 2026)**.

1.2 Board Members are asked to view the content of the report. Further information or queries should be directed to the Director of Corporate Governance (interim).

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

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	**Select all relevant domains below**
	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
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
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*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Seal Register

Date	Document Details	Signed
22/04/2026	Deed of Variation between (1) Velindre University NHS Trust (as the hosting body of NHS Wales Shared Services Partnership) whose principal office is at Companies House, Crown Way, Cardiff, CF14 3UB (the Authority' which expression includes any permitted successor to it and any successor in the exercise of its functions) and (2) MACE Consult Limited, which is a company incorporated in and in accordance with the laws of England and Wales (Company No. 07094851) whose registered office address is at 155 Moorgate, London, EC2M 6XB (the Consultant). The parties entered into a Framework Agreement for the provision of **Lot 1 National Cost Advisor Services** dated 13/11/2024 (the Framework Agreement). Following discussion, the parties have agreed to amend the Framework Agreement to remove the requirement for the Consultant to provide a parent company guarantee to the Authority and / or any potential Client, on the terms contained within the Deed of Variation.	Carl James (Interim CEO) and Sara Moseley (Chair)
22/04/2026	Deed of Variation between (1) Velindre University NHS Trust (as the hosting body of NHS Wales Shared	Carl James (Interim CEO) and

Date	Document Details	Signed
	Services Partnership) whose principal office is at Companies House, Crown Way, Cardiff, CF14 3UB (the Authority' which expression includes any permitted successor to it and any successor in the exercise of its functions) and (2) MACE Consult Limited, which is a company incorporated in and in accordance with the laws of England and Wales (Company No. 07094851) whose registered office address is at 155 Moorgate, London, EC2M 6XB (the Consultant). The parties entered into a Framework Agreement for the provision of **Lot 2 National Cost Advisor Services** dated 13/11/2024 (the Framework Agreement). Following discussion, the parties have agreed to amend the Framework Agreement to remove the requirement for the Consultant to provide a parent company guarantee to the Authority and / or any potential Client, on the terms contained within the Deed of Variation.	Sara Moseley (Chair)

TRUST BOARD

TRUST WIDE POLICIES APPROVED UPDATE

DATE OF MEETING	21 May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **March 2026 to May 2026.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **March 2026 to May 2026.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Executive Management Board	30/03/2026 27/04/2026
• Quality, Safety and Performance Committee	07/05/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The following policies were **ENDORSED** by the Executive Management Board and **APPROVED** by the Quality, Safety and Performance Committee:

- QS03 Handling Concerns Policy
- QS08 Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in a Position of Trust
- QS12 Safeguarding and Public Protection Policy

• IG07 Acceptable Internet Use Policy • IG03 Email and Instant Messaging Use Policy • IG09 Information Governance and Information Security Policy

7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1	QS03 Handling Concerns Policy
Appendix 2	QS08 Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in a Position of Trust
Appendix 3	QS12 Safeguarding and Public Protection Policy
Appendix 4	IG07 Acceptable Internet Use Policy
Appendix 5	IG03 Email and Instant Messaging Use Policy
Appendix 6	IG09 Information Governance and Information Security Policy

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been through the Trust governance process and approved during the period **March 2026 to May 2026.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last report, the following policies have been **APPROVED**, which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	QS03 Handling Concerns Policy	Executive Director of Nursing, AHPs and Health Science	Quality, Safety & Performance Committee	07/05/2026
2	QS08 Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in a Position of Trust	Executive Director of Nursing, AHPs and Health Science	Quality, Safety & Performance Committee	07/05/2026
3	QS12 Safeguarding and Public Protection Policy	Executive Director of Nursing, AHPs and Health Science	Quality, Safety & Performance Committee	07/05/2026

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
4	IG07 Acceptable Internet Use Policy	Executive Director of Finance	Quality, Safety & Performance Committee	07/05/2026
5	IG03 Email and Instant Messaging Use Policy	Executive Director of Finance	Quality, Safety & Performance Committee	07/05/2026
6	IG09 Information Governance and Information Security Policy	Executive Director of Finance	Quality, Safety & Performance Committee	07/05/2026

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - BOARD ASSURANCE FRAMEWORK (TAF)	04 – Organisational Culture
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 ☒

	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result
	Each policy will be individually assessed to ensure compliance with EIA requirements.
ADDITIONAL LEGAL IMPLICATIONS/ IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

QS 08

POLICY FOR THE MANAGEMENT OF SAFEGUARDING ALLEGATIONS /CONCERNS ABOUT PRACTITIONERS AND THOSE IN A POSITION OF TRUST

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professions and Health Sciences
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality, Safety and Performance Committee
Approval Date:	7th May 2026
Date of Equality Impact Assessment:	2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Documents to read alongside this policy:	There is a link to all of the appropriate forms and additional reading material within the appendices to the policy.
Review Date:	November 2026
Version	3

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1. Policy Statement

As an employer and provider of services, Velindre University NHS Trust has a duty to protect individuals in our care from abuse. This policy relates to the management of allegations of abuse made against an employee of the Trust and will enable the organisation to ensure that all instances of concerns or alleged abuse or neglect of children and adults are risk assessed, to ensure patient / donor safety.

Where a concern or abuse is alleged to have occurred in the employee's private capacity (i.e. outside of their Trust employment) careful consideration will need to be given to whether the employee presents any risk to patient's / donors within their working environment in the Trust, and if they may be in breach of their professional code of practice (regulated employees).

2. Scope of Policy

This Policy applies to all Velindre University NHS Trust employees, bank, locum and agency, students, contractors, honorary contracts holders, volunteers, trainees and Trust staff undertaking duties overseas as part of a Trust supported health link staff, regardless of role or whether or not their employment brings them into direct contact with vulnerable adults or children.

This Policy applies in all cases of alleged abuse of a child or adult by an employee of the Trust regardless of whether the abuse is alleged to have taken place in work or in their private lives. In every incident of alleged abuse of a child or adult staff must comply with the Wales Safeguarding Procedures.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

3. Aims and Objectives

This policy has been developed to ensure that employees of Velindre University NHS Trust are aware of their responsibilities and the processes for identifying and reporting professional abuse of children and adults at risk either within the workplace or in the employee's home / external environment. The policy has been developed to ensure a robust and consistent approach in responding to allegations of actual or potential abuse.

- To ensure that all incidents of abuse and neglect of a child or adult at risk are dealt with within the appropriate framework.
- To safeguard children and adults at risk from abuse and avoidable neglect by Trust employees.
- To ensure an equitable, fair and consistent response when concerns are raised.
- To support employees who have made a referral or who have had a referral made against them; and
- To raise awareness of all Trust employees of the possibility of abuse of children and adults at risk, by professionals and other healthcare workers.

4. Responsibilities

Velindre University NHS Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child / adult at risk.

The Trust has a responsibility to notify the police when concerns are raised, if it is in the public interest, even if the individual concerned does not wish the police to be involved.

- **Executive Director of Nursing, Allied Health Professionals and Health Science**

The Executive Director of Nursing, Allied Health Professionals and Health Science has delegated responsibility for ensuring the safeguarding of children in accordance with Section 28 of the Children Act (2004) and for safeguarding under the Social Service and Wellbeing (Wales) Act (2014).

- **Employee Responsibilities**

In line with the Social Services and Wellbeing (Wales) Act (2014), all staff have a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager, the Trust Safeguarding Lead or via the processes set out in NHS Wales Trust Procedure for NHS Staff to Raise Concerns.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

- **Managers**

Line managers are responsible for complying with this Policy and, in all circumstances should notify the Trust Senior Nurse for Safeguarding & Public Protection or the Deputy Director of Nursing, Quality & Patient Experience in order to gain the required support / advice / multi agency involvement.

In some cases, the line manager may feel it appropriate to make a referral to the Occupational Health Service to provide appropriate support for any employee concerned or involved in the process. This must be done with their consent. A management or self-referral to the Occupational Health Service / Employee Assistance Programme should be in addition to and not instead of the processes set out in this Policy.

Managers should ensure that employees who find themselves overstretched in their caring responsibilities outside of work are made aware of support available to them (e.g. Occupational Health Service, Employee Assistance Programme, Flexible Working Policy, third sector organisations).

- **Trust Senior Nurse Safeguarding & Public Protection**

The Trust Senior Nurse for Safeguarding and Public Protection must provide support, oversight and direction to line managers when managing situations in line with this policy and ensure that the Executive Director of Nursing, Allied Health Professionals & Healthcare Scientists is notified and kept updated.

5. Definitions

5.1 **Abuse:** This describes physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, institution or any other place).
(Wales Safeguarding Producers 2019)

5.2 A child is defined as "any person under the age of 18" *(UN Convention on the Rights of the Child 1989).*

5.3 Section 130 (4) defines a "child at risk" as a child who;
(a) Is experiencing or is at risk of abuse or neglect; and
(b) Has needs for care and support (whether or not the authority is meeting any of those needs)

5.4 Section 126(1) defines an adult at risk;
An "adult at risk", for the purposes of this Part, is an adult who:
(a) Is experiencing or is at risk of abuse or neglect;
(b) Has needs for care and support (whether or not the authority is meeting any of those needs); and
(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect of the risk of it.

6. Implementation / Policy Compliance

6.1 The Trust needs to be able to recognise and respond appropriately to allegations raised against an employee. Allegations could be identified in a number of ways, including (but not limited to) the following:

- by the Police;
- by Social Services;
- from an adverse incident and/or completed DATIX report that may identify a potential allegation;
- a concern made by a patient / donor or carer;
- a concern made by another employee;
- by adults disclosing historical abuse which they experienced as a child; or
- a professional or regulatory body.
- an individual involved in a Trust supported international health partnership link.

6.2 During weekday working hours

Allegations of abuse by an employee must be reported without delay to the appropriate line manager who will take any remedial action and have an initial discussion with the Trust Senior Nurse, Safeguarding & Public Protection / Deputy Director of Nursing, Quality & Patient Experience.

A decision will be made at this initial discussion to confirm if this policy needs to be evoked and, who will inform Local Authority or the Police.

Out of hours

Allegations of abuse by an employee must be reported immediately to the On-Site Manager who may refer the matter to the On-Call Manager for advice / support. The on Site and On Call Managers can be contacted via switchboard.

The immediate priority is the protection and safety of a child or adult at risk and managing any associated staff issues. Any immediate risks must be considered, and action taken to mitigate that risk where appropriate. However, under no circumstances should internal enquires into the allegation be commenced until advice has been received from the on-call Managers.

If it is felt that the alleged abuse may be criminal, there must be no delay in reporting the matter to the Police, who will advise on preserving the scene for evidence**.**

All actions taken should be clearly recorded. It is essential that all records are written clearly, accurately, legibly and contemporaneously with all details recorded, to provide as full a picture of the account as possible throughout this process. All records should be signed and dated if not written contemporaneously then the date they were written should be made clear, as well as the date of the contact.

6.3 On being informed of the allegation of abuse, the Trust Risk Assessment form attached as ***Appendix 2*** must be completed to inform Trust action. The Workforce and OD Department will provide advice and support to the relevant line manager in determining if the employee can continue in work, should be moved temporarily to another role or if they should be suspended. Any decision taken to suspend an employee must be taken in line with the relevant Disciplinary Policy.

6.4 When determining the appropriate action to be taken, consideration must be given to:

- how the person's protection is to be ensured.
- whether there are other children or adults who might be at risk.
- what support the employee may require;
- the right of the employee who has had an allegation made against them in respect of their privacy and confidentiality.

In addition, Trust employees who have an allegation made against them need to:

- understand the concerns expressed;
- know the procedures/processes being operated;
- know the timescale set for the process;
- be told what support is available to them;
- be clearly informed on the outcome of any investigation and the implications for disciplinary/capability processes;

Procedures need to be applied with common sense and judgement, and full decision-making documentation.

6.5 The Professional Strategy Discussion

The professional strategy meeting will be convened when safeguarding allegations have been raised about a practitioner/person in positions of trust. A Professional Strategy discussion will take place with the Police; any other appropriate partners and employers. The focus of the Strategy discussion is as follows:

- Whether the matter meets the threshold for progressing to a formal Professional Strategy meeting
- Identification of any activities or caring responsibilities for children or adults that the subject of the allegation is involved in outside of their paid employment
- Consideration of interim safeguards whilst further enquiries are made
- Decision about what information can be shared with the subject of the allegation, the child or adult at risk and their parent/carer
- Decision about employer involvement with the process

- Review adequacy of safeguards in place
- Agree any actions to be taken or any further information needed prior to the Professional Strategy meeting
- Decide whether immediate briefings to senior managers are required

6.6 Professional Strategy Meeting

The professional strategy meeting will be convened by the Local Authority Designated Officer for Safeguarding when safeguarding allegations/concerns have been raised about a practitioner/person in positions of trust. This can either be in a personal or professional capacity, where the individual has wider contact with children or with adults at risk.

The main functions of the strategy meeting are to:

- Ensure the proper co-ordination of child, adult protection, criminal and employment procedures
- Share all relevant information about the allegation/concern in question
- Consider what action may be required to protect the child or adult at risk in question
- Consider the likelihood of harm to other children or adults at risk with whom the person has contact at work or other activities, and agree any actions that are required
- Consider and evaluate the risk of harm to the subject's own children or adults they may have caring responsibilities for, and agree any actions that are required
- Discuss any previous allegations or other concerns.
- Plan any enquiries needed and allocate tasks and set timescales
- Decide who is to be interviewed and lead agency
- Identify a lead contact manager within each agency
- Decide what information can be shared with whom, when and who will do this
- Agree timescales for actions and/or dates for further meetings
- Consider the employees suitability to continue working with children or adults at risk in his or her current position has been called into question
- Consider whether there are disciplinary issues to be followed up
- Agree at what stage in the process the disciplinary issues should be followed up
- Consider any other factors that may affect the management of the case e.g. consideration of the need for a media strategy where there is likely to be press interest.
- Confirm arrangements regarding who will communicate with the person about whom there are concerns and ensure appropriate support is provided • Ensure that the appropriate referrals are made to the Disclosure and Barring Service and registering bodies of the professional involved (this can be completed at any point throughout the process

- The employer/voluntary organisation or registering body may need to consider suspending the employee without prejudice.

The immediate priorities of the Professional Strategy Meeting are to ensure the protection and safety of the child/children or adult's at risk, and to also discuss whether the allegation may have a bearing on the individual's employment. The Trust should not decide in isolation to progress the matter through the relevant Disciplinary Policy. Discussion must take place with the police and social services prior to commencement of proceedings.

6.7 Who will be invited to the Professional Strategy Meeting?

The Professional Strategy Meeting will be chaired by the Local Authority Designated Officer for Safeguarding for children or adults, who will also identify who will attend.

Where the allegations involve concerns or alleged abuse of a child or adult at risk by a Trust employee the employee's line manager, a senior Workforce and OD representative and the Safeguarding Lead, as a minimum must be in attendance at the Professional Strategy Meetings.

6.8 Informing the individual

The person who is the subject of the allegation should generally be informed that they are subject of an allegation at the earliest opportunity. This should be done by the line manager. However, specific details of the allegation cannot be provided until the timings for doing so have been agreed with Children's or Adults Services/Police. This will be considered during the interim safeguarding arrangements discussed and agreed by the Police and the Designated Officer for Safeguarding. In determining when to inform the individual, consideration should be given to any potential risks to the child or adult involved in the allegations, or to any other children or adults connected to the individual's home, work or community life.

When informing the individual careful consideration should be given to the following:

- The person subject to the allegation should be given appropriate support by their employer or nominated individual;
- The person who is the subject of the allegation should be treated fairly and honestly and helped to understand the concerns expressed and processes involved;
- Information about the adult, child or family should not be shared with the individual against whom the allegation was made or anyone representing them;
- Consideration should also be given to the potential for the individual to impede any investigation, remove or interfere with evidence or to intimidate or coerce potential witnesses;

- If suspended, the individual will be kept up to date about events in the workplace by a named contact;
- As soon as possible after an allegation has been received, the accused member of staff should be advised to contact their Trade Union or professional association;
- Workforce &OD should be consulted at the earliest opportunity in order that appropriate support can be provided via the organisation's occupational health, employee welfare arrangements, or individual agency's own safeguarding arrangements.

