Public Trust Board

Thursday 24 September 2026, 10:00 - 13:00

Ystafell yr Wyddfa, Ystafell Pen y Fan, Welsh Blood Service / TEAMS

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

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 30th July 2026

Sara Moseley, Chair

- 1.4.0 DRAFT Public Trust Board minutes 30.07.2026 (v3LF).pdf (15 pages)

1.5. Public Action Log

Sara Moseley, Chair

- 1.5.0 PUBLIC TRUST BOARD ACTION LOG - SEPT 2026.pdf (2 pages)

1.6. Matters Arising

Sara Moseley, Chair

1.6.1. EDI – WBS Brixton Blood Donation Centre Visit

Anne Carey, Chief Operating Officer

- 1.6.1 Trust Board cover paper - EDI WBS Brixton Visit.pdf (6 pages)
- 1.6.1a EDI – WBS Brixton Blood Donation Centre Visit.pdf (5 pages)

10:15 - 10:45
30 min

2. WELSH BLOOD SERVICE STORY

2.1. Celebrating 80 years of the Welsh Blood Service

Alan Prosser, Director of Welsh Blood Service

*Presentation

10:45 - 10:55
10 min

3. KEY REPORTS

3.1. Chair's Report

Sara Moseley, Chair

3.1.0 Chair's Update Report 24.09.26 SM v3.pdf (6 pages)

3.2. Chief Executive's Update

Carl James, Chief Executive Officer

3.2.0 CEO Update September 2026 Trust Board FINAL CJ.pdf (6 pages)

10:55 - 11:35
40 min

4. QUALITY, SAFETY & PERFORMANCE

4.1. Performance Management Framework (July 2026)

Carl James, Chief Executive Officer, Anne Carey, Chief Operating Officer, Amanda Jenkins, Assistant Director of Workforce Planning, Lauren Fear, Director of Place, Portfolio & Partnerships, Matthew Bunce, Executive Director of Finance

4.1.0 Trust Board 24.09.26 PMF July 2026.pdf (39 pages)
4.1.0a Month 4 2026-27 Finance Report Cover Paper - TB 24092026.pdf (8 pages)
4.1.0b Appendix 1 - M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2026 - TB 24092026.pdf (39 pages)
4.1.0c Appendix 2 - nVCC Project Finance Paper (July 26) FINAL.pdf (16 pages)

4.2. Trust Risk Register

Non Gwilym, Interim Director of Corporate Governance

4.2.0 TRR Cover Paper - TB- September 2026 - V04.pdf (5 pages)
4.2.0a Public TRR Appendix -TB September 2026 - V04.pdf (9 pages)

4.3. Board Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

4.3.0 BAF TB COMMITTEE RISK PAPER - SEPTEMBER 2026 - V04.pdf (6 pages)
01 - CAPACITY.pdf (7 pages)
02 - QUALITY.pdf (11 pages)
03 - RDI.pdf (5 pages)
04 - FINANCE.pdf (9 pages)
05 - SUSTAINABILITY.pdf (3 pages)
06 - POD.pdf (5 pages)
07 - DIGITAL.pdf (5 pages)
08 - GOVERNANCE.pdf (4 pages)

11:35 - 11:45
10 min

BREAK

11:45 - 12:00
15 min

5. ORGANISATIONAL DEVELOPMENT

5.1. Partnership Agreements for Cardiff Health Partners (CHP) and Cardiff Cancer Research Partnership (CCRP)

Dr Jacinta Abraham, Executive Medical Director and Lauren Fear, Director of Place, Portfolio and Partnerships

5.1.0 CCRP and CHP Partnership Agreements - Trust Board Cover Paper.pdf (91 pages)
5.1.0a Appendix 1 - Trust Board - September 2026 - CCRP and CHP Agreements.pdf (12 pages)
5.1.0b Appendix 5 - QIA (signed).pdf (7 pages)
5.1.0c Appendix 6 - EQIA (signed).pdf (13 pages)

12:00 - 12:05
5 min

6. ITEMS ESCALATED TO BOARD VIA COMMITTEES

TBC

6.1. Audit & Risk Assurance Committee (oral update)

Gareth Jones, Independent Member and Chair of ARAC

12:05 - 12:40
35 min

7. ITEMS FOR APPROVAL

7.1. NHS Wales Shared Services items for approval

Linsay Payne, Deputy Director of Finance and Corporate Services, NWSSP

- Fleet Modernisation Programme Business Justification Case 2026-2027

7.1.0 Fleet Modernisation Programme Business Justification Case 2026-27 CP VTB Sept 2026.pdf (7 pages)
7.1.0a Appendix 1 - Fleet Modernisation Programme - Year 2 BJC VTB Sept 2026.pdf (44 pages)
7.1.0b Appendix 2 - Commitment of Expenditure - Fleet Modernisation Programme BJC 2026-27 VTB Sept 2026.pdf (12 pages)
7.1.0c Appendix 3 - Quality Impact Assessment - Fleet Modernisation Programme BJC 2026-27 Sept 2026.pdf (8 pages)

7.2. WIBBS Annual Report 2025-2026

Lauren Fear, Director of Place, Portfolio and Partnerships

7.2.0 Wales Infected Blood Support Scheme (WIBSS) Annual Report 2025-26 CP VTB 24 Sept 2026 - final.pdf (4 pages)
7.2.0a Appendix 1 - WIBSS Annual Report 2025-26.pdf (25 pages)

7.3. Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016

Annie Evans, Deputy Director of Nursing, Quality & Patient Experience

7.3.0 Annual Nurse Staffing Report 2025 to 2026 TrustBoardSept26.pdf (6 pages)
7.3.0a NSA Appendix 1 Board_.pdf (13 pages)

12:40 - 13:00
20 min

8. ITEMS FOR NOTING AND ASSURANCE

8.1. Trust Seal Report

Non Gwilym, Interim Director of Corporate Governance

8.1.0 Trust Seal Report 24.07.2026-17.09.2026.pdf (4 pages)

8.2. Trust-wide policy approvals update

Non Gwilym, Interim Director of Corporate Governance

8.2.0 TRUST WIDE POLICIES APPROVED UPDATE SEPT 2026.pdf (4 pages)
8.2.0a APPENDIX 2 GC11 Procedure for Accessing Legal Advice v5_AUG 26.pdf (10 pages)
8.2.0b APPENDIX 3 QS25 Preceptorship Policy Multi_v5_Sep 26.pdf (20 pages)

8.3. NHS Wales Shared Services Partnership Committee Assurance Report (16/07/2026)

Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services

8.3.0 Shared Services Partnership Committee (SSPC) Assurance Report 16 July 2026 VTB CP September 2026.pdf (2 pages)
8.3.0a Appendix 1 - Shared Services Partnership Committee (SSPC) Assurance Report 16 July 2026.pdf (5 pages)

8.4. NHS Wales Shared Services Partnership Audit Committee Highlight Reports (15/06/2026 & 07/07/2026)

Gareth Jones, Independent Member and Chair of the NWSSP Audit Committee

8.4.0a NWSSP Audit Committee Highlight Report 7 July 2026.pdf (5 pages)
8.4.0b NWSSP Audit Committee Highlight Report 15 June 2026.pdf (4 pages)

8.5. Winter Preparedness 2026-27 - Stress Testing

Anne Carey, Chief Operating Officer

- 8.5.0 Trust Board cover paper - EPRR Winter Prep Stress Testing.pdf (6 pages)
- 8.5.0a VCS - EPRR Winter Preparation and Testing.pdf (6 pages)
- 8.5.0b WBS - EPRR Winter Preparation and Testing.pdf (8 pages)

13:00 - 13:00
0 min

9. ANY OTHER BUSINESS

Sara Moseley, Chair

13:00 - 13:00
0 min

10. DATE OF NEXT MEETING

Sara Moseley, Chair

The next meeting will be held on 26th November 2026 at 10:00

13:00 - 13:00
0 min

11. CLOSE

Sara Moseley, Chair

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).

13:00 - 13:00
0 min

12. ITEMS FOR DISCUSSION IN PART B

- Minutes and actions from the previous private Board meeting
- Legal Matters Update
- Input into National Cancer Strategy
- nVCC Beneficial Access Requirements
- nVCC Progress on outstanding issues
- Whitchurch Hospital Grounds next steps
- Emergency Preparedness, Resilience and Response Annual Report 25-26
- Winter Preparedness
- Trust Integrated Improvement Plan
- Private Trust Risk Register
- Board Assurance Framework
- Items for escalation via Committees
- Shared Services items for approval
- nVCC Clinical Systems
- WBS First Floor Lease Approval
- Committee Highlights

MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
30th July 2026 – 10:00am-1:00pm
Trust Headquarters, Nantgarw / via Microsoft Teams

PRESENT	
Sara Moseley	Chair
Lindsay Foyster	Vice Chair
Carl James	Chief Executive Officer
Gareth Jones	Independent Member
Prof. Andrew Westwell	Independent Member
Vicky Morris	Independent Member
Hilary Jones	Independent Member
John Union	Independent Member
Ceri Doyle	Independent Member
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director / Deputy Chief Executive
Gillian Knight	Executive Director of Nursing, AHPs and Health Sciences (interim)
Sarah Jenkins	Executive Director of People and Organisational Development (interim) – *remotely*
ATTENDEES	
Anne Carey	Chief Operating Officer
Victoria Oxley	Director of Strategy, Planning and Performance (interim)
Lauren Fear	Director of Place, Portfolio and Partnerships
Carl Taylor	Chief Digital Officer
Non Gwilym	Director of Corporate Governance (interim)
Jolene Dalton	Head 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: • Ben Leijokari-Olosunde, Aspiring Board Members Programme Member. • Katrina Febry, Audit Lead, Audit Wales. • David Cogan, Patient Representative.	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Ella Wilkins, HEIW (simultaneous translation) • Fiona Davies, Head of Safeguarding and Vulnerable Persons (for item 1.7.0) • Alison Ramsey, Director of Finance and Corporate Service (for item 4.2.0)	
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 21st May 2026** Board members raised the following minor amendments: Page 1 – Incorrect job titles against Gillian Knight / Anne Carey. Page 8 – Wording relating to risk (Datix) under item 5.1.0 required minor amendments Board members were otherwise content that the minutes of the meeting held on 21st May 2026 were an accurate reflection of proceedings.	**Secretariat**
1.4.1	**Minutes of the extraordinary Public Trust Board meeting held on 25th June 2026** Page 1 – correct job title against Lauren Fear. Board members were otherwise content that the minutes of the extraordinary meeting held on 25th June 2026 were an accurate reflection of proceedings.	**Secretariat**
1.5.0	**Action Log** Board members were content to close the two actions noted as 'propose to close'. The remaining open actions were discussed as follows: **26/03/2026 item 5.1.0** – Gillian Knight advised that work to formalise engagement arrangements with the Cancer Alliance, Llais and Maggie's was progressing, with plans agreed but meeting dates still awaited. An update and revised plan are expected at the new September Quality, Safety & Experience (QSE) meeting. The action remains open. **26/03/2026 item 9.4.0** – Carl James reported that Welsh Government had approved requests for additional and repurposed resources. Discussions with service divisions had indicated a positive position, with a final report to be presented at the September Board meeting. The action remains open. **21/05/2026 item 3.1.0** – Anne Carey advised that the action relating to the NHS Blood and Transplant (NHSBT) visit and its implications for future strategy had been deferred due to agenda pressures. The action remains open and it was agreed that an update would be provided at the September Board meeting. **21/05/2026 item 3.3.0 (1)** – Non Gwilym proposed that the Board Assurance Framework action be assigned to her as the named executive lead rather than remaining a collective executive action. An assurance report will be brought back to the Board in September, supported by the wider executive team. The action remains open. **21/05/2026 item 3.3.0 (2)** – Sarah Jenkins reported that work had commenced with the Vice Chair to strengthen the People and Culture elements of the BAF. Three people-related risk themes (staff wellbeing and organisational performance; leadership and management; and culture, values and behaviours) will be developed through the People, Culture and Engagement Committee, with supporting metrics to be introduced and an update to be brought back following the committee's first meeting.	

	21/05/2026 item 5.1.0 - The Chair advised that this matter would be covered within a substantive paper during part B and would be considered as part of that discussion. The Board **NOTED** the agreed status of all actions. It was noted that it would be beneficial for the action log to contain written updates as opposed to verbal updates being provided at the meeting. This was agreed and the Chair advised that the log would be updated as per the discussions above, following the meeting.	
1.6.0	**Matters Arising**	
	There were no matters arising for discussion at today's meeting.	
1.7.0	**Patient Story: Andy's story** Led by Fiona Davies, Head of Safeguarding & Vulnerable Persons Following a video of Andy's story which had been circulated prior to the meeting, Fiona explained that this demonstrated the positive impact of Velindre's dementia-friendly approach, highlighting improvements in staff training (creating dementia champions across the organisation), communication, environmental adaptations (such as smaller, improved waiting areas, consistent signage across the Cancer Centre and dementia-friendly wayfinding) and personalised care. She emphasised that patient feedback had directly informed service improvements and showcased the Trust's commitment to person-centred care for people living with dementia. The effect of dementia on sensory processes and anxiety had also been recognised, and as a result, plans were underway to introduce additional aids such as ear defenders, comfort items such as fidget spinners, and enhanced support for patients who become distressed during treatments. Board members raised the following points / queries: • The wider team was commended for their leadership in developing dementia-friendly services. Andy's story was considered a strong example of the Trust learning from patient feedback and translating concerns into meaningful service improvements, particularly through earlier identification and support for patients with dementia. • A number of challenges are faced by people living with dementia (including their families), highlighting the importance of recognising dementia and supporting patients to understand and communicate their needs. It was suggested that the Trust consider how it could further improve support and diagnosis pathways for this patient group. • That the learning from Andy's story extends beyond dementia care and is being applied across the patient pathway. It was queried how the learning from his experience could improve care for <u>all</u> patients, including those who might have undiagnosed cognitive difficulties, in addition to translating this into wider organisational learning and service improvement. Fiona agreed to meet to discuss how equitable access to services could be provided. The Board thanked Fiona for sharing the story and the Chair advised that the Board would write to Diana Purnell (Support Care Nurse), who had led on this work, to thank her personally.	**GK** **Chair**

2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** The Chair took her report as read and added the following: • The Chair welcomed Carl James to his substantive Chief Executive role, noting that he had successfully progressed through a robust recruitment process and that building a strong, sustainable Executive team and integrated Board remained a priority for the organisation. • The appointment of a new Chair for the NHS Wales Shared Services Partnership, Susan Barnes. The Chair advised that they had already met and highlighted Susan's experience in Shared Services and commissioning; formal quarterly meetings have been established to support collaborative working. • The charity trek had taken place, which the Chair described as an incredible experience, commenting positively on the people involved and the impact of the charity. • There would be focus on one service area for each update, which on this occasion was palliative care. This was described as an incredible service and the Chair encouraged Board members to read the report. She also proposed plans to use the material for internal communications to allow staff to better understand the breadth of expertise and services across the organisation. Lindsay Foyster added that for the first time, there had been a joint meeting of NHS Chairs and Vice Chairs. Both she and the Chair agreed that this was a positive development and reflected a growing recognition of the value of bringing both groups together to strengthen collaboration across Wales. The Trust Board **NOTED** the content of the Chair's update.	
2.2.0	**Chief Executive's Report** Carl James highlighted the following key points: • Congratulations were extended to Sarah Jenkins on her appointment with mid and west Wales Fire Service, noting her contribution to the Trust over the previous ten months. It was confirmed that a successful recruitment process had been completed for Sarah's successor and Carl advised that further detail on the individual and start date would be shared once final arrangements had been completed. • Attendance at the Blood Health National Oversight Group Conference during June; discussions with Chief Executives from the Northern Ireland and Scottish Blood Services had explored opportunities for strategic collaboration and shared learning. Carl also commended two colleagues from the Welsh Blood Service who had presented at the conference, noting their contributions as outstanding. • Thanks were extended to Welsh Blood Service colleagues for maintaining blood and platelet collections during a challenging period of hot weather. High temperatures had led to venue cancellations and donor absences; however, teams had worked creatively to sustain collections and maintain supplies. The Chair suggested that this achievement should be highlighted more widely to colleagues via internal communications.	**TBC**

	The Trust Board **NOTED** the content of the CEO's update.	
3.0.0	**QUALITY, SAFETY & PERFORMANCE**	
3.1.0	**Performance Management Framework (PMF) (May2026)** Colleagues presented the report, which highlighted key issues for the attention of the Board for the month of May 2026. **<u>Overall Performance</u>** Anne Carey provided the following update: • While SACT performance remained challenging, she was encouraged by the strong operational grip and control demonstrated by divisional and directorate teams and the solutions being developed to address performance pressures. • The impact of extreme weather on Welsh Blood Service collections, noting the mitigating actions being taken by teams. Anne also corrected the reported expired platelet figure from 12.5% to 8.0%. Board members raised the following: • Following a detailed workshop that the Quality, Safety and Performance Committee held two months prior regarding SACT (Systemic Anti-Cancer Therapy) and Radiotherapy performance, it was queried whether actions resulting from the workshop had worked, and what improvements had resulted from those actions. Anne responded that a major area of focus was understanding the differing ways teams were working and addressing variation in performance between services. Significant work is underway around consultant job planning, team job planning and the wider infrastructure that supports service delivery. Victoria Oxley supported clearer reporting on improvement actions and advised that a PMF Task and Finish Group was reviewing best practice. • The request for assurance regarding overdue incident and audit actions within the Welsh Blood Service, noting the helpful mitigation plan described in the report. Anne advised that progress was being seen, particularly through improved process compliance and staff training, but agreed that further examples could be provided. • The request for greater visibility of the work undertaken with partner organisations across the cancer pathway, noting that performance is influenced by several stakeholder before patients reach Velindre. Anne advised that work was underway to strengthen reporting on referral treatment times and to share pathway data with Health Boards. • That whilst the organisation should continue to maximise productivity and adapt services to increasing demand, sustained growth in activity may require future discussions with commissioners regarding additional funding. It was advised that final draft business cases were already under development and that an update would follow later in the year in this regard. • A request for clarification on the use of the term "Velindre Organisations" within the Workforce heatmap and associated graphs, noting that it was not an organisational descriptor. It was acknowledged that this appeared to be an error in the report and would be corrected.	**AC** **SJ**