6.9 Informing parents / carers, children, adults at risk or their representatives

- The general principle is that the parents or carers of the adult or children involved and the adult or children where appropriate, should be informed about the allegation as soon as possible but only following discussion with the Designated Officer for Safeguarding responsible for safeguarding allegations/concerns against practitioners and those in positions of trust.
- Parents/carers of the adult or children involved and the adult or children where appropriate, must be informed of the outcome of the strategy discussion/meeting and should, when necessary, be helped to understand the decisions reached. It will be agreed in the Strategy Discussion or Strategy meeting who will undertake this.
- Examples where it may not be appropriate to inform parents, carers, adults or children or their representative immediately could include where the allegation made is against a family member, or if the Police investigation could be hampered by informing the parent/carer, child, adult at risk or their representative. In these cases the timings for the parents or carers being told must be confirmed with the relevant social services and Police.

6.10 Concluding the process

An Outcome Professional Strategy Meeting should be held to decide, whether on the balance of probabilities the concerns are substantiated. If the concerns are not deemed to be substantiated, then the outcome should be recorded as unsubstantiated, unfounded or deliberately invented or malicious. The following definitions will guide strategy meetings in determining which outcome applies; Allegations will have outcomes within the following four categories:

Substantiated – a substantiated allegation is one which is established by evidence or proof.

Unsubstantiated – an unsubstantiated allegation is not the same as an allegation that is later proved to be false. It simply means that there is

insufficient identifiable evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.

Unfounded – this indicates that the person making the allegation misinterpreted the incident or was mistaken about what they witness. Alternatively, they may not have been aware of all the circumstances. For an allegation to be classified as unfounded, it will be necessary to have evidence to disprove the allegation.

Deliberately invented or malicious – this means there is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.

The outcomes discussion would normally precede any decision by the employer to invoke disciplinary procedures. Where the concerns are substantiated, employing or volunteer agencies should consult if not already done so with the Disclosure and Barring Service and other relevant professional bodies about the requirement for a referral. (Further information and guidance from the DBS can be obtained from their website at www.homeoffice.gov.uk/dbs).

If the Professional Strategy Meeting concludes there is to be no further action from a multi-agency perspective then the appropriate Trust manager will need to determine whether there are disciplinary issues in relation to the member of staff concerned that need to be addressed in accordance with the relevant Disciplinary Policy. Consideration also needs to be given as to whether the Professional Registered Body of the member of staff needs to be informed.

Where a criminal investigation results in no further action but it is determined that a disciplinary investigation is to take place subsequently, a request can be made to the police for permission to use the information gained from the criminal investigation in the disciplinary investigation. The police will consider any request on a case by case basis.

6.11 Cross boundary issues

This is an area of work that is best supported by sound inter-authority working. Where child or adult protection enquiries have been made in one area, but the alleged perpetrator lives or works within other areas, there will be need for information to be shared between the two areas. The Delegated Officer for Safeguarding must ensure that they share all information with their counterpart in the other Local authority. Due regard is to be had to the relevant data protection principles which allow sharing of personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). It is usually the responsibility of the Local authority where the alleged abuse took place /concern arose to hold the Professional Strategy Meeting. After discussion

between the Designated Officers for Safeguarding it will be decided and recorded which authority will be responsible for convening the Professional Strategy Meeting and the reasons why.

7. Confidentiality and Record of the Professional Strategy Meeting

In view of the potential sensitivity of the information and the lessons of the Bichard Inquiry (2004), (www.police.homeoffice.gov.uk/publications/bichard-inquiryreport) care should be taken in recording the concern and the outcome of the process.

A record of the meeting will be made and retained by the local authority in accordance with their record, retention and disposal policy. Attendees representing the employer should receive a copy of the summary and recommendations of the meeting with the child's or adult at risk's name removed. All other attendees will receive a copy of the summary and recommendations.

The Designated Officer for Safeguarding will consider any request for a full record of the meeting and ensure that in the event of disclosure, an appropriately redacted version of the record is disclosed.

Where the person makes a data subject access request for the record of the Professional Strategy Meeting, this will be considered, and the nominated Designated Officer for Safeguarding will ensure redaction the document prior to disclosure. Other meeting attendees will be made aware of the request and can be sent a copy of the redacted document where requested

8. Referral to Disclosure and Barring Service (DBS) and Professional Bodies

The Trust, like all employers have a legal duty to refer information to the DBS if an employee has harmed or poses a risk of harm to vulnerable groups and where they have dismissed them or are considering dismissal. Employers also have a duty to refer where an individual has resigned before a formal decision to dismiss them has been made. **Failure to refer such matters to the DBS is a criminal offence.**

Please refer to the Disclosure and Barring Checks on Trust Post Guidance

Further information about the referral process is also available on the DBS website at www.homeoffice.gov.uk/agencies-public-bodies/dbs/services/dbsreferrals/

The Trust may also have a duty to report an employee to other relevant Professional Bodies such as the General Medical Council, Nursing Midwifery Council and the Health and Care Professions Council.

9. Equality Impact Assessment Statement

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 and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure 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 any impact from the policy would have a positive effect to the equality groups mentioned.
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

10. References

- Adapted from ABMU Policy for the Management of Allegations of Abuse of Children or Adults by Professionals and Members of Staff (2016);
- Children's Act (2004);
- General Data Protection Regulations (2018);
- Social Service and Wellbeing (Wales) Act (2014);
- Wales Safeguarding Procedures (2019)

11. Getting Help

Contact the Safeguarding Lead for Velindre University NHS Trust: Senior Nurse Safeguarding and Public Protection.

12. Related Policies

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance
- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Safeguarding and Public Protection Policy (2019)
- Records Management Policy (2018)
- Serious Crime Act (2015)
- Duty of Candour (2023)

13. Information, Instruction and Training

13.1 Training

Employee awareness of safeguarding issues and responsibilities will be undertaken through both safeguarding children and adults at risk mandatory training. All Trust staff who have direct contact with patients are required to complete Level 2 Safeguarding Adults and Children training. Certain groups of staff will require extra training in accordance with the NHS Safeguarding Training Framework. It is the responsibility of the line manager to ensure that employees are made aware of these requirements.

13.2 Audit

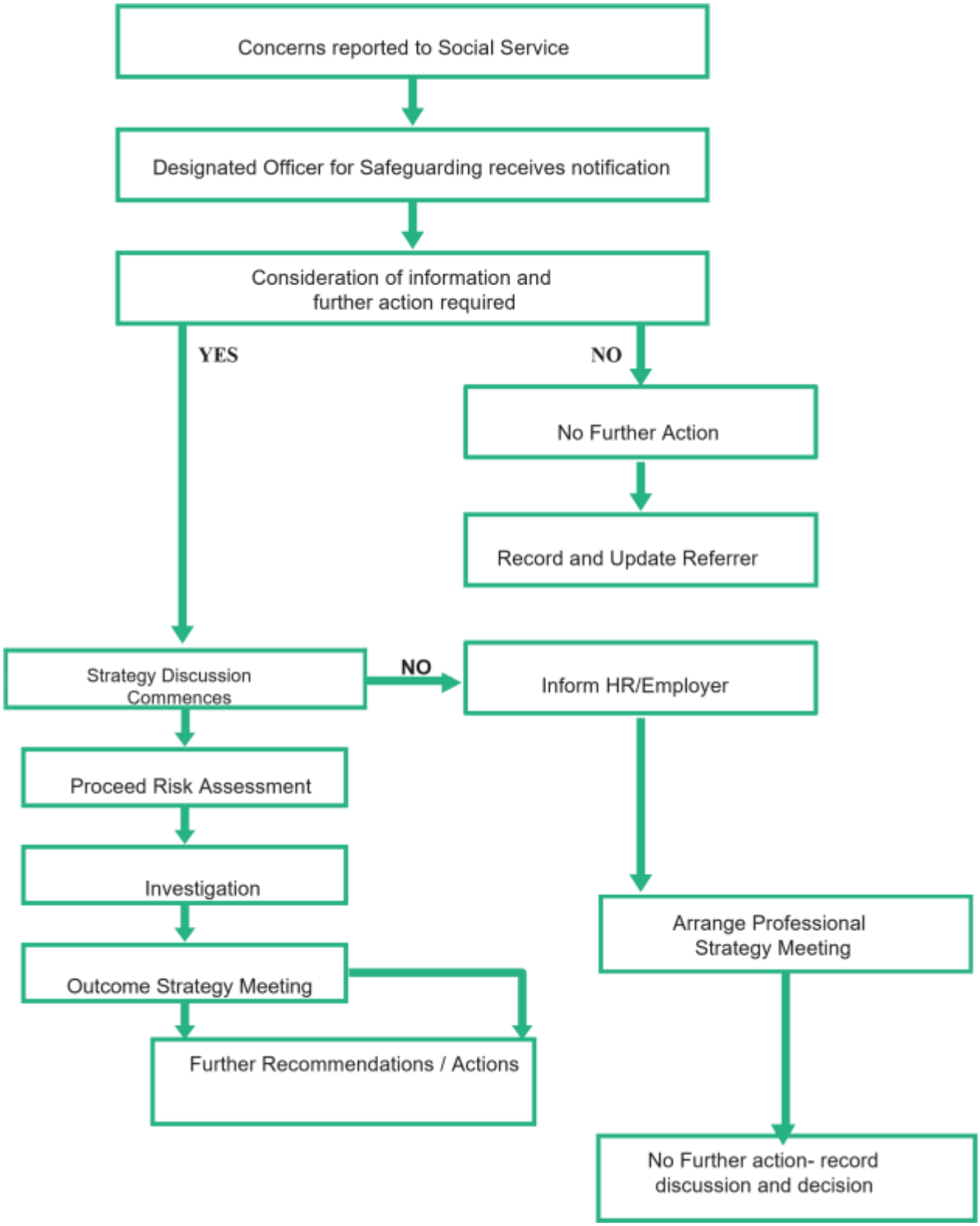
This policy may be subject to audit and will be assessed in line with normal audit planning processes. The outcomes of any audits undertaken will be reported to the Safeguarding & Public Protection Management Group.

14. Main Relevant Legislation

General Data Protection Regulations (2018)
Children's Act (2004)
Safeguarding Vulnerable Groups Act (2006)
Social Service and Wellbeing (Wales) Act (2014)
Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015)
Serious Crime Act (2015)

Appendix 1

Flowchart: Referrals about people whose work brings them into contact with children or adults at risk



Appendix 2

Safeguarding Children and Adults

Guidance Notes on the Completion of a Risk Assessment Form following Allegations Against an Employee

RISK is a combination of the likelihood and severity of a specified event (incident).

This form is used to undertake a detailed risk assessment when potential risks have been identified at a Professional Strategy Meeting and Wales Safeguarding Procedures 2019 and/or when a member of staff is considered to be a risk.

All sections of this form should be completed by the employee's line manager, with support from the appropriate Safeguarding Lead and Workforce and OD as part of the Professional Strategy Meeting proceedings. The objective of this form is to establish whether the individual poses a risk to children/adults at risk, and if so, to establish what appropriate, additional controls can be put in place to ensure that the risks are reduced to an acceptable level. The completed form must be kept in the employees' confidential file.

NATURE OF ALLEGATIONS

TYPE OF ABUSE ALLEGED Select the type of abuse that is being alleged.

SEVERITY OF THE ABUSE ALLEGED

Select severity of abuse alleged as appropriate. If unsure, please contact the Safeguarding Lead

HOW MANY TIMES HAS THE ABUSE OCCURRED

Select whether the abuse has occurred on one occasion or more than one occasion. This information will be shared at the Professional Strategy Meeting.

EXPLANATIONS GIVEN

Select whether no explanation provided, or if explanation provided, whether the explanation is inconsistent or consistent. This information will be shared at the Professional Strategy Meeting.

PERSONS PRESENT AT TIME OF INCIDENT

Select whether the employee was the sole carer at the time of the incident, or whether there were other people present. This information will be shared at the Professional Strategy Meeting.

LEGAL PROCEEDINGS

Select whether care proceedings or criminal proceedings are in place. This information will be shared at the Professional Strategy Meeting.

EMPLOYMENT ISSUES

ROLE WITHIN TRUST Select whether administrative, academic, clinical or other. If other, please give details

ACCESS TO CHILDREN

If employee has access to children or young people under the ages of 18 years, in any capacity whilst in his role in the Trust select yes. If employee only has access to people aged 18 years and above, then select no

UNSUPERVISED ACCESS TO CHILDREN

If the employee does have access to children or young people under the age of 18 years, select how often this access is unsupervised/employee sole staff member present

ACCESS TO ADULTS AT RISK

If the employee has access to adults at risk, select how often this access is unsupervised/employee sole staff member present

RISK ASSESSMENT MATRIX

1. PROBABLE LIKELIHOOD RATING (PLR)

Taking account of the controls in place and their adequacy, how likely is it the individual will harm a patient or visitor during the course of their work for the Trust? Score according to the following scale:

Score	Descriptor	Description
5	Almost Certain	Likely to occur on many occasions
4	Likely	Will probably occur but is not a persistent issue
3	Possible	May occur occasionally
2	Unlikely	Do not expect it to happen but it is possible
1	Rare	Can't believe that this will ever happen

2. PROBABLE CONSEQUENCE RATING (PCR)

Taking account of the controls in place and their adequacy, how severe would the consequence be of such an incident if it were to occur? Apply a score according to the following scale:

Level	Descriptor	Actual or potential impact on individual	Actual or potential impact on organisation
5	Catastrophic	Death or national adverse publicity	National adverse publicity, possible investigation
4	Major	Permanent physical / psychological injury	Service closure Local adverse publicity, possible investigation
3	Moderate	Semi-permanent injury or harm	Needs careful PR
2	Minor	Short term injury or harm	Risk to organisation
1	Insignificant	No injury or adverse outcome	No risk at all to the organisation

RISK LEVEL ESTIMATOR/ RISK RATING (RR)
LIKELIHOOD of Adverse Event Occurring X SEVERITY of Outcome = Risk Rating

Likelihood (PLR) / Severity (PCR)	Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Catastrophic 5	25	20	15	10	5
Major 4	20	16	12	8	4
Moderate 3	15	12	9	6	3
Minor 2	10	8	6	4	2
Insignificant 1	5	4	3	2	1

RR Score	RISK LEVEL	ACTION AND TIMESCALE
1 - 5	LOW	Provide support for the individual. Continue normal working activity with close monitoring
6 - 10	MODERATE	Provide support for the individual. Consider redeployment to low risk area or work with continuous supervision whist enquiries undertaken
11 - 25	UNACCEPTABLE	Provide support for the individual Suspension pending further enquiries

SAFEGUARDING CHILDREN / ADULTS – EMPLOYEE RISK ASSESSMENT FORM

Name of Individual		Designation		Unit/ Department	

Nature of Allegations

Type of abuse alleged: *(please tick)*

Neglect ☐ Emotional Abuse ☐ Sexual Abuse ☐ Physical Injury ☐ Domestic Abuse ☐

Financial ☐

Severity of alleged abuse *(please tick)*

Mild ☐ Moderate ☐ Severe ☐

Has the abuse occurred on: *(please tick)*

One occasion ☐ More than one occasion ☐

Explanations given: *(please tick)*

None ☐ Inconsistent explanation ☐ Consistent explanation ☐

Persons present at time of incident: *(please tick)*

Individual - sole care ☐ Individual and another – shared care ☐

Legal Proceedings: *(please tick)* ☐

None ☐ Care Proceedings ☐ Criminal Proceedings

Employment Issues

Role within Trust: *(please tick)* ☐ _____

Administrative ☐ Academic ☐ Clinical Other *(please state)*

Access to children/adults at risk: Yes ☐ No ☐
(please tick)

Unsupervised Access to children/adults at risk: Never ☐ Occasional ☐ Regular ☐
(please tick))

Initial Risk Rating

Given the information above, what level of risk does the employee pose to the organisation and its service users? *(see page 2)*

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PCR) ☐ = Initial Risk Rating (IRR) ☐

Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Safeguards to minimise risk

Safeguards needed to minimise/eliminate risk: *(see page 2 for suggested actions)*

Feasibility of implementing safeguards:

Revised Risk Rating

With the above action implemented the risk rating figure would be reduced to: = Revised Risk Rating (RRR) ☐

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PSR) ☐

Revised Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Recommendations

Joint Assessment made by:

Name	Signature	Position

Date of Assessment		Review Period		Dates of Review			

Further information on review:	Risk Rating	*Date & Signature*

QS12

SAFEGUARDING AND PUBLIC PROTECTION POLICY

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professions and Health Sciences
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality, Safety and Performance Committee
Approval Date:	7th May 2026
Date of Equality Impact Assessment:	2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	November 2026
Version	Version 3

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1. POLICY STATEMENT

Velindre University NHS Trust (hereafter 'the Trust') has statutory duties to comply with legislation in relation to safeguarding and public protection. It discharges these duties by working within regional partnership arrangements and complying with both UK Government and Welsh Government Codes of Practice and national safeguarding procedures.