	Finance Matthew Bunce presented the Month 2 Finance report (advising that a more up to date, month 3 report exists). The following was highlighted: • Long Term Agreements (LTAs) had been signed with commissioners by the required deadline. A finance-led group continues to review LTA arrangements, including work relating to rebasing issues. • The Trust is still awaiting formal approval from Welsh Government for the financial plan submitted as part of the Integrated Medium Term Plan (IMTP) at the end of March. • The organisation remains on track against its three key financial targets. • Approximately £1.2 million of savings schemes were still rated amber at the time of the report, representing approximately half of the savings programme. However, performance at month three was only approximately £15k below target and therefore the Trust was mainly delivering the savings it had committed to. Board members raised the following: • The representation of risks within the finance report, noting how there had been an error in the way risks had been presented within the paper under the risk section of the cover paper (p72 of papers), in that no risks had been noted when there are many risks pertaining to performance that should be noted here. It was advised that this would be corrected under the risk section noted on p82 of papers. • The request for an update on the risk relating to Same Day Emergency Care funding. Matthew assured the Board that the funding allocation had already been identified, with formal confirmation still awaited. Carl James advised that this appeared to be an administrative issue and agreed to pursue confirmation. The Trust Board: • **NOTED** the May Performance Management Framework for assurance purposes. • **NOTED** the contents of the May 2026 financial report and in particular: o The year to date and forecast revenue and Capital out turn position, and PSPP performance. o The latest position on Velindre Cancer Service LTA income for 2026-27 from our commissioners. o The position with commissioners on the contract rebase agreement, noting that the LTA issue with Hywel Dda has now been resolved. o The current position of the Trust savings plans.	**MB** **CJ**
3.2.0	**VUNHST Risk Register** Non Gwilym introduced the report, highlighting that the Risk Register is improving, but further work is needed to ensure risks, controls, actions and assurances are clearly understood and consistently reported; the focus should now be on improving the quality of risk management and assurance, embedding it within the new governance structure, and ensuring committees can provide meaningful oversight of strategic risks. Board members noted the following:	

	• There are a number of risks where the current ratings remained unchanged, indicating that mitigations are not reducing the level of risk. Assurance was sought that the effectiveness of controls was being reviewed and clearer narrative was requested explaining the impact of actions and progress being made against the risks. Using risk 3832 as an example, Non explained that mitigating actions, including the procurement of a system progressing as planned, had not reduced the risk score because full mitigation had not been implemented. It was noted that future risk reporting should better explain progress and provide assurance where risks remain unchanged despite active mitigation. • Some risk target dates have previously appeared ambitious, and it was queried whether the target date for risk 3969 was realistic given the number of actions still required. It was agreed that while there was confidence that actions would be achieved by the end of July. • Whether sufficient progress is being made with regard to risk 3388; the route to resolution was not clear to the Board and this was a long-standing digital integration issue. The Executive team advised that the matter had been escalated through multiple channels, including direct engagement with Digital Health and Care Wales (DHCW), and that progress was being made, albeit slower than desired. • Risk 2646 was another example of where the current score remained the same, despite significant progress being made. It was advised that this risk related to implementation of the WLIMS laboratory information management system within the Welsh Blood Service, and while local preparation work was complete and rated green, implementation remained dependent on the national rollout programme which had experienced delays and the final implementation timelines sat outside the Trust's direct control, hence the high score. Lindsay Foyster advised that Board that the Vice Chair of DCHW had arranged individual meetings with the Vice Chairs of NHS organisations, with her meeting scheduled for September. She advised that she would be fully briefed on the Trust's digital risks and dependencies beforehand to ensure continued meaningful engagement with DHCW. The Trust Board **NOTED:** • The risks in the quality and safety domain with a score of 12 and above and risks in other domains with a score of 15 and above on the Trust Risk Register. • The new risks added to the register and the risk • which have reduced below Board reporting threshold since the previous reporting cycle. • The update on the Datix risk system replacement.	**NG**
3.3.0	**Board Assurance Framework (BAF)** Non Gwilym advised that while the Executive Management Board, Strategic Development Committee and Quality, Safety and Performance Committee had recognised the BAF's improved readability and accessibility, a number of areas still requiring improvement had been highlighted (such as strengthening clarity around controls, actions and assurances; improved executive oversight).	

	Non advised that the revised committee structure would support clearer allocation of strategic risks to the appropriate committee to improve oversight, challenge and reporting to the Board. Board members raised the following: • That it would be beneficial for the Board to reach agreement on a final version of the BAF to avoid ongoing redesign, rather use the BAF consistently, embed it within the new committee arrangements and refine it through experience. Non supported this and explained that it was the intention to reach a position where committees would take responsibility for reviewing and assuring risks within their remit (as above). • While improvements in the presentation of the BAF were recognised, it was noted that it was not consistent in terms of the relationship between strategic risks and associated risks, which were either unclear or missing. It was also noted that there was an absence of controls and assurance for Velindre Cancer Service and that this information had only been included for the Welsh Blood Service. Anne Carey agreed to address this, although advised that it would take time to resolve properly. The Trust Board: • **NOTED** the status of the Board Assurance Framework and the assurance rating of Level 2. • **ENDORSED** the proposed improvements to future BAF reporting, including clearer narrative on static risk ratings, revised target dates, links to operational risks, and gaps in controls and assurance.	**AC**
4.0.0	**ORGANISATIONAL DEVELOPMENT**	
4.1.0	**Terms of Reference – New Committee Structure** Non Gwilym presented the new Terms of Reference aligned to the Trust's new Board Committee structure for approval, which had previously been considered and agreed in principle at Board. She explained that the changes were designed to improve accountability, clarify delegated responsibilities, strengthen assurance arrangements and reduce duplication. It was advised that the Terms of Reference for the Charitable Funds Committee were still being finalised and would return to the Board for approval in September. A review of Standing Orders would also be undertaken, and any resulting amendments would be brought back to the Board. Non thanked Board members for their contribution and support to this work (in particular, the Vice Chair and Lineofsight colleagues). Board members raised the following: • The Quality Impact Assessment (QIA) document had not been signed off by either the Executive Medical Director of Executive Director of Nursing, (a requirement). Non assured the Board that the correct sign off had been completed in practice and that the QIA document would be amended to explicitly include the required signatures. • Whilst allocating Independent Members across all committees is challenging, Welsh Government guidance and audit best practice recommended that the Audit and Risk Assurance Committee (ARAC)	**NG**

	should include an Independent Member with finance experience, and it was agreed that the current membership of ARAC should be reviewed. It was noted that the proposed memberships had been developed using the governance guidance available at the time and the Vice Chair welcomed sight of the specific recommendation referenced to and noted the challenges in, and importance of, meeting the Terms of Reference requirements for membership to reflect interdependencies across Committees. The Trust Board: • **APPROVED** the committee structure and accompanying Terms of Reference presented as Appendix 1. • **APPROVED** the proposed committee membership and Executive leads as presented in Appendix 2. • **NOTED** that the Charity Committee Terms of Reference are to follow. • **NOTED** the completion and sign-off of the Quality Impact assessment and Equality Impact Assessment available as Appendices 3 and 4.	
4.2.0	**Shared Services Commitments of Expenditure** Alison Ramsey presented two items of Commitments of Expenditure to the Board for approval: **1) Extension of the Student Bursary Award System software contract.** Alison explained that the System supports the administration of Welsh student bursary awards and that an extension was required to ensure continuity of service. Board approval was sought to extend the contract until March 2030. She advised that the extension would ensure continuity of service while Welsh Government considered the future of bursary arrangements. The proposed 1+1+1 extension structure would provide flexibility to respond to future policy decisions, whilst recognising that the current system is highly specialised and would require significant lead time to replace. Board members raised the following questions / comments: • Whether the system was used exclusively for medical students or wider range of students, as the paper was ambiguous. Alison clarified that the system primarily supports the Nursing bursary scheme, although it is not used exclusively for Nursing students. She also explained that "GPUK" referred to the supplier name rather than a category of students. • The paper stated that the contract had been in place since 2022 and referred to a four-year term, which would suggest the contract should expire in 2026. However, the paper also stated that the contract would expire on 31 March 2027. Alison confirmed that the discrepancy reflected the implementation and go-live period following contract award. • Welsh Government's review extends beyond the Bursary Scheme itself and includes consideration of the wider student support package; it is challenging to secure posts for newly qualified nurses and midwives and it was acknowledged that this broader policy work was contributing to delays in final decisions regarding future bursary arrangements. The Trust Board:	

	• **APPROVED** the Student Bursary Award System contract extension for three (3) years with effect from 1 April 2027 to 31 March 2030 with a total cost of £382,515 and in doing so, **AUTHORISED** the Chief Executive to approve the Purchase Order. **2) Award of a contract for the provision of Material Handling Equipment lease, hire and maintenance.** Alison sought approval for a five-year contract for the provision, lease, hire and maintenance of Material Handling Equipment used within logistics and stores operations. She advised that the contract, valued at up to £1.04m excluding VAT, was demand-led with no minimum spend commitment and that supplier financial standing had been reviewed with appropriate mitigations in place. Alison confirmed that Welsh Government had been notified of the proposed contract award given its value exceeded £1 million. The Trust Board: • **APPROVED** the award of Contract SSP-FTS-60006 – Material Handling Equipment Lease, Hire and Maintenance to Toyota Material Handling UK Limited. • **APPROVED** the maximum estimated contract value of £1,040,000 excluding VAT over the full five-year term, including both optional extension periods. • **NOTED** that expenditure will be funded from existing NWSSP Supply Chain, Logistics and Transport operational budgets and controlled through approved purchase orders. • **NOTED** that an initial supplier financial standing concern was identified during the qualification stage, but that a further Dun & Bradstreet report was subsequently run and confirmed an improved failure score of 56, representing a low to moderate risk of severe financial stress. The updated score is above the NWSSP recommended exclusion threshold and supplier financial standing will continue to be monitored during the contract term. • **APPROVED** progression to Intention to Award, standstill and publication of the Contract Details Notice, subject to completion of all required approvals.	
4.3.0	**Trust Policies / Procedures for Approval** A number of policies and guidance had been considered at the July Quality, Safety and Performance Committee, prior to seeking Board approval. Sarah Jenkins presented the Childcare Vouchers Policy, Family Friendly Policy and Consultant Job Planning Framework for approval. She advised that the family-friendly arrangements had been expanded to include wider adoption and related provisions and confirmed that the policies had undergone the required review processes. She also highlighted the importance of maintaining a consistent approach to consultant job planning across the organisation. Jacinta Abraham added that the Consultant Job Planning Framework had been developed through extensive engagement with consultants, BMA representatives and NHS Wales Medical Directors. She highlighted improvements in job planning compliance following implementation of the digital job planning system and noted that the framework would strengthen the	

	Trust's position in demonstrating compliance with Welsh Government expectations and support effective workforce planning. It was also confirmed that this would be reflected in the new People, Culture and Engagement Committee. The Chair queried how the Consultant Job Planning Framework aligned with the Trust's wider governance arrangements, particularly in relation to shared services and clinical governance. Jacinta explained that the framework had been developed specifically for the Cancer Services and Welsh Blood Service divisions and was not intended to apply more widely across Shared Services at present, as Shared Services does not employ consultant medical staff in the same way; separate policies would be required for each organisation. The Trust Board **APPROVED**: • The Childcare Voucher Scheme Guidance. • The 8 documents relating to the Family Friendly Policy. • The updated policy as the standard operating framework for Consultant job planning across Velindre University NHS Trust.	
5.0.0	**COMMITTEE HIGHLIGHTS FOR DISCUSSION**	
5.1.0	**Public Quality, Safety & Performance Committee(QSP) Highlight Report (16/07/2026)** Vicky Morris advised that the key issues escalated through the Public QSP Highlight Report, particularly those relating to the Board Assurance Framework, had already been discussed in detail elsewhere on the agenda. Therefore, no further discussion was required. The Trust Board **NOTED** the highlight report and item of escalation identified at the meeting of the Quality, Safety & Performance Committee held on the 16th July.	
5.2.0	**Public Audit Committee Highlight Report (12/05/2026)** Gareth Jones highlighted concerns regarding outstanding audit actions and the timeliness of action management and late extension requests. The Committee had sought greater assurance on delivery and accountability. Carl James indicated that while progress had been made over the past 12-24 months, he accepted that further improvement was needed and suggested that there were underlying process and system issues contributing to delays and late requests for extensions. Carl agreed to review the outstanding actions with the Executive Team and return with an informed plan. The Trust Board **NOTED** the content of the report and item of escalation identified at the meeting of the Audit Committee held on the 12th May.	**CJ**
5.3.0	**Public nVCC Project Scrutiny Sub-Committee Highlight Report (18/06/2026)** Hilary Jones reported that the nVCC Project had entered a complex phase as it approaches the latter stages of delivery. While the contractor continues to report that the project remains on track, the Sub-Committee was maintaining close oversight of programme risks and delivery milestones to ensure successful completion.	

	Following the update, Carl James thanked the Committee for their continued support, noting that while the building programme itself sits largely outside the Trust's direct control, there was a strong focus on working with delivery partners to ensure successful completion. The Trust Board is asked to **NOTE** the content of the report and item of escalation identified at the meeting of the Audit Committee held on the 18th June.	
6.0.0	**ANNUAL REPORTS FOR APPROVAL** It was confirmed that all reports shared with Board (via the Quality, Safety & Performance Committee) were statutory and that the nine reports listed below had been considered separately via an extraordinary meeting of the Quality, Safety & Performance Committee on the 9th July.	
6.1.0	**Duty of Quality Annual Report** The Trust Board **APPROVED** the Duty of Quality Annual Report.	
6.2.0	**Trust Annual Integrated Quality & Safety Report** The Trust Board **APPROVED** the Annual Integrated Quality & Safety Report.	
6.3.0	**Equality Annual Report** Led by Sarah Jenkins, Interim Executive Director of People & Organisational Development Board members raised the following questions / comments: • A marked reduction in staff numbers beyond age 60. This raised the issue of retention of experienced employees and the use of flexible employment approaches, including retire-and-return arrangements, to retain organisational knowledge and expertise. Sarah Jenkins noted an unanticipated change in behaviour post-COVID, and that balancing retention with future workforce requirements is being actively discussed both locally and nationally. It was also noted that the organisation is already supporting staff beyond the age of 60 via the Virtual Assessment Pathway (VAP) system, which enables those now unable to work 12-hour shifts to still provide high-level skilled assessment via telephone and virtual means. • Whether exit interviews are undertaken to capture reasons for staff leaving the organisation. Sarah advised that these are undertaken on a voluntary basis and this information is fed into the organisational cultural baseline work and triangulated alongside other staff experience data. She also indicated improving levels of psychological safety across the organisation. • Whether the Trust formally recognises long service in a similar way to universities. Sarah confirmed that long service awards are recognised through the Trust's awards arrangements and the Chair noted that personal letters are also issued to mark such achievements. The Trust Board **APPROVED** the Equality Annual Report.	

6.4.0	**Gender Pay Gap Annual Report** The Trust Board **APPROVED** the Gender Pay Gap Annual Report.	
6.5.0	**Welsh Language Annual Report** The Trust Board **APPROVED** the Welsh Language Annual Report.	
6.6.0	**Social Partnership Duty Annual Report** The Trust Board **APPROVED** the Social Partnership Duty Annual Report.	
6.7.0	**Fire Safety, Estates, Health & Safety, Sustainability Annual Report** The Trust Board **APPROVED** the Fire Safety, Estates, Health & Safety, Sustainability Annual Report.	
6.8.0	**Wellbeing of Future Generations Act (2015) Annual Report** The Trust Board **APPROVED** the Wellbeing of Future Generations Act (2015) Annual Report.	
6.9.0	**Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025-26** The Trust Board **APPROVED** the Professional Registration, Appraisal and Revalidation Annual Assurance Report 2025-26.	
7.0.0	**CONSENT FOR NOTING**	
7.1.0	**Trust Seal Report** The Trust Board **NOTED** the contents of the Trust Board Seal Register.	
7.2.0	**Chair's Urgent Actions for Ratification** The Trust Board **RATIFIED** the Chairs Urgent Action taken between the **22/05/2026 – 23/07/2026.**	
7.3.0	**Trust-wide policy approvals update** The Trust Board **NOTED** the policy approvals update.	
7.4.0	**Extraordinary Public Quality, Safety & Performance Committee Highlight Report (09/07/2026)** The Trust Board **NOTED** the key deliberations from the extraordinary meeting of the Quality Safety & Performance Committee.	
7.5.0	**Public Strategic Development Committee Highlight Report (07/07/2026)** The Trust Board **NOTED** the content of the report.	
7.6.0	**Public Charitable Funds Committee Highlight Report (04/06/2026)** The Trust Board **NOTED** the content of the report.	
7.7.0	**Local Partnership Forum Highlight Report (02/06/2026)** The Trust Board **NOTED** the content of the report.	
7.8.0	**Shared Services Partnership Committee Assurance Report (14/05/2026 & 25th June 2026)** The Trust Board **NOTED** the content of the report.	