2. SCOPE OF POLICY

This Policy applies to all staff employed by or working within the Trust, regardless of whether or not their employment brings them into direct contact with adults or children at risk. The principles set out in this Policy will also apply to other individuals and groups, including bank staff and agency workers, students, contractors, honorary contract holders, volunteers and trainees. In every incident of alleged abuse of a child or adult at risk, staff must comply with the Wales Safeguarding Procedures.

3. AIMS AND OBJECTIVES

To ensure that all staff who work within the Trust understand their responsibilities in relation to safeguarding children and adults at risk, and in relation to public protection.

This document will ensure that staff are clear about their statutory duties and about action they must take in response to safeguarding and/or public protection concerns.

To enable the Trust to fulfil its statutory duties safely and competently it must:

- Ensure effective measures are in place to safeguard people and protect children and adults at risk; and,

- Ensure appropriate systems and processes are in place, including those to support sharing of information, to enable staff to work effectively and in partnership with other agencies with regard to safeguarding and public protection.

4. RESPONSIBILITIES

Governance & Reporting Arrangements

The Trust's governance and reporting structure is set out below.

Executive Responsibility	• The Chief Executive Officer has overall responsibility for safeguarding and public protection. • The Executive Portfolio is delegated to: Executive Director of Nursing, Allied Health Professionals and Health Science. • Supported by: The Deputy Director of Nursing, Quality & Patient Experience.

Operational Responsibility	• Director, Velindre Cancer Centre • Supported by: The Director of Operations, Velindre Cancer Centre • Director, Welsh Blood Service • Supported by: The Head of Nursing
Named Lead	Head of Safeguarding & Vulnerable Groups, or the Deputy Director of Nursing, Quality & Patient Experience will provide advice, guidance, and support for any safeguarding or public protection concerns disclosed, witnessed or suspected within the Trust.

The Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child/adult at risk.

Employee Responsibilities

The Social Services and Wellbeing (Wales) Act (2014) states that everyone has a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager or the Safeguarding Lead.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

5. DEFINITIONS

Safeguarding involves working with partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm, and involves activities to actively prevent individuals from becoming at risk of abuse, neglect or other kinds of harm.

Public Protection includes actions taken to protect, promote and improve the health, safety and well-being of the population.

Safeguarding Children
A child is defined by the Children Act 1989 as anyone less than 18 years of age.

A **'child at risk'** is defined in the Social Services & Wellbeing (Wales) Act 2014 as a child who:

a) Is experiencing or is at risk of abuse, neglect or other kinds of harm; and
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs).

Safeguarding children is the responsibility of everyone working in the Trust. This responsibility extends to children who are patients, children who are visitors to the Trust, children of any adults who are patients or donors of the Trust, and children of staff members.

Adults at Risk An 'adult at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as an adult who:

a) Is experiencing or is at risk of abuse or neglect;
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs); and
c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Statutory Duty to Report
From April 2016 the Social Services & Wellbeing (Wales) Act 2014 introduced the statutory duty for all who work for the Trust to report to the Local Authority any concerns that a child or an adult is at risk. See Appendix 1

Deprivation of Liberty Safeguards (DoLS)
The process to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty, but who lack the capacity to consent to that care and/or treatment, and where detention under the Mental Health Act 1983 is not appropriate.

Multi Agency Public Protection Arrangements (MAPPA)
The Trust is required to discharge its duties as a Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency under s325 Criminal Justice Act 2003.

MAPPA is the process through which the police, probation and the prison services (Responsible Authority) work together with other agencies that have a duty to cooperate to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public.

A MAPPA Strategic Management Board (SMB) covering the South Wales Police Force area is responsible for overseeing MAPPA related activity, including agreeing the role and representation of different agencies within the SMB, and developing protocols and memoranda of understanding which formalise these. The Trust is not represented on the MAPPA Strategic Management Board.

MAPPA offenders are managed on a multi-agency basis through Multi-Agency Public Protection meetings at Level 2 and 3:
- MAPPA 2: High risk of harm – monthly meetings
- MAPPA 3: Very high risk of harm – on a basis of need

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)
The Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 definitions are:

Gender Based Violence–

a) Violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation.
b) Female genital mutilation.
c) Forcing a person (whether by physical force or coercion by threats or other psychological means) to enter into a religious or civil ceremony of marriage (whether or not legally binding);

Domestic Abuse is abuse where the victim of it is or has been associated with the abuser.

Sexual Violence includes sexual exploitation, sexual harassment, or threats of violence of a sexual nature.

6. IMPLEMENTATION

6.1 Safeguarding Children and Adults at Risk:

The Wales Safeguarding Procedures describe in detail actions to be taken at all stages of the child and adult safeguarding process.

They are available via the Trust's policies page and on the Trust's safeguarding & public protection intranet pages. The procedures must be adhered to in all safeguarding matters.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

6.2 Cardiff and Vale Regional Safeguarding Board Polices & Procedures

All multi-agency safeguarding policies and procedures are approved by the Cardiff and Vale Regional Safeguarding Board, of which the Trust is a member agency. They are available via their website at www.cardiffandvalersb.co.uk

6.3 Individual Roles & Responsibilities to Safeguard Children & Adults at Risk

All staff must know who to contact to express concerns and how to report those concerns to the Local Authority

- If it is believed the child or adult **is or may be at risk** this must be **reported immediately by telephone** to the relevant Local Authority.

- The **reporting** of concerns should be **discussed with** the child's **parents** and the child as appropriate to their age and understanding. Or with the **adult at risk** or their family/representative if they lack mental capacity to make decisions for themselves.

- The **exception** to this is if such a discussion would place the child/adult at greater risk of harm.

- The telephone report must be **confirmed in writing** within **24 hours** using the referral Forms (available on the Safeguarding and Public Protection website).

- If, having made the initial report in writing the report maker has not received an acknowledgement from social services **within 7 working days**, they must contact social services.

- Referrers who are **not satisfied** with the response from the Local Authority must discuss this with the Trust's Safeguarding Lead.

- All staff must discuss any **uncertainty** about concerns or **differences of opinion** with the Trust's Safeguarding Lead.

- If the Trust's Safeguarding Lead is **unavailable** the concern must be discussed with the relevant Local Authority Social Worker.

- After this discussion a **decision** must be made as to whether or not the child or adult meets the definitions of a child or adult at risk.

- If it is believed that the child or adult is **not at risk** consider if they would benefit from additional services and with their **consent** make the appropriate referrals.

See Trust Adult at Risk and Child Risk Reporting forms. APPENDIX 2&3

6.5 Concerns about the behaviour of a member of staff

If the behaviour of a member of the Trust staff, in or out of work, causes concern and may pose a risk to children or adults at risk, staff are instructed:

- Do not dismiss concerns;
- Do escalate your concerns
- To discuss concerns with the Trust's Safeguarding Lead or if not available a senior member of the Workforce and OD Team.
- The Trust Safeguarding Lead or the Workforce Business Partner will act in accordance with the Trust Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust.

6.6 Deprivation of Liberty Safeguards Procedures [DoLS]

The Trust flowchart describes the actions to be taken in the Cancer Centre with regards to the Deprivation of Liberty Safeguards process.

They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.7 Multi Agency Public Protection Arrangements [MAPPA]

The Trust has a flowchart for when high risk offenders or prisoners are admitted to hospital.

They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.8 Violence Against Women Domestic Abuse Sexual Violence Procedures [VAWDASV]

The Trust has Policy and Guidance to support victims of violence against women, domestic abuse and sexual violence. The policy and guidance is designed to promote the safety of victims of domestic and sexual violence who are receiving services provided by the Trust, and explains the processes and procedures that staff will use to identify and respond to violence against women, domestic abuse & sexual violence.

They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.9 Information Sharing

Information must be shared in accordance with the Data Protection Regulations 2018 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so.

In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the practitioner deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others. It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You **must** make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied. There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action – the information shared should be necessary for the purpose and be proportionate.

Safeguarding information will be retained in line with Trust information governance related policy.

https://gov.wales/information-sharing-safeguard-children-and-adults-leaflet

You should seek advice from the Information Governance Lead and Safeguarding Lead if you are unsure

7. EQUALITY IMPACT ASSESSMENT

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 and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure 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 any impact from the policy would have a positive effect to the equality groups mentioned.

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

8. GETTING HELP

Contact Senior Nurse Safeguarding and Public Protection

[See Safeguarding and Public Protection Guidance Booklet for referral process flowcharts]

9. RELATED POLICIES

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance
- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Records Management Policy (2018)
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

10. TRAINING AND EDUCATION

Safeguarding and Public Protection training is vital in protecting our patients and donors, their families and our communities from harm.

Safeguarding training is available both on a single agency and a multi-agency basis in line with the NHS Safeguarding Training Framework.

11 LEGISLATION AND NHS REQUIREMENTS

The Trust has to comply with relevant legislation, external standards and good practice guidance including:

- Social Services & Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 [Looked After Children] & Part 7 [Safeguarding Children & Adults at Risk]
- Children Act 1989, section 47 [child protection investigations]
- Children Act 2004 sections 25, 27 and 28 [duty to cooperate to safeguard & promote welfare of children]
- Mental Capacity Act 2005 as amended in the Mental Health Act 2007 [Supervisory Body and Managing Authority requirements for the Deprivation of Liberty Safeguards]
- s325 Criminal Justice Act 2003 [Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency]
- Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 [develop and implement a local strategy with the Local Authority]
- s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police]
- Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour]
- Safe Care Standard 2.7 of Health & Care Standards in Wales
- Duty of Candour 2023 (To be open and honest with people they are caring for if things go wrong and harm has occurred.)

12 REVIEW AND AUDIT

Review of this policy will be undertaken no later than three years after the date of approval. The policy may be subject to audit and will be assessed in line with normal audit planning processes, the outcome of any audits undertaken will be reported to the Trust Safeguarding and Public Protection Management Group.

13 ACKNOWLEDGEMENTS

This policy has been informed by a similar policy: Cwm Taf UHB Safeguarding and Public Protection Policy (2018)

Appendix 1

An overview of the duty to report process

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

Appendix 2

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Does the adult at risk have/need an advocate?	
Adult at risk advocate details	
Is the adult at risk subject to legislative powers, such as DoLS, MHA or Power of Attorney?	
If yes, please provide details	
Is the adult at risk aware of the report?	
If No, please explain why	
Is there any evidence to suggest that the adult at risk lacks mental capacity to consent to this report?	
Do they consent to their information being shared with other agencies?	
Is there an overriding reason to share this concern without consent?	

Where the abuse occurred	
Where did the alleged Abuse occur?	
Address if not Home/Hospital	
If this occurred in an NHS Service, if so, please state which service and where	
Service	**Location**
Other - Please State:	

Details of the person affected	
Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Subtype of Person Affected	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Preferred Language	
Is interpreter required	
Ethnicity	
Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Was the person injured in the incident?	
Injury – Check Merge code	
Body Part Check Merge code	
Treatment Check Merge code	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other Person(s) Affected	
Are there adults or children at the property?	
Are they also considered at risk?	
If yes - what is the risk?	

Associated Persons	
Is the associated person a member of the same household?	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Title	
Forenames	
Surname	
Address	
Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Employees	
Contact Role	
Contact Type	
Subtype	
Relationship to Individual at Risk	
Title	
Forenames	
Surname	
Email	
Address Line 1	
Address Line 2	
Address Line 3	
Telephone Number	
Other Employer Details	

Does the alleged person of concern have any **contact with children** in any employment role?	
Does the alleged person of concern have any **contact with adults** in any employment role?	
Is the alleged person of concern aware of the report?	
Any other relevant information about this individual Put N/A if there is no other information	

Witnesses	
Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement	
Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

Appendix 3

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for Report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Has consent for report been obtained from the person with the parental responsibility?	
Has consent been obtained from the child/young person?	
Is there an overriding reason to share this concern without consent?	
If yes, please explain why	
Views of the person with the parental responsibility about making this report	
Views of the Child / Young Person about making this report:	

Where the abuse occurred	
Where did the alleged Abuse occur?	
Other Please state:	
Address if not Home/Hospital	
If this occurred in an NHS Service, if so, please state which service and where	
Location	
Secondary Location	
Service Submitting report	
Service Responsible for Individual at Risk	

Details of the person affected	
Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Has the family resided in another area	
If yes, why and where?	
Has the Child / Young Person arrived from overseas?	
Immigration Status:	
If yes, Date of Arrival?	
Home Office Registration Number:	
Preferred Language	
Is interpreter required	
Communication Needs	
Cultural Needs:	

Ethnicity	
CP Register	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Looked after?	
Injuries	
Injury	
Body Part	
Treatment	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other persons involved

Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	

Associated Persons	
Is the associated person a member of the same household?	
Relationship	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Contact Subtype	
Title	
Forenames	
Surname	
ID Number Type	
ID Number	
Gender	
Date of Birth	

Date of Death	
Email	
Address	
Postcode	
Primary Telephone Number	
Secondary Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Witnesses	
Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement	
Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

Ref: IG 03
Email and Instant Messaging (EIM) Use Policy

Executive Sponsor and Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	7th May 2026
Date of Equality Impact Assessment:	20th October 2025
Equality Impact Assessment Outcome:	Approved - 5th February 2026
Review Date:	May 2029
Version:	1

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1. Aim

The aim of this Policy is to set out the key areas of responsibilities and the Trust's commitment to ensuring the organisation uses Email and Instant Messaging lawfully and correctly.

For the purposes of this Policy, the Trust takes the view that the principles of confidentiality continue to apply to the use of Email and Instant Messaging in respect of information including commercial data, and all personal data, whether employee, patient, donor and/or service user.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that the use of email and instant messaging is conducted lawfully and in conjunction with this policy.

2. Policy Statement and Objectives

The Email and Instant Messaging Policy (EIM) policy provides direction as to how NHS Wales Corporate EIM must be used.

This policy also sets out the roles and responsibilities of those using NHS Wales Corporate EIM services. These responsibilities include, but are not restricted to, ensuring that:

- The confidentiality, integrity, availability and suitability of information, NHS computer systems and third-party systems are maintained by ensuring use of EIM services is governed appropriately.

- All those identified within the scope of this policy are aware of their obligations in accordance with legislation, standards, guidance and Organisational policy.

This Policy sets out the high level intent of the Trust and also recognises the diversity of the respective Divisions and associated organisations under its control. This policy must be read in conjunction with all relevant national policies, which includes but is not exclusive to the Trust's Information Governance Policy

3. Scope

This policy applies to the workforce of all Velindre University NHS Trust staff, students, trainees, secondees, volunteers, contracted third parties and any persons undertaking duties on behalf of NHS Wales. Thereafter defined as "*EIM Users*".

This policy applies to all EIM Users, regardless of access location, device type (e.g., corporate, third-party, or personal BYOD), or access method.

Corporate EIM solutions include NHS Wales systems such as NHS Wales Email, NHS Wales Microsoft 365 platform and MS Teams. This Policy does not include Non-Corporate Communication Channels

(NCCC) which includes Instant Messaging services such as WhatsApp, Telegram, Cisco Webex, Facebook Messenger, We Chat etc. It is to be noted that unsupported and non-endorsed IM systems, such as those identified above must not be used for business purposes unless sanctioned for use by the individual organisation.

4. Roles and Responsibilities

This policy applies to all employees and contractors working for, or on behalf of the Trust. Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information.

The Chief Executive Officer as the Accounting Officer of the Trust has overall responsibility for ensuring compliance with applicable legislation and regulation. Specific responsibilities will be delegated to the Data Protection Officer, Senior Information Risk Owner and the Caldicott Guardian or an Executive Director as appropriate.

Directors / Managers of Hosted Bodies and Divisions are responsible for the implementation of this policy within their area of responsibility. In addition, they must ensure that their staff are aware of this policy, understand their responsibilities in complying with the policy requirements and are up to date with mandatory Information Governance and Cyber Security training.

Breaches of this policy must be reported via local incident reporting processes and dealt with in line with the All Wales Disciplinary Policy where appropriate.

EIM Users must familiarise themselves with policy content and ensure that policy requirements are implemented and followed within their own work area. Mandatory Information Governance training must be undertaken upon appointment and at least every two years thereafter.

The effectiveness of this Policy will be monitored by each Organisation's Corporate Governance function supported by their Information Governance Team.

5. Policy

5.1 Position Statement

All corporate emails and instant messaging (IM) are monitored to allow enforcement of this policy via Digital Teams using authorised software.

Corporate EIM facilities must only be used lawfully and must not be used for sending defamatory communications, or for harassment, unauthorised purchases, or for publishing views and opinions (defamatory or otherwise) which may lead NHS Wales into disrepute.

Corporate EIM only may be used for the communication of confidential information in line with applicable legislation such as the UK General Data Protection Regulation (UK GDPR), Freedom of Information Act 2000, ICO Guidance and Health Board/Trust/Special Health Authority policies and procedures.

The use of email to communicate personal data is a last resort, and any data that includes personal data must be sent via the All Wales Secure File sharing Portal. If this is not possible all personal data must be encrypted prior to sending, and the password communicated securely to the recipient. This requirement is mandatory for all patient and staff information. Local Digital and IG teams can supply an up to date list of approved secure email domains and systems for sending personal data.

This Policy does not consider the use of Non-Corporate Communication Channels (NCCCs) and personal email accounts. Staff are to note that business information contained within personal email accounts and NCCCs remain subject to applicable UK Data Protection Legislation.

Any use of NCCCs must be authorised by the Trust through the Information Governance Team and a register kept of NCCC Groups.

Users must be diligent when using EIM facilities to ensure intended recipients are selected for that communication, this is essential to avoid misdirection of data. A breach as a result of misdirection must be reported within DATIX Once for Wales (OFW) in the same manner as any other incident within NHS Wales. Trust procedures and standards must be followed for best practice use of EIM facilities. Subject matters considered inappropriate are detailed in appendix A

5.2 Personal Use

NHS email accounts must not be used to send or receive personal / private emails, unless for one of the following purposes:

- Emails to occupational health
- Email for Health and Wellbeing
- Communications connected with approved personal development / training
- Communications with Trade Unions and Professional Bodies
- Emergency emails

Users must not subscribe to or provide any NHS email address to any third-party organisation for personal use unless authorised or endorsed by your organisation.

6. Records Management

Information sent by corporate EIM may be subject to a request for information under the Freedom of Information Act 2000, the Environmental Information Regulations (EIR), Access to Health Records Act,

or Data Protection legislation and therefore should be managed in accordance with the organisations records management policy and any accompanying procedures.

The corporate EIM system itself **must** not to be used as a storage facility. The following practice must be followed in relation to EIM:

- All EIM should either be deleted or saved securely to the appropriate record (e.g. to a clinical / business record, SharePoint or network drive).
- Any EIM emails that are retained within the email system will be automatically archived by the EIM system. This data is then retained for a period of 7 years.

7. Access to EIM under Information Request Procedures

Information held on computers, including those held in EIM accounts may be subject to requests for information under relevant legislation and regulation. All staff should be mindful that it may be necessary to conduct a search for relevant information to respond to the request, and that the author's consent or knowledge is not required such search activity.

8. Monitoring and Compliance

The Trust reserves the right to monitor and audit activity in business premises, use of business facilities and working practices of its employees to ensure compliance with this policy, legislative requirements and the effectiveness of services provided.

It includes monitoring and auditing equipment such as CCTV systems, access control entry systems and any ICT equipment used in the service.

When monitoring employee activity, the Trust will assess:

- The purpose of the auditing and what it aims to achieve
- Whether the processing of personal information is necessary to fulfil the purpose of the monitoring, whilst at the same time ensuring that the business interests that monitoring seeks to protect are legitimate
- Whether the monitoring is lawful, both generally and in particular when considering data protection law
- Whether consideration of the information rights of employees has been appropriately considered (a balancing test)

The tools used for monitoring will be used according to the purpose that has been clearly defined. Data that is processed must be kept secure and access to the data must be lawful.

To ensure compliance with this policy all corporate EIM is monitored to allow for enforcement of this policy. Any suspected security breaches or unauthorised access must be reported immediately to the Trust's Data Protection Officer and the Digital Helpdesk.

Where a breach has occurred an audit of activity will take place to ascertain root causes, this may result in the extraction of corporate EIM without the knowledge of the Staff member.

9. Training, Awareness and Practical Considerations

The Trust demonstrates that employees understand their responsibilities to ensure that personal information is protected and processed in accordance with the applicable procedures, taking into account the related security requirements.

Section 8 of the Trust's Data Protection and Confidentiality Policy details the provision of training in relation to the processing of personal data. Staff are to read that Policy in conjunction with this EIM Policy.

10. Complaints

Anyone whose data is processed by the Trust is entitled to make a complaint if they are unhappy with the way their data has been processed.

Data Protection complaints are that same as any other complaint, however, the individual handling the complaint will be the Head of Information Governance who may need to undertake an investigation into the facts surrounding the complaint prior to responding to the complainant.

Members of Staff are to provide the following address for any individual who wishes to complain to the Trust about how their data has been handled:

Mr Ian Bevan via
VelindreInformationGovernance@wales.nhs.uk
Head of Information Governance
Velindre University NHS Trust
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff / Caerdydd
CF15 7QZ
Tel / Ffon - 029 20196161

It should be noted that an individual has the right not to complain to the Trust, but to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

11. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on Data Protection and Confidentiality activity (including complaints) will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

An annual Caldicott review and audit will be carried out, by associated organisations within the Trust, in respect of the way patient and/or donor information is managed and recommendations for progress established.

The Trust notifies details of the personal data it processes to the Information Commissioner for inclusion on the register of Data Controllers. The notification is reviewed annually by the Trust. The register is maintained by the ICO and is available in the public domain for inspection by anyone.

The policy will be reviewed every 3 years, unless affected by major internal or external changes such as: Legislation; Practice change or change in system/technology; or Changing methodology.

12. References - Specific applicable Legislation and Standards

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (incudes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Access to Health Records Act 1990 (where not superseded by Data Protection Legislation)
- Health & Social Care Act 2012
- Data (Use and Access) Act 2025

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott Principles
- Information Security ISO27001
- Information Commissioners Codes of Practice
- ICO's Employment Information Guidance
- Common Law Duty of Confidence

13. Equality Impact Assessment

This policy has been subject to an equality assessment. Following assessment, this policy was not felt to be discriminatory or detrimental in any way with regard to the protected characteristics, the Welsh Language or carers.

14. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this Policy, please contact: -

Ian Bevan
Head of Information Governance
Velindre NHS Trust HQ
2, Charnwood Court

Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Email – VelindreInformationGovernance@wales.nhs.uk
Tel – 029 2031 6161

15. Further Information

This Policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Confidentiality Breach Reporting Policy
- Records Management Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Internet Use Policy
- Social Media Policy

Appendix A - Inappropriate use

For the avoidance of doubt, NHS Wales will generally consider any of the following inappropriate use, including but not limited to:

- Deliberately attempting to circumvent EIM controls protecting the confidentiality, integrity and availability of the NHS Wales network on NHS Wales owned equipment and services, and knowingly not reporting any suspected security breaches or unauthorised access.
- Using someone else's corporate EIM account without permission.
- Allowing access to NHS Wales email services by anyone not authorised to access the services, such as by a friend or family member.
- Sharing confidential or sensitive information without proper security measures and authorisation.
- Sending or saving unlawful, offensive, or inappropriate content, including defamation, harassment, or discrimination.
- Knowingly violating copyright or intellectual property rights.
- Obtaining or distributing illegal software via EIM.
- Deliberate attempts to bypass security systems protecting the network.
- Purposely overloading systems to disrupt service to other users.
- Disabling or overloading ICT systems or attempting to bypass security protections.
- Introducing malicious software, such as viruses or trojans, into the network.
- Sending unsolicited commercial or advertising emails.
- Sending unauthorised or illegal software or data through EIM.
- Forwarding chain emails or spam internally or externally.
- Subscribing to third-party notifications for non-work-related purposes using your work email.
- Sending and receiving personal material i.e. non-business related material via EIM unless covered within section 5.1.
- Accessing personal email services from NHS Wales devices and networks is prohibited for security reasons, except for services permitted by the organisation.
- Access to internet based EIM providers such as Gmail, Hotmail, Yahoo etc is prohibited for reasons of security with the exception of:
  - Access to email services provided by a recognised professional body or a trade union recognised by the employer
  - Any UK university hosted EIM accounts (accounts ending .ac.uk);
  - Any email account hosted by a body which the employee continue to in conjunction with their NHS role, such as a local authority or tertiary organisation.

Annex 1: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
01/2017	V1	Andrew Fletcher (on behalf of the Internet and Email policy sub group)	Original policy as approved (v1)
26/06/2018	2	Andrew Fletcher (Chair of the IGMAG policy sub group)	Original policy as approved (v2)
14/01/2021	3	Andrew Fletcher (Chair of the IGMAG policy sub group)	Original policy as approved (v3)
26/09/2024	Draft v3.1	Daniel Owen (Chair of OSSMB)	Included Instant messaging and updated policy.
15/01/2025	Draft v3.2	Ian Bevan (Chair of IGMAG)	Review updated Policy and local assessment of risk
06/02/2025	Draft v3.3	Andrew Fletcher (Chair of IGMAG policy sub group) / Ian Bevan (Chair of IGMAG)	Consistency checking with agreed information governance policy positions
11/02/2025	Draft v3.4	Andrew Fletcher (Chair of IGMAG policy sub group) / John Sweeney (IG Manager DHCW)	Consistency checking with agreed information governance policy positions
11/03/2025	Draft v3.4	IG Leads – IGMAG	Review post update
10/06/2025	Draft v4.0	Ian Bevan (Chair of IGMAG)	Review and update
24/07/2025	DRAFT v5	Ian Bevan, HoIG, VUNHST	Convert to Trust Policy

Ref: IG 07

ACCEPTABLE INTERNET USE POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety & Performance Committee
Approval Date:	7th May 2026
Date of Equality Impact Assessment:	12th September 2025
Equality Impact Assessment Outcome:	Approved – 5th February 2026
Review Date:	May 2029
Version:	1

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1. AIM

The aim of this Policy is to set out the key areas of responsibilities and the Trusts commitment to ensuring the organisation accesses the NHS Wales provided Internet lawfully and correctly.

For the purposes of this Policy, the Trust takes the view that the principles of confidentiality continue to apply to the use of the Internet in respect of information including commercial data, and all personal data, whether employee, patient, donor and/or service user.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that the use of the Internet is conducted lawfully and in conjunction with this policy.

2. PURPOSE

This policy provides direction as to how NHS Wales's internet facilities are being used appropriately to assist in delivering services.

The policy sets out the responsibilities of all users when using the internet. These responsibilities include, but are not restricted to, ensuring that:

- The Confidentiality, Integrity, Availability (CIA) and suitability of information and NHS computer systems are maintained by ensuring use of internet services is governed appropriately.
- All those identified within the scope of this policy are aware of their obligations in accordance with legislation, standards, guidance and Organisational policy.

This policy must be read in conjunction with the Information Governance Policy and relevant organisational procedures.

3. SCOPE

The Policy applies to all staff employed within the Trust regardless of status i.e. permanent, temporary, bank, agency, honorary contract holders and volunteers who process patient, donor, staff and service user personal data, there after defined as "Internet user".

This policy applies to all Internet users that make use of the NHS network infrastructure and / or NHS equipment to access internet services regardless of the location from which they accessed and the type of equipment that is used including corporate and third party equipment.

The terms "internet access" or "internet use" encompass any use of any resources of the internet including but not limited to social media / social networking, browsing, streaming, downloading, uploading, posting, "blogging", chat and email. The NHS Wales Social Media Policy provides information on the appropriate use of social media.

4. ROLES AND RESPONSIBILITIES

Within Velindre University NHS Trust, the Chief Executive Officer (CEO) as the Accounting Officer is accountable for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. Specific responsibilities will be delegated to the Data Protection Officer, Senior Information Risk Owner and the Caldicott Guardian or an Executive Director as appropriate.

Managers are responsible for the implementation of this policy within their department/directorate. In addition, they must ensure that their staff are aware of this policy, understand their responsibilities in complying with the policy requirements and are up to date with mandatory Information Governance and Cyber Security training. Breaches of the policy must be reported via local incident reporting processes and dealt with in line with the All Wales Disciplinary Policy where appropriate.

The workforce must familiarise themselves with the policy content and ensure the policy requirements are implemented and followed within their own work area. Mandatory Information Governance and Cyber Security training must be undertaken at least every two years. Breaches of this policy must be reported via local incident reporting processes.

5. POLICY

5.1 Position Statement

Access is provided to internet users to assist them in the performance of their workforce duties and the provision of these facilities represents a major commitment on the part of Velindre University NHS Trust in terms of investment and resources.

Velindre University NHS Trust will support its workforce in understanding how to safely use internet services and it is important that users understand the legal, professional and ethical obligations that apply to its use. If used correctly, the internet can increase efficiency and safety within patient care.

5.2 Acceptable Use

Internet use, including NHS Wales User IDs, websites and e-mail accounts, must only be used for Velindre University NHS Trust sanctioned activity. Internet users should be aware that internet use is monitored by Digital teams using automated software as set out in Section 7 of this Policy.

To avoid inadvertent breaches of this policy, inappropriate material as identified in Appendix 1 of this Policy will be blocked where possible. Inappropriate material must not be accessed and must be reported in accordance with existing organisational Policy if accessed inadvertently. Internet users must not attempt to circumvent technical

restrictions. Exceptions may be authorised for certain staff where access to specific business related internet services are a requirement of the role, such exceptions will be made on a case by case basis. Subject matter considered inappropriate is detailed in appendix A.

Some sites such as approved video streaming sites may be blocked due to their general impact on network resources and access to these for work purposes may be requested by contacting the Local Digital Service Desk.

Regardless of where accessed, users must not participate in any online activity, create, transmit or store material that is likely to bring the organisation into disrepute or incur liability on the part of Velindre University NHS Trust.

Business Sensitive Information or Personal Data (which includes photographs and video recordings) of any patient, member of the public, or member of staff must not be uploaded to any form of non Velindre approved online storage, online processing, media sharing sites, social media, blogs, chat rooms or similar, without both the authorisation of the Senior Information Risk Owner (SIRO) and the consent of the individual who is the Data Subject of that recording.

It is each user's responsibility to ensure that their internet facilities are used appropriately to ensure service availability

5.3 Personal Use

Velindre University NHS Trust allows internet users reasonable personal use of internet services providing this is within the bounds of the law and decency and compliance with Velindre University NHS Trust policies.

Personal use should be incidental and reasonable and should be limited to before or after normal working hours, or during agreed break times. These limitations are also necessary due to network demands and therefore local restrictions may apply dependent on the duration of access and the capacity of resources available. In addition to this, users must not stream or download large volumes of data (e.g. streaming audio or video, multimedia content, software packages) as these may have a negative impact on network resources, unless these are required for business purposes.

Internet users who use NHS equipment outside NHS Wales premises must use a secure connection provided by Velindre University NHS Trust (for example via VPN). Use of the equipment for such purposes is still subject to the same conditions as laid out in this policy.

NHS Internet access facilities must not be used to run or support any kind of paid or unpaid personal business venture whether it is conducted in a user's own time or otherwise.

6. MONITORING AND COMPLIANCE

Internet users must be aware that all Velindre University NHS Trust network activity including internet activity is effectively monitored regardless of the device it is being used upon to ensure the Confidentiality, Integrity and Availability of the service. Velindre University NHS Trust reserves the right to adopt different monitoring patterns as required to maintain service delivery and the integrity of NHS services. Monitoring of internet activity must comply with applicable legislation, standards and ICO guidance.

The distribution of any information through the Internet (including by e-mail, instant messaging systems and any other computer-based systems) may be scrutinised by NHS Wales and NHS Wales reserves the right to determine the suitability of the information. This Policy is to be read in conjunction with the Trust's Email and Instant Messaging (EIM) Policy.

NHS Wales uses software to record the amount of time spent by internet users accessing the internet and the type of websites visited by staff. Attempts to access any prohibited websites are also recorded and may be subject to disciplinary action in accordance with NHS Wales Disciplinary Policy.

7. INVESTIGATIONS OF SUSPECTED MISUSE

Monitoring of systems and reporting incidents of misuse will be used in investigations where it is suspected that there is a breach of either policy or legislation or where there are relevant and legitimate concerns around an internet user's performance, (e.g. excessive internet usage). In deciding as to whether an investigation is appropriate employees will be afforded their rights under applicable legislation and NHS Wales Policy and Standards.