7.9.0	**Shared Services Partnership Audit Committee Highlight Report (28/04/2026)** The Trust Board **NOTED** the content of the report.	
7.10.0	**Joint Commissioning Committee Highlight Report (26/05/2026)** The Trust Board **NOTED** the content of the report.	
8.0.0	**QUESTIONS FROM THE PUBLIC**	
	Two questions had been received from the public prior to the meeting, relating to the sale of the Whitchurch land. Lauren Fear was invited to respond to the questions as follows: **Question 1 - Long-term protection of the sports clubs** "The Trust has previously stated publicly that the existing sports clubs on the Whitchurch Hospital site are valued community assets and that their leases are not at risk as part of the disposal process. Can the Board confirm whether the successful purchaser will be contractually required, as a condition of the sale, to protect the long-term viability of the existing sports clubs and their operations, and if so, how that protection will be secured and enforced?" Lauren reiterated the Trust's commitment to securing the long-term future of the sports clubs at the Whitchurch site through engagement, planning protections and assessment of bidders' proposals. While contractual protections would be unusual where planning controls already exist, further legal and planning advice was being sought on additional mechanisms to support the clubs, with further discussion anticipated at September's Board meeting. **Question 2 - Agent of Change** "Given that Whitchurch Heath Cricket Club and the other sports clubs have operated on the site for many decades, what steps is the Trust taking within the disposal process to ensure that the Agent of Change principle is reflected in any future redevelopment, so that existing sporting activities are protected from future complaints or operational restrictions arising from new residential development, including cricket, training, noise, parking and other established community use?" Lauren advised that the Agent of Change principle is a planning matter to be addressed through the future development process and would require any new development to take account of existing sports club activities. She confirmed that the Trust is actively engaging with bidders to ensure matters such as ongoing sports use and parking requirements are reflected in emerging proposals. Lauren also advised that the requester would receive a direct written response to both questions following the meeting.	
9.0.0	**ANY OTHER BUSINESS** The Chair had not been made aware of any items prior to the meeting. However, she acknowledged that this was Andrew Westwell's final Trust Board meeting and paid tribute to his contribution as an Independent Member.	

	Vicky Morris noted Andrew's excellent chairing of the Research, Development and Innovation (RD&I) Committee. She recognised his expertise at both Board and Committee level, highlighting the lasting impact he had made within the Trust's RD&I space. Jacinta Abraham noted Andrew's collaborative style which had put colleagues at ease and encouraged participation. Additionally, it was noted that he had provided constructive challenge, backed by evidence, to encourage change and improvements to the Trust's work. She also recognised the role he had played in strengthening relationships with Cardiff University, Cardiff and Vale University Health Board and other partners, to ensure the Trust was seen as an equal partner. In conclusion, the Chair expressed the importance of recognising publicly the role that Independent Members play and the expertise, time and passion they bring to the organisation. She acknowledged that Andrew had been a dedicated member of the Board, instrumental in the development of the Research, Development and Innovation agenda and had brought significant expertise, challenge and commitment to the organisation. The Board wished Andrew well for his future endeavours.	
10.0.0	**DATE OF NEXT MEETING** The next public meeting will take place on Thursday, 24th September 2026 at 10:00h at the Welsh Blood Service, as the service notes its 80th anniversary.	
11.0.0	**CLOSE**	
12.0.0	**ITEMS FOR DISCUSSION AT PART B**	
	• Integrated Plan for Board Development • nVCC update • Private Risk Register • Integrated Radiotherapy Solution (IRS) • Talbot Green Infrastructure • oVCC Decommissioning Programme • Transforming Access to Medicines (TrAMs) Business Case • NWSSP Commitments of Expenditure • Trust Policies for Approval • Claims and Redress Annual Report (2025-2026)	

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	**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**~~ **24/09/2026**	**Update September 2026:** There is a plan to refresh the Trust's Engagement Strategy. Work to strengthen the patient and donor voice remains ongoing. Formal partnerships have been established with Maggies and LLais, with the LLais CEO now a member of the QSE Committee (attended on 15/09/26). Implementing true co-production remains a focus, as is the full implementation of the People's Experience Framework. It is proposed to close this action as it stands, and to agenda a slot on the next Trust Board to provide a full update with regards to 'Embedding the patient & Donor voice accross the Trust'. **Update at July Board** - work to formalise engagement arrangements with the Cancer Alliance, Place and Maggie's was progressing, with plans agreed but meeting dates still awaited. An update and revised plan are expected at the September QSP meeting. The Trust will be refreshing its Patient Engagement Strategy with the Patient Experience and Engagement Team to strengthen arrangements for engagement, involvement and co-production. Formal partnerships are also being established with organisations such as Llais and Maggies, alongside work with the Cancer alliance and other stakeholders, to ensure patient, donor, carer and community views are systematically captured and used to inform service improvement and strategic decision-making. A revised paper will be presented to QSP for assurance and will return to Board once the refreshed engagement and co-production framework has been agreed.	**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 monies.	Chief Digital Officer	~~**21/05/2026**~~ ~~**24/09/2026**~~ **26/11/2026**	**September update -** Confirmation has been provided to the Executive Management Board. Awaiting final confirmation from the nVCC Readiness Board via Gardiner & Theobold. **Update at July Board** - Welsh Government has approved requests for additional and repurposed resources. Discussions with service divisions had indicated a positive position, with a final report to be presented at the September Board meeting.	**OPEN**
21/05/2026	**3.1.0**		**Performance Management Framework**				
		76	Following the Director of WBS's visit to NHSBT to discuss initiatives for engaging diverse communities to recruit to blood donor databases, actions and plans to be refreshed based on learning and further detail to be brought back to a future Board meeting.	Chief Operating Officer	**24/09/2026**	**September Update -** summary provided under matters arising **Update at July Board** - This action and its implications for future strategy had been deferred due to agenda pressures. An update will be provided at the September Board meeting.	**PROPOSE TO CLOSE**
21/05/2026	**3.3.0**		**Board Assurance Framework**				
		77	Clarify whether the alignment of the BAF to strategic objectives reflects current year deliverables or the full three year IMTP period.	Interim Director of Corporate Governance	~~**30/07/2026**~~ **24/09/2026**	**September 2026:** The BAF is aligned to the strategic objectives referenced in the three year IMTP 2026-29. **Update at July Board** - It was proposed that the Board Assurance Framework action be assigned to the DoCGas the named executive lead rather than remaining a collective executive action. An assurance report will be brought back to the Board in September, supported by the wider executive team.	**PROPOSE TO CLOSE**
21/05/2026	**3.3.0**		**Board Assurance Framework**				
		78	Further clarification regarding BAF06 (People and OD). Clearer articulation to be brought back to Board.	Interim Executive Director of People & OD	~~**30/07/2026**~~ **24/09/2026**	**September 2026:** BAF06 dicussed at People, Culture and Engagement Committe. Further amendments to be considred by committee in November. Update also reported to Audit and Risk Assurance Committee. **Update at July Board** - work had commenced with the Vice Chair to strengthen the People and Culture elements of the BAF. Three people-related risk themes (staff wellbeing and organisational performance; leadership and management; and culture, values and behaviours) will be developed through the People Committee, with supporting metrics to be introduced and an update to be brought back following the committee's first meeting. **23/07/2026** - SJ checking with team. Deadline extension to be requested and subsequently, further discussion around BAF took place in QSP and agreed that a review of all BAF would take place for the next cycle of committees.	**PROPOSE TO CLOSE**

30/07/2026	**1.7.0**		**Patient Story**				
		82	Meet with Head of Safeguarding & Vulnerable Persons to discuss how equitable access to services could be provided for all patients.	Interim Executive Director of Nursing, AHPs and HCS	**24/09/2026**	**September 2026 Update**: Discussion held. A longer term strategic plan is required with regards to the Vulnerable Persons portfolio, as considerable work is required in order to ensure equitable acess to services and to ensure that individualised care needs are met. The capacity to deliver on this work has been raised as a risk on the Risk Register. This will be addressed via the Trust's Safeguarding and Vulnerable Persons Management Group. It is proposed this action is closed.	**PROPOSE TO CLOSE**
30/07/2026	**1.7.0**		**Patient Story**				
		83	Board to write to Diana Purnell (Support Care Nurse) who had led on the work for Dementia patients to thank her personally.	Chair	**24/09/2026**	September update - Letter in draft, to be sent imminently.	**PROPOSE TO CLOSE**
30/07/2026	**2.2.0**		**Chief Executive's Report**				
		84	Highlight more widely to colleagues via internal communications the achievement by WBS colleagues in creatively maintaining blood and platelet collections during a challenging period of hot weather, despite high temperatures leading to venue cancellations and donor absences.	TBC	**24/09/2026**	Director provided update via video message shared on internal channels.	**PROPOSE TO CLOSE**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		85	Provide assurance regarding overdue incident and audit actions within the Welsh Blood Service; While progress is being seen, particularly through improved process compliance and staff training, further examples to be provided.	Chief Operating Officer	**24/09/2026**	Verbal update to be provided.	**OPEN**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		86	Clarify use of the term "Velindre Organisations" within the Workforce heatmap and associated graphs, as this is not an organisational descriptor; this is an error in the report to be corrected.	Interim Director of POD	**24/09/2026**		**OPEN**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		87	Error in the way the risks within the finance report had been represented within the paper under the risk section of the cover paper. No risks had been noted when there are many risks pertaining to performance that should be noted here. It was advised that this would be corrected under the risk section noted on p82 of papers.	Executive Director of Finance	~~**24/09/2026**~~ **26/11/2026**	The Head of Financial Planning & Reporting is reviewing presentation of these risks and will ensure they are appropriately reported in the month 6 Finance Report and PMF. Estimated date of completion: 16th October 2026.	**OPEN**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		88	Update to be provided on the risk relating to Same Day Emergency Care funding. While the Board was assured that the funding allocation had already been identified, CEO advised that this appeared to be an administrative issue and agreed to pursue confirmation.	Chief Executive Officer	~~**24/09/2026**~~ **26/11/2026**	**September update** - CEO discussed with Director of Finance Welsh Govt on a number of occasions. Final clarifications will be provided by the Executive Director of Finance at the November Board.	**OPEN**
30/07/2026	**3.2.0**		**VUNHST Risk Register**				
		89	A number of risks have inherent and current ratings unchanged, indicating that mitigations are not reducing the level of risk. Provide assurance that the effectiveness of controls is being reviewed and provide clearer narrative explaining the impact of actions and progress being made against the risks.	Interim Director of Corporate Governance	**24/09/2026**	Further review has been undertaken to consider whether static inherent and current risk ratings indicate that mitigations are not reducing the level of risk. Direct reference to this action and the outcome of the review are included in the Trust Risk Register paper submitted for Trust Board.	**PROPOSE TO CLOSE**
30/07/2026	**3.3.0**		**Board Assurance Framework (BAF)**				
		90	It was noted hat there was an absence of controls and assurance for Velindre Cancer Service and that this information had only been included for the Welsh Blood Service. It was agreed to address this, although may take time to resolve properly.	Chief Operating Officer	~~**24/09/2026**~~ **26/11/2026**	**September update** - there is a set Risk Group to be set up as part of the Line of Sight work. The individual meetings with WBS took place resulting in the changes that have fed through. VCS has not occurred due to the formal group being arranged.	**OPEN**
30/07/2026	**4.1.0**		**Terms of Reference - New Committee Structure**				
		91	While the Board was assured that the correct sign off had been completed in practice, ensure QIA document explicitly includes signatures from Executive Medical Director and Executive Director of Nursing.	Interim Director of Corporate Governance	**24/09/2026**	Complete.	**PROPOSE TO CLOSE**
30/07/2026	**5.2.0**		**Public Audit Committee Highlight Report**				
		92	Review outstanding audit actions with the Executive Team and return with an informed plan.	Chief Executive Officer	**26/11/2026**	Complete. Updated report shared with Audit and Risk Assurance Committee on 17 September 2026.	**PROPOSE TO CLOSE**

TRUST BOARD		
EDI – WBS Brixton Blood Donation Centre Visit		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Alan Prosser, WBS Director Andrew Harris, Head of Donor Engagement	
PRESENTED BY	Chief Operating Officer	
REPORT SPONSOR	I, **Anne Carey, Chief Operating Officer**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	N/A	N/A
	No scrutiny route due to nature of report, for "Matters Arising" only.	
ONWARD SCRUTINY ROUTE	Any onward route will be determined by Trust Board following consideration of the presentation.	
PURPOSE OF THE REPORT	FOR DISCUSSION	
	To inform Trust Board of the importance of EDI to the resilience of the blood supply and to share learning from the Welsh Blood Service visit to the Brixton Blood Donation Centre, including opportunities to strengthen place-based engagement, accessibility and donor conversion.	
EXECUTIVE SUMMARY	Increasing donor diversity is important to long-term supply resilience because the clinical need for ethnically matched blood is higher than population statistics. The supporting presentation summarises research commissioned on diversity in Wales and learning from a visit to the Brixton Blood Donation Centre on 10 February 2026. The visit highlighted the value of accessible locations, flexible hours, a strong community identity, sustained partnerships, representative staffing and engagement that extends beyond blood donation. The combined learning supports a targeted approach that aligns clinic location, communications and community engagement, with a focus on converting willing non-donors and reactivating lapsed donors.	

ACTION / DECISION	The Board is asked to: **NOTE** the importance of EDI and donor diversity to long-term blood supply resilience; **RECEIVE** the learning from the Brixton Blood Donation Centre visit; and **SUPPORT** continued exploration of community-based, accessible and inclusive approaches to donor recruitment, conversion and retention.
ADDITIONAL RESOURCES	None – visit report is attached as an appendix.

RELEVANT TRUST STRATEGIC GOALS

This report addresses the following goal(s) within the Trust's strategic plan:

- Outstanding for quality, safety, and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations
- A sustainable organisation that plays its part in creating a better future for people across the globe

RELEVANT TRUST WELLBEING GOALS

This report addresses the following wellbeing goal(s):

- A Healthier Wales
- A More Equal Wales
- A Wales of more Cohesive Communities
- A globally responsible Wales

QUALITY AND SAFETY IMPLICATIONS

This report impacts one or more of the following Six Domains of Quality:

- Equitable
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.		
Status: QIA not required - not a strategic decision		
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report Not required for this information paper. EDI is the central subject of the presentation and the anticipated impacts are positive, through more inclusive engagement and improved access to donation opportunities.		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	EDI – WBS Brixton Blood Donation Centre Visit

APPENDIX 1 - KEY CONSIDERATIONS

1. **SITUATION**

1.1 This paper brings together the key learning from the Welsh Blood Service visit to the Brixton Blood Donation Centre and recent equality, diversity and inclusion (EDI) work. It is intended to support Trust Board consideration under Matters Arising.

2. **BACKGROUND**

2.1 A Welsh Blood Service delegation visited the Brixton Blood Donation Centre on 10 February 2026 to network with colleagues, understand the benefits and challenges of a fixed-site clinic, explore community engagement with young people and ethnically diverse communities, and consider how a donation centre can become a recognised part of its local community. Welsh Blood Service has also commissioned research into diversity in Wales and how engagement mechanisms could improve sign-ups across its donation portfolio.

3. **MATTERS FOR CONSIDERATION**

3.1 ASSESSMENT

3.1.1 The Brixton visit identified a donor-focused model based on a highly accessible location, long and flexible opening hours, a strong local identity, visible donor recognition and extensive community partnership activity. The centre is positioned as a welcoming community space, with representation supported through a diverse workforce, local employment and volunteering.

The key learning is to make donation settings feel owned by the communities they serve, build engagement beyond donation itself and remove practical barriers through location, convenience and representation. Research presented by Welsh Blood Service similarly indicates that geography and accessibility matter alongside messaging. It identifies 25- to 35-year-olds as a key acquisition segment and highlights conversion of willing non-donors and reactivation of lapsed donors as significant opportunities.

Recent activity includes recruitment events at the Eisteddfod and Royal Welsh Show, National Blood Donor Week and a Metallica partnership. Planned activity includes university freshers events, exploration of pathways from stem cell volunteering to blood donation,

further tailoring of pathways for diverse volunteers and donors, and embedding EDI across partnership activity.

3.2 FINANCIAL IMPLICATIONS

3.2.1 No specific additional funding request is made in this paper. The supporting slides note that further consideration will be required in relation to the scrutiny case for fixed-term staff.

3.3 LEGAL IMPLICATIONS

3.3.1 No specific legal implications are identified in the supporting slides.

3.4 PEOPLE IMPLICATIONS

3.4.1 The learning supports a workforce and volunteer approach that reflects the communities served. The supporting slides also identify a future scrutiny case for fixed-term staff; no staffing decision is sought through this paper.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 No specific Welsh language implications are identified in the supporting slides. Any future engagement activity in Wales should continue to be delivered in line with the Trust's Welsh language responsibilities.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

No specific Board Assurance Framework risk is identified in the supporting slides. The presentation describes increasing donor diversity as essential to long-term supply resilience and indicates that inclusive, community-based engagement can help strengthen trust, participation and access.

Operational Risks

3.6.2 No specific Datix or Trust Risk Register entries are identified.

Risk Number	Risk title	Risk lead	Current score
N/A	No operational risk entry identified	N/A	N/A

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 Trust Board is asked to note the importance of EDI and donor diversity to long-term supply resilience; receive the learning from the Brixton visit; and support continued development of targeted, accessible and community-based approaches to donor recruitment, conversion and retention.