Managers are expected to speak to staff of their concerns should any issues arise. If breaches of this policy are detected an investigation may take place. Where this or another policy is found to have been breached, disciplinary procedures may be followed.

Concerns about possible fraud, corruption or any other illegal activities must also be reported to the appropriate NHS Wales counter fraud team and where a criminal offence is suspected may be reported to the authorities.

For Velindre University NHS Trust to achieve good cyber security and information governance practice, staff must be encouraged to recognise the importance of good governance and report any breaches of this policy to enable lessons learned.

Internet users must be provided with the necessary tools, support, knowledge and training to help them deliver their services in compliance with legislation. Ultimately a skilled workforce will have the confidence to challenge bad practice and understand how to use information legally and securely in the right place and at the right time. This will help raise awareness among other internet users and should minimise the risk of incidents occurring or re-occurring.

8. TRAINING AND AWARENESS

Information Governance and Cyber Security is everyone's responsibility. Information Governance, Records Management and Cyber Security training is mandatory for all NHS Wales staff and must be completed at commencement of employment and at least every two years subsequently. Non-NHS employees must have appropriate Information Governance and Cyber Security training in line with the requirements of their role.

The Cyber Security department within the organisation may produce ad hoc guidance and awareness documents and provide simulations as undertaken by real threat actors.

Section 8 of the Trust's Data Protection and Confidentiality Policy details the provision of training in relation to the processing of personal data. Staff are to read that Policy in conjunction with this Acceptable Internet Use Policy.

9. GOVERNANCE AND REPORTING

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on Data Protection and Confidentiality activity (including complaints) will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

The Trust notifies details of the personal data it processes to the Information Commissioner for inclusion on the register of Data Controllers. The notification is reviewed annually by the Trust. The register is maintained by the ICO and is available in the public domain for inspection by anyone.

The policy will be reviewed every 3 years, unless affected by major internal or external changes such as: Legislation; Practice change or change in system/technology; or Changing methodology.

10. EQUALITY IMPACT ASSESSMENT

This policy has been subject to an equality assessment. Following assessment, this policy was not felt to be discriminatory or detrimental in any way with regard to the protected characteristics, the Welsh Language or carers.

11. CONTACTS

A copy of this policy and other policies and procedures referenced are available on the Trust's Intranet site. The Information Governance team is available to provide advice, guidance and support and can be contacted via e-mail:

VelindreInformationGovernance@wales.nhs.uk.

12. REFERENCES – SPECIFIC APPLICABLE LEGISLATION AND STANDARDS

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (includes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Access to Health Records Act 1990 (where not superseded by Data Protection Legislation)
- Health & Social Care Act 2012
- Data (Use and Access) Act 2025

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott Principles
- Information Security ISO27001
- Information Commissioners Codes of Practice
- ICO's Employment Information Guidance
- Common Law Duty of Confidence

APPENDIX A: INAPPROPRIATE USE

For the avoidance of doubt, inappropriate use includes, but is not limited to:

- Intentionally introducing malicious software (malware) such as Viruses, Worms, and Trojans into the NHS Wales network.
- Deliberately attempting to circumvent internet access controls on NHS Wales owned equipment and services protecting the confidentiality, integrity and availability of the NHS Wales network.
- Personal use beyond that which is permitted under para 5.3.
- Allowing access to NHS Wales internet services by anyone not authorised to access the services, such as by a friend or family member.
- Communicating or disclosing confidential or sensitive information via the internet without authorisation or without the appropriate security measures being in place.
- Downloading or communicating any information or images which are unlawful, or could be regarded as defamatory, offensive, abusive, obscene, hateful, pornographic, violent, terrorist, indecent, being discriminatory or using the internet to inflict bullying or harassment on any person.
- Downloading, uploading, transmitting, viewing, publishing, storing or distributing defamatory material or intentionally publishing false information about NHS Wales or its staff, clients or patients.
- Knowingly accessing, or attempting to access internet sites that contain obscene, hateful, pornographic, violent, terrorist, racist or otherwise illegal material. This will include such pages on social media sites.
- Knowingly and without authority view, upload, or download material that may bring Velindre University NHS Trust into disrepute.
- Sending or saving information or images which could be considered defamatory, obscene, hateful, pornographic, violent, terrorist, racist or otherwise illegal material.
- Downloading or installing or executing or distributing unlicensed or illegal software.
- Downloading or installing or executing software without authorisation or changing the configuration of existing software using the internet without the appropriate permissions.
- Breaching copyright or Intellectual Property Rights (IPR)
- Accessing Software as a Service (SaaS) platforms not approved by the organisation (digital teams hold a service catalogue which identifies SaaS platforms)
- Unauthorised access to other accounts or unauthorised websites or services – employees are encouraged to seek advice from Digital teams prior to access to a site which they believe may be interpreted as unauthorised.
- Any deliberate malicious activity to attempt to cause a denial of service to other users or services (for example, deliberate or reckless overloading of access links or switching equipment).
- To access sites with the intention of making a personal gain (for example - running a business).

- Access to internet based e-mail providers such as Gmail, Yahoo etc is prohibited for reasons of security with the exception of:
  - Access to email services provided by a recognised professional body or a trade union recognised by the employer;
  - Any UK university hosted e-mail account (accounts ending in .ac.uk);
  - Any email account hosted by a body which the employee contributes to in conjunction with their NHS role, such as a local authority or tertiary organisation.

Ref: IG 09

INFORMATION GOVERNANCE AND INFORMATION SECURITY POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	7th May 2026
Date of Equality Impact Assessment:	20th October 2025
Equality Impact Assessment Outcome:	Approved – 5th February 2026
Review Date:	May 2029
Version:	1

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1. AIM

The aim of this Policy is to set out the key areas of responsibilities and the Trusts commitment to ensuring the organisation complies with application statutory and common law, guidance and standards.

This policy also aims to provide all employees of the Trust with a framework in which to ensure that the processing of data is conducted lawfully and in conjunction with this policy.

The policy consolidates and replaces the following national policies with new Trust level Policies:

- NHS Wales Information Governance Policy
- NHS Wales Information Security Policy
- NHS Wales Internet Use Policy
- NHS Wales Email Use Policy

The new Trust level Policies are:

- Velindre University NHS Trust Information Governance and Information Security Policy (this Policy)
- Velindre University NHS Trust Acceptable Internet Use Policy
- Velindre University NHS Trust Email and Instant Messaging Use Policy

2. POLICY STATEMENT AND OBJECTIVES

This policy provides direction to the Workforce with the scope, to ensure that all information is acquired, stored, processed, shared and transferred, safely and securely in accordance with the law and associated standards.

The objectives of the policy are to; set out legal, regulatory, and professional requirements; and provide the Workforce with the necessary principles to understand and fulfil their responsibilities in ensuring the Confidentiality, Integrity, Availability (CIA) and security of information.

3. SCOPE

The scope of this policy covers all Divisions and Hosted Bodies within Velindre University NHS Trust.

This Policy applies to all staff employed within the Trust regardless of status i.e. permanent, temporary, bank, agency, honorary contract holders and volunteers who process patient, donor, staff and service user personal data.

Furthermore, this policy applies to all forms of information processed by or on behalf of Velindre University NHS Trust regardless of format, including but not limited to paper or electronic records.

4. ROLES AND RESPONSIBILITIES

Within Velindre University NHS Trust, the Chief Executive Officer (CEO) as the Accounting Officer is accountable for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation. Velindre University NHS Trust must have in place appropriate local information governance management arrangements.

To comply with data protection legislation, Velindre University NHS Trust must have in place the following roles:

- **Data Protection Officer (DPO):** An independent data protection expert who is responsible for monitoring an organisation's compliance; informing and advising the organisation on its data protection obligations and acting as a contact point for data subjects and the Information Commissioner's Office (ICO).

Whilst not a legal requirement, to facilitate good governance in accordance with the seven Nolan Principles for Public Life, organisations must also appoint to the following key roles:

- **Senior Information Risk Owner (SIRO):** An Executive Director or member of the Senior Management Board of an organisation with delegated responsibility from the CEO for the organisation's information risk policy. The SIRO is accountable and responsible for information risk across the organisation;
- **Caldicott Guardian:** A senior person with delegated responsibility from the CEO for protecting the confidentiality of patient and service-user information, and helping to ensure this information is used ethically, legally and appropriately;

Directors and Managers are responsible for the implementation of this policy within their department/directorate. They must ensure that members of the Workforce within their area of responsibility are aware of this policy, understand their responsibilities in complying with the policy requirements, and that they are up to date with their mandatory Information Governance, Records Management and Cyber Security training. Successful completion of which is managed via the module within the Electronic Staff Record. Where members of the workforce are not employees of Velindre University NHS Trust and they have a role that requires them to create, amend, access, or otherwise disseminate personal data or corporate information, processes must be in place to ensure they undertake regular suitable Information Governance training upon on appointment and regularly thereafter in keeping with similar arrangements for NHS Wales Staff.

The workforce must familiarise themselves with this policy and ensure its requirements are implemented and followed within their work area. Instances of non-compliance with this policy must be reported in accordance with local procedures.

5. POLICY

5.1 Principles

The workforce of Velindre University NHS Trust are accountable under applicable statutory legislation and common law for the safe, secure and lawful processing of information.

5.2 Standards

This policy aims to give the workforce clear direction to enable them to maintain the following four key standards:

- **Openness:** Velindre University NHS Trust will support the principles of openness and transparency and welcomes the right of access to information provided by relevant legislation.
- **Legal Compliance:** Velindre University NHS Trust will comply with relevant legislation, and the common law, relating to the management and use of information.
- **Information Security:** Velindre University NHS Trust will establish and maintain policies, procedures and guidance for the effective and secure management and operation of all information assets regardless of whether these are in paper form or stored within its digital network.
- **Information Quality Assurance:** Velindre University NHS Trust will promote information quality and effective records management through the provision of relevant policies, procedures, guidance, and training.

5.3 Data Protection Impact Assessments (DPIA)

Data Protection by Design and by Default is a legal requirement as set out in Article 25 UK GDPR, the principle methodology to enable compliance with this requirement is the completion of a DPIA to assess risks to the rights and freedoms of the individual (data subject). Similarly, the requirement to carry out a DPIA is a legal requirement under Article 35 UK GDPR where any processing is likely to result in a high risk to the rights and freedoms of individuals or in any case where there is to be:

- A systematic and extensive profiling with significant effects on an individual.
- Large scale use of special categories of data or of personal data relating to criminal convictions and offences.
- Public monitoring (including the use of CCTV).

For the purpose of this policy, processing may be high risk where the processing:

- Involves the use of innovative technologies, or the novel application of existing technologies, including Artificial Intelligence (AI).
- Relates to an automated decision-making process that influences whether an individual or group of individuals can access a product, service, opportunity or benefit based on profiling or involves the use of special category data.
- Consists of any profiling of individuals on a large scale.
- Is of biometric data for the purposes of identifying an individual.
- Is of genetic data except for the provision of direct care by a healthcare professional.
- Where data is combined, compared or matched with other personal data obtained from multiple sources.
- Where data has not been obtained directly from the data subject and the use of the data means that contacting data subjects to advise of the processing would prove impossible or involve disproportionate effort.
- Involves tracking an individual's geolocation or behaviour, including but not limited to the online environment.
- Relates to children or other vulnerable individuals for marketing purposes, profiling or other automated decision-making, or;
- If online services are to be offered directly to children.
- Is of such a nature that a personal data breach could jeopardise the health or safety of individuals.

The workforce must consider whether a DPIA is required and seek the advice and guidance of the Trust's Information Governance team at the beginning of any project (which includes prior to procurement) and prior to the processing of any personal data.

5.4 Third Parties and Contractual Arrangements

Whenever Velindre University NHS Trust engages a data processor or any other form of supplier that involves the collection, storage, processing, analysis, use and dissemination of personal data, there must be a written contract or other legal instrument in place that clarifies responsibilities and liabilities for information and data. Agreements between Velindre University NHS Trust and any processors must provide that no sub processor should be appointed without prior authorisation.

Where the processor utilises a sub processor, the Trust must be satisfied that the sub processor has an equivalent level of protection for the personal data as those in the contract between Velindre University NHS Trust and the processor before authorising that sub processor.

A proposed transfer of personal data outside of the UK is referred to as a 'restricted transfer'. In such circumstances individual rights around personal data must be protected or one of a limited number of exceptions must apply in order for the transfer to proceed. Velindre University NHS Trust must assess and apply such protections as specified in legislation and ICO guidance to such transfers. The Workforce must contact the Information Governance team to seek advice and guidance before such transfers are made.

5.5 Information Sharing

Velindre University NHS Trust must put in place formal agreements prior to sharing information with other organisations. Such agreements provide a framework for the secure and confidential obtaining, holding, recording, storing and sharing of information. Advice must be sought from the Information Governance team in such circumstances.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is in place to assist organisations to share personal data effectively and lawfully.

The Trust is a signatory to the Accord it must therefore use WASPI templates where they are relevant to the proposed sharing. Further advice is available on the WASPI website: www.waspi.gov.wales.

5.6 Sharing Personal Data in an Emergency

In an emergency situation (e.g. where there is a serious threat to life or safety) personal data may be shared without a formal agreement. The sharing of such information must be formally documented, evidencing why the information needed to be shared. In these circumstances the decision can be documented retrospectively. Members of the Workforce should exercise their professional judgement in such circumstances. Velindre University NHS Trust should support the Workforce to make appropriate decisions by providing support, guidance and training.

5.7 Inappropriate Use of the NHS Wales Network

Inappropriate use of NHS Wales Digital Services is prohibited. For the avoidance of doubt, the Appendix to this policy sets out what is considered to be inappropriate use.

Velindre University NHS Trust's Workforce must not use Velindre University NHS Trust IT systems in any way to access, create, transmit or store material (including on Non-Corporate Communication Channels (NCCC)) that is likely to bring Velindre University NHS Trust into disrepute or incur liability on the part of Velindre University NHS Trust. Where a job requires a member of the Workforce to send, receive, or access material that could be considered offensive, arrangements must be authorised to facilitate this requirement.

To avoid any inadvertent breaches of this policy, Velindre University NHS Trust will block any communications and internet sites containing prohibited content by default. Procedures must be in place to consider applications for exceptions.

Any requests for guidance by Staff relating to the use of Social Media should be forwarded to local Communications Teams to ensure that advice and guidance is timely and up to date. In all instances, anyone using social media on behalf of the organisation or service has a responsibility to conduct themselves in an appropriate manner, as they should when addressing the media or any public meeting or forum. Users must ensure that Digital facilities are used appropriately at all times.

The NHS Wales digital network must not be used to run or support any kind of paid or unpaid personal business venture whether it is conducted in a user's own time or otherwise.

5.8 Communications using NHS Wales IT resources

For further guidance in respect of EIM use, the workforce should consult the Trust EIM Policy.

Security measures appropriate to the level of risk must be employed in all circumstances, with particular caution applied when data is sent outside of the NHS Wales Digital network. When sending any communication users must be vigilant and ensure that contact details (including email addresses) are up to date and correct. Tools such as the Secure File Sharing Portal must be used where appropriate.

Limited personal use of NHS Wales communications systems is permitted.

Users must not subscribe to third party services unless they are part of a recognised scheme for the employer (e.g. health and wellbeing schemes promoted by the employer). For the purpose of this policy, the following uses are considered to be consistent with work purposes:

- Communications sent to Occupational Health.
- Communications connected to Health and Wellbeing incentives.
- Communications connected with approved personal development / training.
- Communications with Trade Unions and Professional Bodies.
- Communications in an emergency situation.

5.9 Access Management

Access to information must be based on an individual's role.

Taking into account the capabilities of applications and Digital systems, the minimum level of access required for the NHS Wales Workforce to undertake duties associated with their employment should be provided. The Workforce must only access information required to undertake duties associated with their employment. Access to any information, including information about themselves or any other individual, is prohibited unless it is required as part of their role and does not constitute a conflict of interest.

Members of the Workforce are responsible for ensuring that the security of information is maintained regardless of the setting (for example, when working from home or working in the community).

Where file servers exist, access must be restricted to those designated members of the Workforce that require access as part of their role (typically system administrators, data architects and similar roles). The Workforce must not access or attempt to access this equipment unless it is a part of their role.

Passwords for individual accounts must not be disclosed, and users of Digital systems must not under any circumstances allow their accounts to be used by others.

Where shared accounts exist to access any historic Digital infrastructure or to log on to the network using dedicated IT equipment, usernames and passwords should be changed regularly and not shared beyond the team responsible for operating those services. Any local or national systems and services accessed via these computers must only be done so using individual usernames and passwords to enable audit of services.

Leavers and movers procedures must be followed when a member of the Trust's Workforce either leaves their current role for another in a different department or leaves the organisation. This ensures that access to systems and buildings is managed appropriately, and that security is not compromised. Confidential information, including access rights to confidential information on systems, must not be transferred to a new role if not required for that role.

Any suspected breach of security must be reported as soon as possible in accordance with local procedures in force within Velindre University NHS Trust.

5.10 Personal Devices

Users are not permitted to use their personal device or web browser to access or attempt to access the NHS Wales internal network that exists behind password protected security controls, unless accessed via the software made available by Velindre University NHS Trust. Users must also ensure that they have Multi-Factor Authentication (MFA) in place so that all access is as secure as possible

Users must not store or attempt to store confidential information on personal devices unless this is stored using software made available by the NHS in Wales for that purpose.

By default, photographs must not be taken of individuals in any patient areas of NHS premises using a personal device. In areas designated as ‘staff only’ that are not accessed by patients, a personal device must not be used to take any photograph unless approved by the appropriate head of service following a risk assessment to ensure that the confidentiality of individuals in those images and the security of any organisational measures that may be in place.

5.11 Backup

Where it is proposed that any and all information (including Personal Data) is to be stored in a location not connected to the NHS network, a risk assessment must be undertaken and reviewed by Velindre University NHS Trust’s SIRO or another individual with delegated authority to make decisions. In all circumstances, information must be uploaded to the relevant filing structure, to include shared drives, clinical systems, records management systems, or SharePoint sites as soon as is reasonably practical given the circumstances. Organisational procedures or other guidance must be in place to ensure members of the NHS Workforce are aware of their responsibilities.

Velindre University NHS Trust must ensure backup arrangements are in place across relevant IT systems and services, to support business continuity, disaster recovery and regulatory compliance.

5.12 Disposal of confidential information and computer hardware

Confidential information in paper format, and any Digital equipment that is capable of storing information must be disposed of using accredited secure waste disposal companies (the Supplier). Organisational leads procuring such services must ensure that the supplier complies with legislation and UK national and NHS Wales security standards prior to contract award. The contract must contain Contract Clauses as set out in current ICO Guidance to ensure that the roles and responsibilities of both Parties are clear and that liability for both Parties in the event of data breach is clear.

5.13 Records Management of Communications

Communication tools (for example, Outlook and Teams chat messages) must not be used as a long-term storage facility. Emails / messages that need to be retained must be saved securely to the appropriate record (e.g. to a clinical / business record or shared network drive).

Retention policies must be set as appropriate in accordance with the current issue of the Welsh Government Records Management Code of Practice for Health and Social Care.

5.14 Requests for Information by members of the Public, Data Subjects or as part of legal request for information

Members of the Workforce should be aware that it may be necessary to conduct a search and disclose information in response to information requests under applicable legislation including but not exclusive to; the Data Protection Act 2018 (UK GDPR), Freedom of Information Act 2000, Environmental Information Regulations 2004 and Inquiries Act 2005, to conduct an investigation or as part of a Public Inquiry, and that this may take place with or without their knowledge or consent.

5.15 Intellectual Property

Intellectual property created by Velindre University NHS Trust remains the property of that organisation. Unpublished documents created by the Velindre University NHS Trust Workforce must not be published or made available to any individual not employed by Velindre University NHS Trust outside of normal organisational arrangements, such as Publication Schemes created under the Freedom of Information Act 2000, or in response to a request for information in line with the law and approved processes.

All software, information, and programmes developed for Velindre University NHS Trust by the NHS Wales Workforce during the course of their employment will remain the property of the organisation.

5.16 Information Asset Management

The processing of information assets must be catalogued and managed by Velindre University NHS Trust, using an Information Asset Register which must be regularly reviewed and updated and contribute to the organisation's Record of Processing Activity (ROPA).

The Wales Control Standard for Electronic Health and Care Records describes the principles and common standards that apply to shared electronic health and care records in Wales. A register of core national systems is maintained by Digital Health and Care Wales.

5.17 Incident and Risk Management

Velindre University NHS Trust must have policies and procedures in place to:

- Identify and manage risks to the confidentiality, integrity and availability of data and information for which they are responsible.
- Report, manage and resolve any breaches under this policy.
- Identify and implement lessons learned.

Information Asset Owners are responsible for determining the appropriateness of any security measures required to protect information assets based on local risk assessments, including Data Protection Impact Assessments.

Incidents must be reported promptly and in any case in line with current legislation.

5.18 Training and Awareness

Information Governance, Records Management and Cyber Security Training is mandatory for the Velindre University NHS Trust Workforce and must be completed at commencement of employment and at least every two years. Non-Velindre University NHS Trust employees must have appropriate Information Governance training in line with the requirements of their role.

5.19 Monitoring and Compliance

Velindre University NHS Trust reserves the right to monitor and audit activity in business premises, use of business facilities and working practices of its workforce to ensure compliance with this policy, legislative requirements and the effectiveness of services provided.

It includes monitoring and auditing equipment such as CCTV systems, access control entry systems and any IT equipment used in the service.

When monitoring employee activity, Velindre University NHS Trust must assess:

- The purpose of the auditing and what it aims to achieve

- Whether the processing of personal information is necessary to fulfil the purpose of the monitoring, whilst at the same time ensuring that the business interests that monitoring seeks to protect are legitimate
- Whether the monitoring is lawful, both generally and in particular when considering data protection law
- Whether consideration of the information rights of employees has been appropriately considered (a balancing test)

6. REVIEW

this policy will be reviewed every three years or more frequently where the contents are affected by major internal or external changes such as:

- Changes in Legislation
- Practice change or change in system/technology
- Changing methodology

7. EQUALITY IMPACT ASSESSMENT

This policy has been subject to an equality assessment.

The assessment determined that this policy was not discriminatory or detrimental in any way with regard to the protected characteristics, the Welsh Language or carers.

8. CONTACTS

A copy of this policy and other policies and procedures referenced are available on the Trust's Intranet site. The Information Governance team is available to provide advice, guidance and support and can be contacted via e-mail: VelindreInformationGovernance@wales.nhs.uk.

9. FURTHER INFORMATION

This policy should be read in conjunction with the following Trust policies:

- Confidentiality Breach Reporting Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy
- Information Security Policy
- Email and Instant Messaging (EIM) Use Policy

In addition there will be underlying divisional, associated organisational protocols and procedures in place to support Trust wide policies.

Appendix 1: Inappropriate Use

For the avoidance of doubt, Velindre University NHS Trust consider any of the following to be inappropriate use:

- Knowingly accessing Velindre University NHS Trust IT services of another Trust employee with or without their knowledge (for example, using someone else's username and password). This excludes sending a communication as an authorised delegate of that member of Velindre University NHS Trust Workforce (for example, an executive assistant sending a communication on behalf of a senior manager, where those delegated responsibilities have been agreed)
- Allowing access to any NHS Wales IT services to someone not authorised to access those services (for example, allowing a friend, family member to use a Velindre University NHS Trust laptop or access resources via a personal device).
- Uploading, communicating, or otherwise disclosing confidential information in any way without authorisation, or without the appropriate security measures being in place.
- Knowingly downloading, viewing, communicating or saving, or attempting to download, view, communicate or save any information or images which are unlawful or could be considered to be:

    - Defamatory
    - Offensive
    - Abusive
    - Obscene
    - Hateful
    - Pornographic
    - Indecent
    - Displaying, promoting or describing acts of violence
    - Displaying, promoting or describing acts of terrorism
    - Discriminatory
    - Bullying or harassing to any person.

- Intentionally publishing or communicating false information about Velindre University NHS Trust or the NHS Wales Workforce, clients or patients.
- Knowingly breaching copyright or Intellectual Property Rights (IPR).
- Hacking into others user accounts or using the NHS Wales network to hack into other accounts.
- Downloading, installing, sending or otherwise distributing unlicensed, illegal or unauthorised software.
- Deliberately attempting to circumvent security systems protecting the integrity of the NHS Wales network.
- Deliberately disabling or overloading any ICT system or networks, or attempting to disable or circumvent any system intended to protect the privacy or security of employees, patients or others;
- Altering any of the system settings on NHS Wales owned IT equipment or trying to change the access server to avoid, or attempt to avoid, restrictions imposed by the filtering software.

- Intentionally introducing malicious software such as Viruses, Worms, and Trojans into the Trust's network.
- Knowingly and without authority viewing, uploading, or downloading material that may bring NHS Wales into disrepute; or material that could cause offence to others.
- Distributing unsolicited commercial or advertising materials.
- Using IT equipment supplied or paid for by Velindre University NHS Trust with the intention of making a personal gain (for example - running a business).
- Communicating unsolicited personal views on political, social, or religious matters with the intention of imposing that view on any other person. This does not preclude Trade Union officials from communicating with the NHS Wales Workforce on Trade Union related matters.
- Forwarding chain messages or spam (unsolicited messages) within Velindre University NHS Trust or to other individuals or organisations.
- Excessive personal use or personal use outside of that described in this policy or local policies and procedures.

TRUST BOARD	
STRATEGIC PARTNERSHIPS UPDATE	
DATE OF MEETING	21/05/2026
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	Lauren Fear, Director of Place, Portfolio & Partnerships
PRESENTED BY	Lauren Fear, Director of Place, Portfolio & Partnerships & Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Parnerships
EXECUTIVE SUMMARY	This strategic partnerships update will focus on the following recent developments in: • Cardiff Health Partners • Cardiff and Vale University Health Board - Velindre University NHS Trust Strategic Partnership • South-East Wales Cancer Programme • Collaborative Centre It is important to note that in the execution of all Trust Board portfolios, each Board Member and their teams rely on strategic partnerships to effectively fulfil accountabilities. This update contains those the Directorate of PPP has had a leadership role in over the last period.

	There is on-going development of the scope of our collective "partnership" approach, including updating across the full scope of Trust Board activities.
RECOMMENDATION / ACTIONS	Trust Board to NOTE the update

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Agreed as an update directly to Trust Board	

1. CONTENTS

This update will focus on the following recent developments. Over the latest cycle, there has been a planning focus across these strategic partnerships for 2026/7 and beyond and therefore this update summarises these plans also for:

- Cardiff Health Partners
- Cardiff and Vale University Health Board - Velindre University NHS Trust Strategic Partnership
- South-East Wales Cancer Programme
- Collaborative Centre

2. UPDATE ON RECENT DEVELOPMENTS

2.1 <u>Cardiff Health Partners</u>

2.1.1 There was a Cardiff Health Partners (CHP) workshop as part of the Trust Board Development day on 30th April. The workshop is also taking place in Cardiff and Vale University Health Board and Cardiff University, as the founding anchor organisations to develop a shared understanding of:

- Why CHP exists
- What value it must provide
- The conditions required for organisations to commit resource

2.2.2 The session was designed to be open, exploratory and honest, focusing on shared ambition rather than immediate solutions.

2.2.3 The Trust's core purpose and key ambition for being part of CHP was discussed by Board Members. The discussion focused on a shared ambition for CHP to act as a system enabler, rather than an additional organisational layer or programme.

The Trust's purpose in CHP was articulated across the following themes:

- Improving outcomes and equity
- System integration and collaboration
- Simplifying the system for citizens and staff
- Enabling improvement and change at scale
- Leadership and collective accountability
- Value and sustainability

2.2.4 The Board then considered how to best shape the CHP "moonshots." These goals will be combined with the other partners input. Summary of the Trust's priorities which will be used to shape the final goals:

Moonshot 1: Prevention-Led Cancer and Blood System

- Shift upstream from treatment to prevention, earlier diagnosis and longer, healthier lives.
- Establish prevention and early intervention as a core, explicit purpose of the Trust's role within CHP.
- Use data, research and community insight to identify population-level risk and inequality.
- Align partners to deliver earlier diagnosis, targeted prevention and proactive surveillance.
- Ensure prevention priorities are informed by patient and community voice.
- **CHP role:** Enable prevention at scale through aligned data, research capability, community partnerships and system resources.

Moonshot 2: Organisation of European Cancer Institutes (OECI) -Level Excellence and Access to the Newest Treatments

- Deliver globally recognised cancer care and research through system alignment.
- Support and sustain OECI overarching accreditation as a system-level ambition.
- Enable access to the newest treatments, trials and innovations required for world-class care.
- Align workforce, pathways and infrastructure to international standards.
- **CHP role:** Align partner assets, pathways and investment to support accreditation, research delivery and consistent quality.

Moonshot 3: Treatment and Innovation Closer to Home

- Deliver specialist care and innovation in accessible, equitable and patient-centred ways.
- Redesign pathways to enable appropriate care closer to home with specialist oversight.
- Reduce unwarranted variation in access to advanced diagnostics, treatments and trials.
- Leverage digital and community-based models to support personalised care.
- Improve experience, outcomes and sustainability.
- **CHP role:** Connect specialist expertise, community delivery, digital capability and partners.

Moonshot 4: Research, Workforce and Learning Fit for the Future

- Build a resilient research and workforce ecosystem.
- Protect and resource research and innovation activity during operational pressure.
- Mobilise partner assets to raise Trust's research profile and system-wide adoption.
- Develop a future-ready workforce through strategic training with universities.
- Provide broader, integrated learning experiences for students and trainees.
- **CHP role:** Align people, funding, knowledge and training into a sustainable research and workforce system

2.2.5 In summary, the Trust Board positions CHP as a key transformation engine by embedding it within leadership behaviour, strategic planning, governance and delivery routes, creating permission to work differently, and committing to sustained, patient-focused partnership. CHP enables the Trust to connect people, priorities, resources and expertise, align missions across the system, and deliver scale, impact and credibility that cannot be achieved through organisational action alone.

2.2.6 Next steps, to be completed by end of Q2 2026/7:

1. Agree and formally endorse CHP's mandate as one of the Trust's primary mechanism for system-level transformation, including its role within existing governance.
2. Agree CHP moonshots across all three organisations, confirming priority outcomes and CHP's added value, following completion of the three workshops.
3. Align CHP with strategic planning, using the IMTP cycles to align priorities, missions and delivery routes with partners.

4. Agree clear, patient-centred outcome measures, including equity and experience, and confirm reporting and review arrangements.
5. Confirm Executive leadership sponsorship and operating principles for CHP, including decision-making, prioritisation and pace.
6. Agree partnership, resourcing and risk-sharing principles, including approach to pharmaceutical and industry partnerships.
7. Adopt a phased implementation approach, identifying early opportunities for CHP to demonstrate tangible impact and build credibility.

2.3 Cardiff and Vale University Health Board - Velindre University NHS Trust Strategic Partnership

2.3.2 Cardiff and Vale University Health Board and Velindre University NHS Trust share a long-standing partnership that has been central to delivering high-quality cancer services for the population of South East Wales. In 2025/26, this relationship was further strengthened through the establishment of a formal partnership programme designed to support a unified strategic response to an increasingly complex and rapidly evolving oncology landscape.

2.3.3 The partnership aims to ensure both organisations can meet the challenges and opportunities created by rapid innovation in oncology, including the emergence of Advanced Therapy Medicinal Products (ATMPs). These treatment advances offer significant potential to improve outcomes but require new delivery models, enhanced acute management pathways, and closer integration across provider boundaries.

2.3.4 Guided by an Executive Partnership Group, the collaboration focuses on joint strategic planning and the development of sustainable models of delivery for complex oncology and advanced therapies. This work aims to streamline patient journeys and improve patient experience, ensure timely access to appropriate care, and maximise the use of combined expertise and estate across both organisations.

2.3.5 Key priorities for 2026/7 include:

- Developing a shared partnership vision and future model of care. This will provide the strategic framework for decision-making and support the development of a phased delivery plan and mobilisation of key workstreams.
- Reviewing the options for the shared delivery of lower-acuity haemato-oncology services. This work offers a practical and manageable starting point for testing

joint ways of working and establishing the foundations for shared service delivery across both organisations.
- Providing a coordinated provider planner input into the Advanced Therapies Wales Therapeutic Apheresis Project.

2.3.6 At the Trust Board Development session on 30th April, the joint clinical model was discussed in more detail and the alignment to the Trust's priorities for the next period.