Brixton Blood Donation Centre Visit

10/02/2026. Alan Prosser, Eleri Schiavone, Aiysha Baillie, Andrew Harris

Visit Objectives:

- ❑ Networking opportunity – meet colleagues working across the border to share learning.
- ❑ Understand the benefits and challenges of operating a fixed-site donation clinic.
- ❑ Understand how NHSBT engages with the local community, particularly young people and ethnically diverse communities, through community partnerships.
- ❑ Understand how they have successfully positioned a fixed site as a recognised part of the local community, rather than simply a place to donate blood.

Visit Report

- **Highly accessible location**, positioned directly outside a busy train station with ample parking, situated in a high-footfall area near the local high street.
- **Donor-focused operating model**, offering flexible opening hours from 8am to 9pm, including daytime and evening sessions to meet community needs.
- **Strong community identity**, with rooms named after local landmarks, locally influenced design, and community involvement in the centre's development and launch.
- **Effective donor recognition scheme**, featuring a donor wall where individuals leave blood group or first-time donor stickers, creating a visible display of community participation and impact.
- **Extensive community engagement**, led by dedicated coordinators working with local groups, artists and cultural organisations through initiatives such as artwork displays, music events and group donation programmes.
- **Community-first approach**, positioning the donor centre as a welcoming community space and encouraging engagement before individuals become donors.
- **Commitment to representation and inclusion**, reflected through a diverse workforce, local employment opportunities and active involvement of community volunteers in centre activities.

Key takeaway messages

1. **Make the donor centre feel like it belongs to the community**
   - Reflect local identify
   - Help community shape space
2. **Build engagement beyond blood donation**
   - Community partnerships to create ownership and participation
   - NHSBT offered funding opportunities
3. **Remove barriers to donation**
   - Locate where donors already are with convenient hours
   - Staff reflect community served



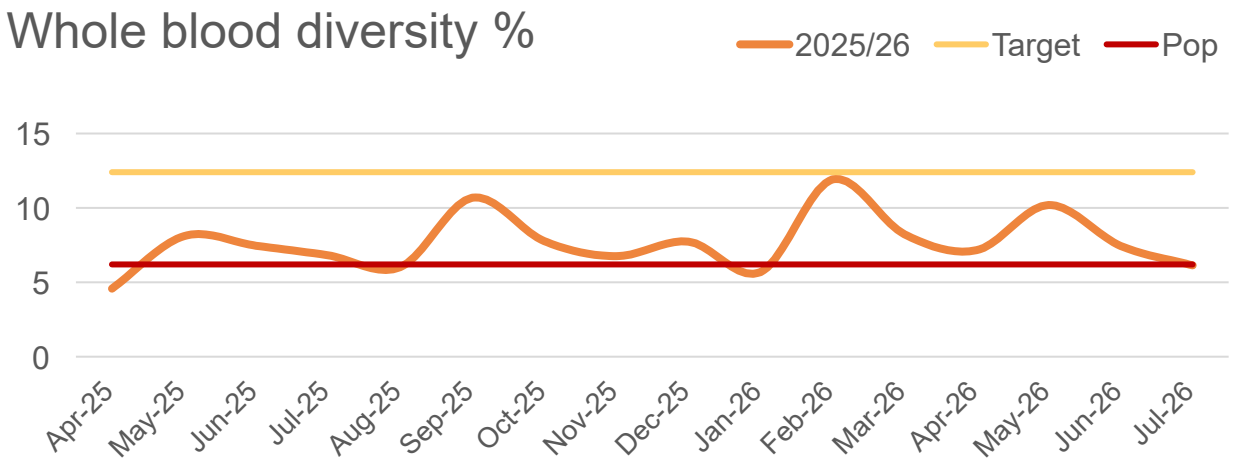
EDI

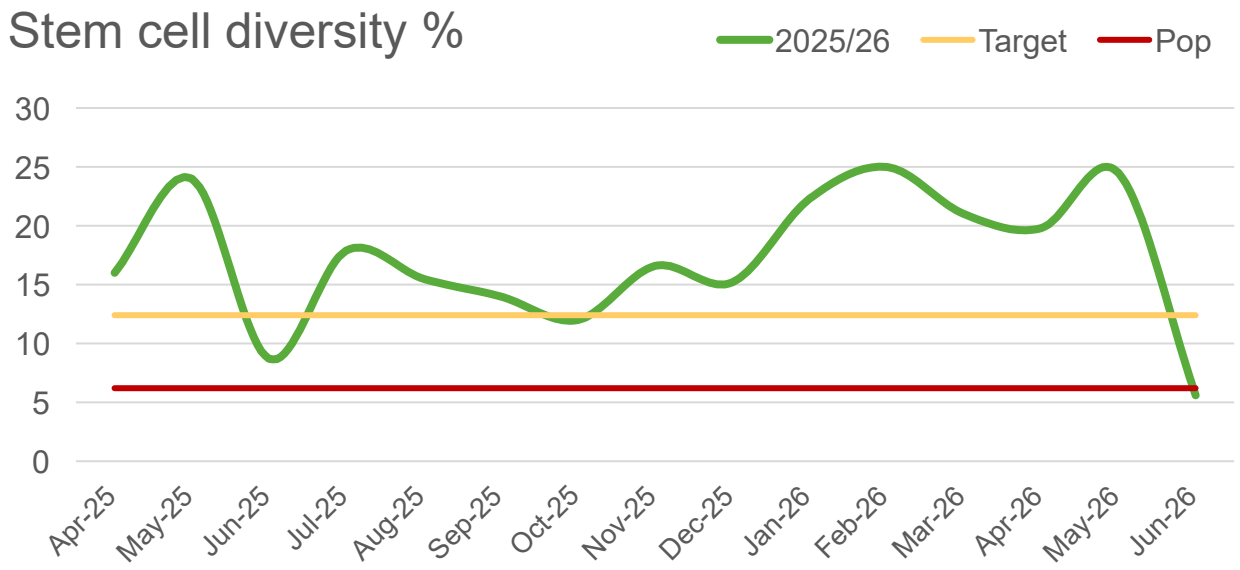
Increasing donor diversity is essential to long term supply resilience with clinical need for ethnically matched blood being higher than population statistics.

We commissioned research on diversity in Wales, specifically how we could improve our engagement mechanisms to improve sign ups across WBS' donation portfolio.

Key take aways

- **Geography matters as much as messaging**
- **Prioritising 25- to 35-year-olds rather than focusing exclusively on the youngest eligible donors**
- **Location and accessibility are critical drivers of success**
- **The biggest opportunity is conversion**





Recent activity:

- Summer recruitment events including the Eisteddfod (529 stem cell registration requests) and the Royal Welsh Show (319 stem cell registration requests).
- National Blood Donor Week and Metallica partnership.

Future activity:

- University freshers has over 40 events planned for the team, we anticipate over 1000 swab sign ups and diversity around 20%.
- Further exploration into how we can convert stem cell volunteers into blood donors.
- Further tailor pathways for diverse volunteers and donors.
- Embedding EDI in all partnership activity.
- Scrutiny case for the fixed-term staff.

TRUST BOARD		
CHAIR'S UPDATE REPORT		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Sara Moseley, Chair	
PRESENTED BY	Sara Moseley, Chair	
REPORT SPONSOR	N/A	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	N/A	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	To inform Trust Board and wider organisation of the Chairs work over the past two months	
EXECUTIVE SUMMARY	An overview of the work that the Chair has undertaken over the past few months. To include meetings, site visits and conferences alongside a Spotlight report on a specific service within the Trust to highlight their work and purpose within the Trust.	
ACTION / DECISION	The Board/Committee is asked to: • Note and discuss the contents of the Chair's update report.	
ADDITIONAL RESOURCES	N/A	
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	N/A	

KEY CONSIDERATIONS

1. SITUATION

To provide an overview of the Chairs activity over the past two months

2. BACKGROUND

N/A

3. MATTERS FOR CONSIDERATION

3.1 FINANCIAL IMPLICATIONS

N/A

3.2 LEGAL IMPLICATIONS

N/A

3.3 PEOPLE IMPLICATIONS

N/A

3.4 WELSH LANGUAGE IMPLICATIONS

N/A

3.5 RISKS / REPUTATIONAL IMPLICATIONS

N/A

Independent Member objectives and 121s

Through the early summer, I have been meeting with Independent Members to review the progress and performance over the past year and to set new objectives. This comes following the establishment of a new Government and confirmation of my own objectives from the Cabinet Minister for Health and Care.

New Velindre Cancer Centre Committee

As we get closer to the completion of the new hospital – a mission which has been at least a decade in the making and of crucial importance to our patients and colleagues – we have increased the frequency of this Committee and deepened the focus on preparedness as well as construction. Chaired by IM Hillary Jones with Carl James as Executive lead, the work of scrutiny, assurance and managing risk is acute. There will be much more on this during the course of our meeting today, but I wanted to thank colleagues for immense focus on detail, preparation and quality. The final phase of any huge project like this can be very stressful (as well as exhilarating) and it's a testament to all that we are identifying, raising and addressing the many hundreds of decisions to be made and actions taken professionally, openly and respectfully.