2.3.7 Priority actions agreed for 2026/7:

To develop and mobilise a coordinated programme of joint service planning across oncology, haemato-oncology and advanced therapies with an agreed future model of care, defined workstreams, and a phased delivery plan in place.

Key Milestones:

Joint Model of Care

- Develop and agree Vision for the Partnership and delivery 'Roadmap' Q1
- Model of Care enabling workstreams established Q1
- Develop and agree phased delivery plan Q4

Haemato-Oncology Project

- Agreed service specification for low-acuity haemato-oncology services developed Q2
- Baseline assessment and demand capacity analysis of lower-acuity haemato-oncology services undertaken and gap analysis undertaken Q2
- Develop and agree preferred Model of Care for low-acuity haemato-oncology services Q4

Prevention

- As part of the ongoing partnership, strategic cancer prevention has been identified as a key area where collaborative working can deliver greater impact than independent efforts. This is work will also be under the banner of Cardiff Health Partners.
- Scoping sessions have been held between Velindre and CAVUHB colleagues confirmed a shared commitment to strengthening the prevention agenda. Both organisations recognise the opportunity to maximise research, development and innovation (RD&I) potential and to embed prevention more systematically across services.

- Milestones for delivery Q2 2026:
    - Reviewing primary care cluster profiles to identify areas with the greatest potential impact.
    - Reviewing the Make Every Contact Count (MECC) training offer across both organisations.
    - Developing a draft high-level plan to guide early collaborative activity

2.4 South-East Wales Cancer Programme

2.4.2 The Programme's overarching aim is to improve cancer prevention, early detection, treatment, and palliative care, delivering services that are high quality, equitable, and centred on patient needs for the population of South East Wales. The Programme Board provides strategic oversight, guiding the design, implementation, and evaluation of the programme to ensure these objectives are achieved. All projects and change initiatives within the programme are aligned to the individual cancer strategies of partner organisations, while also prioritising areas where regional collaboration delivers added value and strengthens outcomes across South East Wales.

2.4.3 Plan for 2026/7:

Support effective and consistent approach to Multi-Disciplinary Teams (MDT) across South East Wales by supporting implementation and spread of NHS Performance and Improvement MDT Charter and associated 'Bridging Document'

- Year 1 delivery – Q4.
- Impact - Consistent approach and standards across all MDTs which are auditable and support identification of resource gaps.

Regional Oncology workforce plan

- Year 1 delivery – Q4
- Impact - Establish a regional oncology workforce baseline with an associated Workplan Plan to address any gasp identified.

Shared Patient Treatment List (PTL) established

- Year 1 delivery – Q4
- Impact - Cancer patients tracked in real time across their pathway with all the relevant demographic, referral, clinical and operational data visible to those responsible for patient care. Hospital Initiated Referral (HIR) from Individual HBs into VCS will also provide an in-built validation to the PTL

2.5 Collaborative Centre

2.5.2 The Collaborative Centre, as part of the new Velindre Cancer centre, is intended to bring together research, innovation, digital, education, our staff, patients and donor and external partners into a more integrated way of working, supporting improved patient care and wider impact.

2.5.3 The Trust is currently undertaking focused work which will deliver:

- Operating model
- Investment plan
- Service offer catalogue
- Implementation plan
- Key metrics and indicators to track progress and demonstrate value
- External facing prospectus and wider marketing materials
- Next phase of staff engagement – linked to wider culture programme
- Leadership alignment and governance

2.5.4 As part of this phase, a wide variety of stakeholders are being engaged in order to:

- Sense-check emerging priorities and direction for the collaborative.
- Test how proposed areas of focus would support teams and services in practice.
- Gather feedback on what will be most important for day-to-day use.
- Ensure the plan reflects real needs and is deliverable.
- Identify opportunities and considerations to ensure the centre is relevant and beneficial to partners.
- Test how the centre's proposed offer could best support partners' priorities.

2.5.5 The output will be shared with the Trust Board over the course of the next reporting cycle.

3 SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **NOTE** the update.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (BAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Alignment
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
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	☐

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE	
DATE OF MEETING	21st May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Tessa Harper-Hughes, Business Support Officer
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Interim Chief Executive
REPORT PURPOSE	FOR NOTING

ACRONYMS	
AMaT	Audit Management and Tracking (System)
CEO	Chief Executive Officer
DHCW	Digital Health and Care Wales
EDI	Equality, Diversity and Inclusion
EMB	Executive Management Board
EPMA	Electronic Prescribing and Medicine Administration
EQIA	Equality Impact Assessment
FBC	Full Business Case
IMTP	Integrated Medium Term Plan
IRS	Integrated Radiotherapy Solution
KPIs	Key Performance Indicators
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, plus other identities
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
QIA	Quality Impact Assessment
QSP	Quality, Safety & Performance Committee
RAG	Red, Amber, Green (risk rating system)
RISP	Radiology Informatics System Procurement
SBAR	Situation, Background, Assessment, Recommendation
SDC	Strategic Development Committee
SRO	Senior Responsible Owner
SRU	Satellite Radiotherapy Unit

TAF	Trust Assurance Framework
TCS	Transforming Cancer Services
TrAMS	Transforming Access to Medicines
VCS	Velindre Cancer Service
VUNHST	Velindre University NHS Trust

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 20 January 2026.

1.2 Key highlights from the meeting are reported below.

1.3 Trust Board is requested to **NOTE** the contents of the report and any actions being taken to address any issues highlighted in the meeting.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**No items were escalated for Trust Board action at this meeting.** The Committee did not identify any matters requiring immediate escalation. However, members highlighted the need for continued scrutiny of strategic risks, workforce capacity and national programme dependencies through future reporting.
ADVISE	**Outreach – Governance Route and Assurance (VCS / nVCC)** The Committee received a verbal update on revised governance and assurance arrangements for Outreach, which is now positioned as an outcome of the clinical delivery model, rather than a standalone project. The Committee raised concerns regarding: • Health Board capacity to deliver outreach at scale. • The need to confirm whether the 45% outreach assumption remains valid ahead of nVCC opening. • Assurance that business case commitments are being fully discharged. The Committee requested the following at the next meeting cycle: • An update on governance, including any changes to governance structures. • A review of the revised delivery model, describing its current structure and implementation. • Assurance of outreach targets, with supporting evidence demonstrating achievement. These should include input from nVCC scrutiny arrangements.

ASSURE	**Board Assurance Framework (BAF)** The Committee reviewed the updated BAF and noted improved engagement and discussion at Executive level. However, concerns were raised that several risk scores remain static, particularly patient safety and culture-related risks. Members highlighted: • Limited movement in risk scores over time • Target scores set far into the future without interim milestones • Gaps in controls and assurance without clearly defined actions The Committee **AGREED Assurance Level 2** and requested clearer milestones, updated actions and alignment with IMTP development. **Velindre Cancer Service (VCS) Futures** The Committee **NOTED** progress across the programme but highlighted ongoing workforce, PMO and data challenges. Assurance **Level 3** was **AGREED**. **Welsh Blood Service (WBS) Futures** Overall progress was **NOTED** as Amber/Green, with escalated risks primarily driven by national digital dependencies. Assurance **Level 3** was **AGREED**. **Digital Programme Highlight Report** The Committee **NOTED** significant capacity pressures due to converging national and Trust programmes and welcomed the commissioning of a Digital Diagnostic. Assurance **Level 3** was **AGREED**. **Clinical & Scientific Strategy / Culture & Inclusion** The Committee **AGREED Level 3 assurance** for both areas, noting the need for clearer evidence of impact and movement in risk scores.
INFORM	**Draft Health Technology Wales (HTW) Strategic Plan** The Committee received and noted the draft HTW Strategic Plan. Members highlighted the need to clarify references to social care, given governance constraints, ahead of final approval following consultation. The Committee **NOTED** the draft plan and requested further clarification before sign-off.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE	
DATE OF MEETING	21st May 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Tessa Harper-Hughes, Business Support Officer
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Interim Chief Executive
REPORT PURPOSE	FOR NOTING

ACRONYMS	
AMaT	Audit Management and Tracking (System)
BAF	Board Assurance Framework
BECS	Blood Establishment Computer System
CCIO	Chief Clinical Information Officer
CEO	Chief Executive Officer
CXIO	Chief Experience and Information Officer
DHCW	Digital Health and Care Wales
EDI	Equality, Diversity and Inclusion
EMB	Executive Management Board
EPMA	Electronic Prescribing and Medicine Administration
EQIA	Equality Impact Assessment
FBC	Full Business Case
IMTP	Integrated Medium Term Plan
IRS	Integrated Radiotherapy Solution
KPIs	Key Performance Indicators
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, plus other identities
LIMS	Laboratory Information Management System
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
PROMS	Patient Reported Outcome Measures
QIA	Quality Impact Assessment
QSP	Quality, Safety & Performance Committee

RAG	Red, Amber, Green (risk rating system)
RISP	Radiology Informatics System Procurement
SBAR	Situation, Background, Assessment, Recommendation
SDC	Strategic Development Committee
SRO	Senior Responsible Owner
SRU	Satellite Radiotherapy Unit
TAF	Trust Assurance Framework
TCS	Transforming Cancer Services
TrAMS	Transforming Access to Medicines
VCS	Velindre Cancer Service
VUNHST	Velindre University NHS Trust

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 17 March 2026.

1.2 Key highlights from the meeting are reported below.

1.3 Trust Board is requested to **NOTE** the contents of the report and any actions being taken to address any issues highlighted in the meeting.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**nVCC Readiness and Outreach Programme Progress** • Ongoing concerns regarding urgency and progress, particularly in relation to outreach and interdependencies. • Significant resource pressures identified across digital, workforce, clinical leadership, and implementation functions. • Further detailed reporting to be provided to the nVCC Project Scrutiny Sub-Committee, with a more developed plan expected back to SDC in July. **Welsh Blood Service Digital and Infrastructure Risks** • Risks highlighted in relation to the Bone Marrow Donor Registry digital system, including legacy systems, international data standard pressures, and lack of identified funding. • Potential risks to supply chains associated with LIMS implementation without phased delivery. • Committee noted that significant risks were not clearly articulated in written reporting and require strengthening.
ADVISE	**IMTP 2026/27 – 2028/29** • Plan delivers a balanced financial position, but risks remain around delivery of cost improvement and efficiency plans. • Several refinements required, including: ○ Consistency of terminology and reduction of acronyms

	○ Strengthening of equity and clinical pathway content ○ Clarification of workforce and wellbeing targets • Tight timescales identified ahead of submission to Welsh Government and Board **Board Assurance Framework (BAF)** • Concerns raised regarding static risk scoring and need for more dynamic use of the BAF. • Queries regarding whether certain risks (e.g. University status) meet the threshold for strategic risks. • Need for stronger Executive ownership and clear actions to address gaps in controls. **Portfolio Prioritisation and Strategic Narrative** • Concerns that quantitative scoring may misrepresent strategic priorities (e.g. nVCC, BECS). • Committee advised that narrative context should be strengthened to ensure clarity of strategic importance. **Workforce and Capacity Risks** • Recurrent theme across agenda items highlighting: ○ Dependence on digital and specialist workforce capacity ○ Risks associated with fixed-term funding models • Identified as a Trust-wide strategic issue requiring further work outside Committee.
ASSURE	**Microsoft Enterprise Agreement** • Strategic case endorsed, supporting continuation of Microsoft 365 services (July 2026–2030). • Agreement balances affordability with operational and patient safety risks. **Digital Programme** • Positive progress noted, including: ○ Successful recruitment to CCIO and CXIO roles ○ Windows 10 migration is nearing completion (~99%) ○ Digital deep-dive work progressing • Recognised as a critical enabler of IMTP delivery. **Value Based Healthcare Programme** • Progress made in procurement of national PROMs platform and programme development. • Strong alignment with broader agendas, including sustainability and productivity. **Trust Nursing Strategy** • Good progress against the three-year strategy. • Alignment with national nursing vision and movement towards annual delivery priorities supported. • Strengthened framework for assurance (moving beyond RAG ratings)

INFORM	• Portfolio mapping confirms alignment of strategic priorities with IMTP, with minor gaps identified. • Velindre Cancer Services Futures and Digital Programme reports received Level 3 assurance with reporting improvements required.
APPENDICES	**NOT APPLICABLE**

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee**
Chaired by	Professor Tracy Myhill OBE, NWSSP Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of Meeting	19 March 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Chair's Report - The Chair updated the Committee on her activities since the meeting held on 22 January 2026. This included attendance at Chairs' meetings in January and February, with detailed discussion at the February meeting on the Welsh Risk Pool and its associated financial challenges. She also reported progress on the Governance and Accountability Review, attendance at Welsh Risk Pool meetings, and her contribution to Welsh Government work to develop a procedure for the performance management, removal and suspension of non-officer members across NHS Wales, drawing on her HR expertise. Additional activity included attendance at the NWSSP Audit Committee with Velindre, engagement with Welsh Government, Velindre and NWSSP on the Review Implementation Group, one-to-one meetings with the Chief Executive, and participation in the NWSSP Health and Wellbeing Conference, where she spoke on resilience. Forthcoming commitments were outlined, including further Chairs' and governance meetings and a joint session with Chairs, Chief Executives and the Director General.

Chair reflected on her 4.5-year tenure and thanked the Committee, Vice Chair, Senior Leadership Group and colleagues for their support and constructive challenge. She highlighted a number of key achievements and NWSSP's contribution during and beyond the COVID-19 pandemic, confirmed her intention to continue supporting NHS Wales in a different capacity, and expressed confidence in NWSSP's future. Committee Members formally recorded their thanks, noting the Chair's leadership, partnership working and the positive culture established during her tenure.

The Committee **NOTED** the Chair's Report.

Chair's Action – Ratification of All Wales e-Rostering Solution - The Committee **RATIFIED** the Chair's Urgent Action taken between meetings to approve the expansion of the All Wales e-Rostering contract to include Cardiff and Vale University Health Board medical and dental staff. It was confirmed that the action was taken in line with the Scheme of Delegation, that all necessary approvals had been secured, and that appropriate governance processes had been followed. For assurance, it was noted that Velindre Trust Board approval had also been sought and would be ratified via Chair's Action at the Trust Board meeting on 26 March 2026, and that a further paper would address the on-boarding of additional Health Boards.

Managing Director Update - The Managing Director presented a comprehensive update on key developments across NWSSP since the previous meeting. This included progress on the Governance and Accountability Review, with the Implementation Group meeting regularly and the review confirming the governance framework as fundamentally sound, with recommendations in hand to strengthen assurance. An update was provided on the Welsh Risk Pool, noting that the £49m Welsh Government support for 2025–26 is non-recurrent, creating future financial pressure. Work is underway to strengthen forecasting, data quality, transparency and mitigation, alongside a renewed focus on prevention, clinical learning and reducing patient harm as the root cause of risk. Committee Members emphasised the need for clearer response planning, improved intermediate-level intelligence and stronger system learning, with assurance provided on actions underway to address these issues.

Updates were also provided on the implementation of the Resident Doctor contract, highlighting complexity and risk, with a comprehensive update and future deep dive scheduled; workforce streamlining and supply challenges, including data gaps and funding constraints, with coordinated oversight in place; recent senior leadership appointments for the Medical Director and the Director of Pharmacy Technical Services; emerging work on the future hosting of NHS Employers; and accommodation challenges linked to the TrAMS programme, with a proposal submitted to Welsh Government.

The overarching report provided the Committee with updates across a range of service areas, including Transforming Access to Medicines (TrAMs), Radiopharmacy and the Hub Programme; the NHS Wales Influenza Vaccination Programme; a Procurement Services overview (including the potential impact of the Middle Eastern conflict and issues relating to Hi-Fatigue G bone cement); Primary Care Services and the Medical Examiner Service (including the Workforce Intelligence System and misdirected mail); Laundry Services; decarbonisation and adaptation activity; accommodation; engagement and leadership activity; and awards and recognition.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Report.

Items for Approval

Chair's Recruitment - The Committee **APPROVED** the recruitment arrangements for the appointment of the next NWSSP Chair by the SSPC, informed by the Governance and Accountability Review and ongoing engagement with Welsh Government, and Velindre as host. It was noted that further discussions had resulted in a revised and proportionate approach that aligns with a public appointment process, whilst remaining deliverable within the required timescales. The Committee agreed to proceed with Option 3, including the proposed composition of the appointment panel, the establishment of a stakeholder panel, and the progression of a minor amendment to the SSPC Standing Orders in collaboration with Velindre colleagues. It was confirmed that the recommendation of the appointment panel would return to the full Committee, for discussion.

All Wales e-Rostering System - The Committee **APPROVED** the award relating to the expansion of the All Wales e-Rostering contract to include Medical and Dental staff and to novate current local Medical and Dental contracts for Betsi Cadwaladr, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. It was noted that other NHS organisations may join the arrangements at a future point in time, requiring a Change Control Notice. Assurance was provided that the expansion aligns with the implementation of the Resident Doctor contract, is anticipated within the original procurement, complies with contractual and governance requirements, presenting no financial risk to NWSSP or Velindre, with corresponding approval to be sought from the

Velindre Trust Board.

Oversight Arrangements for NHS Wales Energy Procurement and Contract Management - The Committee **APPROVED** the revised Terms of Reference for the Wales Energy Group (WEG) and Wales Energy Operational Group (WEOG), following a review requested by the Committee to ensure proportionate and effective oversight. Assurance was provided that the arrangements are streamlined, reflect mature procurement and contract management processes, retain flexibility to respond to market volatility, and that arrangements had been supported by Directors of Finance.

Overarching Service Level Agreement (SLA) for 2026–27 - The Committee **APPROVED** the annual update to the overarching SLA for 206-27, noting that it had been reviewed by NWSSP Legal and Risk Services and that no fundamental changes were proposed. Assurance was provided that amendments were limited to clarification and incremental improvements, and that the SLA had been uplifted by 1.1% in line with the unequivocal pass-through expectation set by Welsh Government, reflecting ongoing engagement with Service Leads throughout the year, alongside end-of-year clarification.

All Wales Laundry Services Service Level Agreement (SLA) for 2026–27 - The Committee considered **APPROVED** revised All Wales Laundry Services SLA, noting that it provides the operational framework and performance metrics for the service. Assurance was provided that the document had been developed through stakeholder consultation, remains broadly consistent with the previous SLA, includes targeted amendments to improve clarity and alignment with standards, and had received positive feedback from customers.

Provision of Radiopharmaceutical Products Service Level Agreement (SLA)for 2026–29 - The Committee **APPROVED** the SLA for the provision of radiopharmaceutical products from NWSSP Pharmacy. Assurance was provided that the SLA had been developed through extensive stakeholder engagement and multi-stage review, sets out service scope, quality, performance and pricing arrangements, and supports readiness for service go-live in summer 2026, including transition arrangements with Swansea Bay University Health Board.

Items for Noting and Discussion

NWSSP Integrated Medium-Term Plan (IMTP) 2026–2029 – Financial Position Update - The Committee received the update to the financial position underpinning the NWSSP IMTP, relating to the underlying £0.744m deficit arising from unfunded employer national insurance costs had now been fully mitigated through the identification of recurrent savings. Assurance was provided that the IMTP has been updated to reflect a balanced position, with no other changes from those previously agreed, and remains on track for submission in line with planning deadlines. Opportunities to further support NHS Wales through an opportunities pipeline will be developed and brought back as part of the 2026–27 work plan. The Committee **NOTED** the amendments and continued to **ENDORSE** submission of the IMTP to Welsh Government.

Future NHS Workforce Solution Briefing - The Committee received an update on progress with the Future NHS Workforce Solution, noting confirmation of early adopter status for NWSSP alongside DHCW, Hywel Dda and HEIW, intended to ensure strong Welsh influence over system design. Committee Members noted ongoing risks and challenges associated with data quality, system design and delivery, and the scale of change involved. Assurance was provided that governance, reporting and escalation arrangements are in place, with continued engagement at national level and further detailed updates

scheduled. The Committee **NOTED** the progress made and **ENDORSED** the early adopter status for NWSSP.

Transforming Access to Medicines Services (TrAMS) Programme and Service Management Board Update - The Committee **NOTED** the update provided, noting the six-month review of the Programme Board Terms of Reference and confirmation that full representative membership from across NHS Wales is now in place. It was noted that no further changes are planned at this stage, with the next review aligned to the phased opening of the South-East Radiopharmacy and the establishment of a Service Management Board to oversee delivery and performance.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the financial position as break-even at the end of February 2026, with the full-year forecast also at break-even following agreed distributions of £6m and the offsetting of the National Insurance savings. Capital expenditure remains within the approved allocation and agreed with Welsh Government, with minor in-year profile adjustments for Radiopharmacy and TrAMS schemes. An update on the Welsh Risk Pool confirmed the forecast position at £194.5m, requiring the full £49m Welsh Government allocation, with the risks at the upper end of the range not yet having materialised. The focus was now on year-end closure and review of the position for 2026–27.

People and Organisational Development (POD) Report – The Committee noted the latest workforce position as at February 2026. The report confirmed staff turnover remains slightly above the NHS Wales average, with further analysis underway, sickness absence remains stable, and progress continues across wellbeing, inclusion, leadership development and employee experience initiatives.

Performance Information Report – The Committee noted strong performance against agreed KPIs from October 2025 to January 2026, with two indicators below target and appropriate explanations and improvement actions in place. Committee Members welcomed the positive performance position while challenging whether current targets remain sufficiently ambitious, with assurance provided that this will be reviewed to ensure measures continue to drive improvement and value.

Outcome Measures Report – The Committee noted the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value, continuing to demonstrate NWSSP's value and impact. Strong performance across customer satisfaction, workforce engagement, professional influence and decarbonisation was reported. Committee Members noted enhancements to reporting and confirmed that outcome measures will continue to evolve, including greater benchmarking and trend analysis in future reports.

Transformation Management Office (TMO) Update Report – The Committee noted the update on the breadth of programme activity underway within the TMO. Oversight of a portfolio of 20 live initiatives was reported and generally positive delivery status across major programmes. Improvements in project RAG status were noted, alongside the addition of new projects. Committee Members reiterated the need to ensure delivery pace and challenge remain appropriate given the consistently positive position.

Integrated Medium-Term Plan (IMTP) Quarter 3 of 2025–26 Update - The Committee noted the latest progress update for quarter 3 of 2025-26, providing assurance on delivery of the plan and the effectiveness of quarterly monitoring arrangements. Most

objectives remain on track, with a small number at risk due to capacity or external factors. Committee Members highlighted the need for greater pace in specific areas, including Scan4Safety, with further benchmarking and costing work underway to inform future planning.

NWSSP Corporate Risk Register – The Committee noted the latest update with the current risk profile, including six red-rated risks relating to cyber security, pharmaceutical supply, TrAMS and Radiopharmacy delivery, financial and workforce pressures, the Future Workforce Solution and Welsh Risk Pool forecasting. It was noted that several risks are stable or reducing, due to management actions, with one new risk escalated relating to Resident Doctor terms and conditions.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Items for Information

The Committee received the following items for information:

- Finance Monitoring Returns (Months 9, 10 and 11)
- Personal Protective Equipment (PPE) Report
- NWSSP Audit Committee Assurance Report from 10 February 2026
- SSPC Forward Plan 2026-27

Part B - Private

The Committee **APPROVED** the proposals for Future Workforce Solution Charges, Linen Products and Microsoft Enterprise Agreement.

Matters requiring Board/Committee level consideration and/or approval

The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Date of Next Meeting	Thursday 14 May 2026, 10.00am to 12.00pm

Cyd-bwyllgor Comisiynu
Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	17/03/2026
Statws Cyhoeddi / Publication Status	Open/Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Huw George, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Huw George, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	April 2026	Noted

1. SITUATION/BACKGROUND

This report has been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (JC) at its public meeting on 17 March 2026.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC Standing Orders (SOs).

3. HIGHLIGHT REPORT

(Links to reports highlighted March 2026 - NHS Wales Joint Commissioning Committee).

Status	Update
Alert / Escalate	**Director of Commissioning for Specialised Services** • An update was provided on the increased Obesity Surgery Services Risk (Risk 61 - Current score red 20). Members noted that an interim arrangement was in place with Swansea Bay University Health Board (SBUHB) for access to obesity services for patients based in North Wales and efforts continued to find an alternative provider in North Wales. • Members also noted the on-going risk concerning Joint Accreditation Committee of the European BMT Society (JACIE) certification for BMT and CAR-T services at Cardiff and Vale University Health Board (CVUHB) and SBUHB, with an early July 2026 deadline for meeting accreditation requirements. Assurance on revenue needs was required from a commissioning standpoint. A review of previous funding will be conducted, and a business case will be submitted through the NWJCC governance processes to confirm whether the necessary revenue for the production facility was available. There is a requirement for capital plans to be approved by July 2026. CVUHB continued to collaborate closely with Welsh Government to meet this timeline. This remains a significant risk, noted in the organisational risk register (Risks 80 and 81 – red 15), and as the capital situation evolves, ongoing review of the risks will be required. • Inconsistent Health Board attendance at Individual Patient Funding Request (IPFR) Panel meetings had led to more Chair's Actions, which affected how decisions were made. CEOs will review their HB participation, to ensure improved attendance.
Advise	**Recommendation 4: Rural Response Options** - The report provided an update and options regarding Recommendation 4 – Rural Response. Previous updates had highlighted the need for public engagement, considering operational improvements such as ambulance handover times and availability. - The earliest projected timeframe for establishing a new consolidated air ambulance base was the first quarter of the 2027/2028 financial year.

Status	Update
	- The report outlined three options and the JCC approved **Option 3** which included re-engaging with the public and providers to revisit and potentially revise commissioning intentions, given the extended planning window before the consolidated base becomes operational. - The work will be brought into the organisations planning structures and would feature in prioritisation discussions and the development of the next Integrated Medium-Term Plan (IMTP). A standalone report containing a proposal will be scheduled for the November 2026 JCC meeting and in the meantime updates on progress will continue to be provided in the Director of Commissioning for Ambulance Services and 111 reports. - **Approach to the Commissioning of Hospices Services in Wales** - The co-produced report aimed to establish a consistent baseline and explore national, local, or regional commissioning models. The report set out options to be considered during the next year about where commissioning sits, whether that's nationally, locally, or regionally. Committee members acknowledged the complexity of the hospice sector, the patchwork of providers, and the unpredictability of voluntary income, with the JCC's role as a system leader and convener highlighted. The JCC endorsed the commissioning approach outlined in the report.
Assure	The Committee received the following sub-committee assurance reports: - **Quality, Safety and Outcomes Sub-Committee** - **Planning, Performance and Finance Sub-Committee** - **CTMUHB Audit & Risk Committee** IPFR HB attendance was highlighted as a concern. See Alert/Escalate section above. **Governance & Risk Management:** - The **Organisational Risk Register** as of 31 January 2026 was received. Risks had been reviewed and scrutinised by the NWJCC Sub-Committees prior to the JC. Members noted a reduction in reported risks. This progress was attributed to a comprehensive re-basing exercise and improved risk descriptions as opposed to a reduction in the risk held by the NWJCC.

Status	Update
	- An intention was shared to present the NWJCC Joint Commissioning Assurance Framework, an updated Risk Appetite Statement, and a revised Risk Management Procedure (aligned to the Cwm Taf Morgannwg University Health Board policy) at the July JC meeting. See Alert/Escalate section for updates on two specialised services commissioning risks that were highlighted as areas of concern. The **Corporate Governance Report** including updates on the internal audit programme, hosting arrangements and Welsh Health Circulars was shared. The JC endorsed QSOC and PPF Terms of References for HB approval; and approved JC Annual Effectiveness Survey questions and QSOC, PPF and JC Forward Plans of Business.
Inform	The **Chair's Report** summarised the JC Strategy Session held on 16 February 2026, which covered topics including the development and key issues emerging through the development of the NWJCC IMTP. The **Chief Commissioner's Report** included updates on: - The NWJCC Welsh Government Scrutiny Session - Collaborative Commissioning Leadership Group (CCLG) IMTP Development sessions and the approach to in-year Financial Risk. - The progress made in relation to implementing the new organisational structure for the NWJCC; and - National Programmes of Work, including the Sexual Assault Referral Centre programme. Reports from each of the Commissioning Directors: **Director of Commissioning for Ambulance Services and 111** Members noted: - An update on the implementation of the new ambulance performance framework and the independent evaluation by Edge Hill and Swansea Universities, with plans for health board input into the evaluation methodology and interim evaluations to monitor both short-term and long-term outcomes. **Director of Commissioning for Specialised Services** Members noted:

Status	Update
	- In addition to the update provided in relation to the JACIE and Obesity Surgery risks, plastic surgery waiting times in South Wales had improved significantly, with SBUHB treating all patients waiting over 104 weeks by March 2026. The need for appropriate commissioning of this service was recognised. **Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups** Members noted: - The NWJCC's continuing oversight of the St Andrew's mental health facility which included attendance at weekly Gold and Silver meetings and multi-agency involvement to manage service quality. Eleven Welsh patients currently remain in St Andrew's, with no concerns reported, and coordination remained ongoing between the NWJCC, alternative providers, and health boards in Wales to repatriate these patients. - The Welsh Gender Service review will proceed in two phases: an internal review beginning in quarter one of 2026/2027, followed by an independent external review in quarter three, subject to funding and alignment with English reviews, with patient involvement and the selection of a credible specialist reviewer highlighted as essential. - Members discussed delays in the Royal College of Psychiatrists' review of eating disorder inpatient care, emphasising the need for system-wide cooperation and forthcoming meetings with Welsh Government and service leads. The JC received the **Month 10 and 11 Finance Reports** and the **Operational Performance Report.** The month 11 financial position forecast a £6.7 million overspend, improved from earlier in the year, with all known risks and opportunities included, and efforts underway to ensure a stable year-end outcome. Members also welcomed on-going and continued improvements to performance reporting, including enhanced data quality, user friendly formats and the integration of key metrics. New key performance metrics for 2026/27 will significantly impact Welsh providers, with modelling underway to assess implications and ensure shared understanding of risks, to be fed back to the JC. The **NWJCC Foundation Plan update for Quarter 3** was received and members noted that most priorities were moving

Status	Update
	forward as intended, albeit some areas had experienced delays due to capacity limitations and dependence on external organisations. There were plans to in place to strengthen delivery confidence assessments and improve early risk identification in upcoming reports.
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	23/03/2026
Statws Cyhoeddi / Publication Status	Open/Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Huw George, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Huw George, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	April 2026	Noted

1. SITUATION/BACKGROUND

This report has been prepared to provide Health Board's with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (JC) at its public Extraordinary meeting on 23 March 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted March 2026 - NHS Wales Joint Commissioning Committee).

Status	Update
Alert / Escalate	Since the 23 March 2026 Extraordinary public meeting wording for the recommendation approving the Annual Plan has been agreed via Chair's Action. **The NWJCC Annual Plan for 2026-27 has been approved subject to the requirement for the JCC to work collaboratively with Local Health Boards to urgently develop the 2026/27 priorities to maximise cost improvement efficiencies and savings to improve the additional financial requirement of £16.2m in year.**
Advise	The NWJCC Annual Plan for 2026-2027 was presented for approval. Welsh Government (WG) had initially required the preparation a full three-year Integrated Medium-Term Plan, however clarification had been received that a one-year plan set within a three-year context should be submitted. This resolved the previous governance concerns about committing to multi-year plans when Health Boards (HBs) were only submitting one-year plans. Financial Overview - • The year started with a major deficit that was reduced through the efforts of NWJCC and HB colleagues. • Activity growth, especially in specialist and NHS England services, increased costs which were addressed in the Plan. • A 1.1% funding pass-through (non-pay) had been passed to providers. • The NWJCC would expect providers to deliver 2% efficiency savings equating to £12 million. • Commissioners would collectively contribute a £16.2 million uplift across seven HBs. • The Plan contained inherent risk, and Members noted that work would continue with HBs during 2026/27 to mitigate commissioning risks and to identify further savings opportunities. Members discussed how to describe and present the £16.2m in year risk. Various options were proposed in relation to the

Status	Update
	wording, but members opted to approve the plan in principle subject to allowing a short period to refine the wording around the treatment of the £16.2 million risk for consistency across HBs. There was a commitment to engage all Lay Members and HB representatives in the decision-making process, with the objective of reaching a conclusion within the following 48 hours. The Joint Commissioning Committee resolved to: • **Approve** the Annual Plan for 2026-27 in principle, subject to urgent further discussion and consensus on the wording regarding the £16.2 million deficit.
Assure	N/A
Inform	N/A
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality**	Effective
	Efficient; Equitable; Person-centred; Timely; Safe

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.