PACT meeting, Lady Cory Field

Following a meeting with members of the Whitchurch community in February, I met with local residents at Lady Cory Field with colleagues from Cardiff Council to discuss various matters including the importance of the general maintenance of the area. We recognise the challenges a major construction project can present for the local community and are grateful to residents for their continued engagement with us.

Chairing the Maxwell Family Fund

Craig and Tracy Maxwell are remarkable people. Driven by a desire to secure a better future for others facing cancer, Craig and his family have raised an extraordinary £1.7 million for research since his diagnosis. Craig is now one of Wales' leading cancer research fundraisers, inspiring thousands of supporters to help accelerate innovation for future patients. In July, more than £400,000 from the Maxell Family Fund was awarded to fund the next phase of the QuicDNA Max programme – liquid biopsy research that could transform how cancer is diagnosed, monitored, and treated.



"*What started as a personal journey has grown into something far bigger than we could ever have imagined. Through the Maxwell Family Fund, we're not only honouring everyone who has supported us along the way but investing in research that has the potential to transform cancer*

diagnosis and treatment for future generations. Knowing that funds raised by our family, friends, supporters, and communities across Wales are now helping advance QuickDNA Max is incredibly special. We hope to create a legacy that gives hope to others facing cancer."

Chairing the Fund meeting in August was a privilege and I look forward to supporting their fundraising efforts in the future.

Harvard Alumni conference and Velindre Staff Networks

As a senior civil servant and Director of Communications for Welsh Government in 2010, I was sponsored to take part in a 'Women and Power' programme in Harvard. Back then I was working in an immensely demanding leadership role and raising two quite young children, one with a disability, on my own during the week. The experience was life-changing for me – driven mainly by the relationships I formed with other women and the conversations I had with them. This year, the Harvard alumni met in Cardiff, and I was, again, sponsored to attend. We came together from 17 countries - a Somalian midwife, Mexican economist, American lawyers, Ugandan women's activist. Alongside a Welsh COO, former Chef Constable and Permanent Secretary. The kindness, hope and diversity of thinking was hugely refreshing - a reminder of what Velindre's own staff networks – including the Women's Network – are all about. Support, challenge, sustenance and energy.

Health Science Visit

I spent an afternoon with Gill Knight, Director of Nursing, AHPs and Health Science and health scientists, including with Radiology and Medical manager, Marie Glyn Jones and Tony Millin, Director of Medical Physics and Clinical Engineering. Velindre has significant strength and depth in health science with expert colleagues including medical physicists, laboratory scientists, clinical engineers and bioinformatics specialists playing a vital role in the delivery of innovative, highly specialised services. They all play a vital role in diagnostics, testing, ensuring accuracy of clinical decisions and research and are a crucial part of our future success - advancing innovation and developing new healthcare technologies and services. Thank you all for your time and for sharing your experiences and ambitions for the future.

Establishing the new Board Committee structure

Six months ago, we embarked on an intensive programme to review our governance and decision-making arrangements. Our aim was to strengthen our collective focus on setting strategy, delivering agreed plans, scrutinising performance and fostering a safe, compassionate and ambitious culture. Above all, we wanted to ensure that our focus remains firmly on achieving the best possible experiences and outcomes for patients and donors.

I am immensely grateful to our Vice-Chair, Lindsay, for coordinating this work, and to all Board members and governance colleagues who have worked so diligently through the detail. I attended

the inaugural meetings of the new People, Culture and Engagement and Finance and Performance Committees and it was immediately evident that both will bring welcome focus and greater depth to areas that are critical to our success. We will continue to reflect and improve after each meeting, embedding an iterative approach to learning and development.

NHS Chairs 'Well-led' workshop

Welsh Government and NHS Wales Chairs held a workshop in August to discuss the development of a 'Well Led Framework' that will support us all in developing effective, compassionate and patient-focused services.

Eisteddfod y Garreg Las August 2026: Stem cell donations: what we do and the impact it has

The Welsh Blood Service may be best known for supplying blood across Wales, but it also gives people
with blood cancers and other life-threatening disorders a second chance through stem cell donation. Established in 1988, the Welsh Blood Service stem cell registry is Wales's only donor registry and
a vital part of NHS Wales. It recruits, tests and supports volunteer donors, connecting patients in Wales and beyond with potentially lifesaving matches. As around 75% of patients cannot find a suitable family match, volunteer donors are essential.

The Registry works closely with specialist cancer and transplant services, including the Welsh Blood Service, Velindre Cancer Centre and the University Hospital of Wales transplant team. Together, they provide an end-to-end pathway: recruiting and managing donors, collecting donations at Velindre and supplying stem cell products to clinical teams. This collaboration supports timely access to potentially lifesaving treatment within NHS Wales. Recruitment, managed through Blood Donation Services, remains a priority. Thousands join each year through community events, educational outreach, blood donation sessions and targeted campaigns.

Recruitment particularly targets under-represented Black, Asian, mixed and minority ethnic communities. Because patients are more likely to match donors with a similar ethnic background, greater diversity is essential to improving transplant opportunities and outcomes. The Registry now has more than 79,000 volunteer donors and belongs to a global network searched daily by clinicians seeking the best patient matches.

Since its creation, the Registry has supplied more than 1,700 stem cell products from Welsh donors worldwide and imported over 700 products to give Welsh patients the best available matches. Internationally recognised for quality, safety and clinical expertise, it operates under a Human Tissue Authority licence, holds WMDA and JACIE accreditation, and works with transplant centres and registries worldwide.

At the National Eisteddfod, I saw colleagues from the service engage the public, share stories, answer questions and encourage people to take a simple swab test that could save a life. Their passion and commitment reflected the very best of our values. Every new donor brings hope to a patient and family, and every conversation and returned swab increases the chance of a lifesaving transplant.

Professor Tom Crosby OBE

On behalf of the Trust Board, and personally, I extend my heartfelt condolences to Tom's family, friends and colleagues following his passing.

Tom's association with Velindre was marked by a deep commitment to its purpose and to the people it serves. He brought wisdom, integrity and humanity to his work, and his contribution was valued greatly by all who had the privilege of working alongside him.

He was immensely kind; totally dedicated to his calling and to Velindre. He invested so much time and effort with patients, colleagues, behind the scenes in the Welsh, UK and international cancer networks, promoting cancer awareness and on superhuman bike challenges with one goal in mind - improving patient outcomes.

I will remember the warmth and generosity he showed to others and to me. Tom had a quiet ability to bring perspective, reassurance and kindness to a conversation. He listened carefully and never lost sight of the human impact behind the decisions we make.

His passing is a profound loss. Tom leaves a legacy of service and compassion that will endure, and he will be remembered with genuine affection and gratitude across the Trust.

TRUST BOARD		
CHIEF EXECUTIVE'S UPDATE REPORT		
DATE OF MEETING	[24/09/2026]	
STATUS	Public	
REPORT AUTHOR	Kyle Page, Business Support Manager	
PRESENTED BY	Carl James, Chief Executive Officer	
REPORT SPONSOR	I, **Carl James, Chief Executive Officer**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	N/A
	DD/MM/YYYY	N/A
	N/A	
ONWARD SCRUTINY ROUTE	No further scrutiny required.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)	
	This paper provides the Trust Board with an overview of the Chief Executive's activity since the July Trust Board meeting.	
EXECUTIVE SUMMARY	This paper provides the Trust Board with an overview of the Executive's activity since the July Trust Board meeting.	
ACTION / DECISION	The Board/Committee is asked to **NOTE** the content of the Chief Executive's Update Report for **ASSURANCE** purposes.	
ADDITIONAL RESOURCES	N/A	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
None		

RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):
None
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
None
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	Appendix title
APPENDICES	Appendix 1	CEO Report

KEY CONSIDERATIONS

1. SITUATION

1.1 This report provides information to the Board regarding the Chief Executive Officer's activity since the previous Trust Board meeting.

2. BACKGROUND

2.1 This report is for information and assurance only.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

EXECUTIVE RECRUITMENT

i. Following the update at the last Trust Board regarding the appointment of the substantive Executive Director of Workforce and Organisational Development on the 16th July, I am pleased to confirm that the role was offered to and accepted by Sarah Green. Sarah comes to us from Somerset Health & Care Academy, and it is anticipated that she will commence in post at the beginning of November.

ii. I am also pleased to confirm that following interviews for the Director of Corporate Governance during September, we have offered the role to the successful candidate and are currently going through final administrative processes and an update will follow. Similarly, we interviewed for the substantive Executive Director of Nursing this month and are in discussions with the successful candidate. A recruitment campaign for the remaining post, Executive Director of Strategy, Planning and Digital, will follow.

MEETINGS OF NOTE

i. **nVCC Project Board and Project Readiness Board meetings – 29th July and 26th August**
The July and August meetings of the nVCC Project Board and Project Readiness Board focused on key programme milestones and readiness for go-live. Discussions covered Project Agreement changes and notices, equipment approvals, programme-level updates, key risks and issues, scenario planning and mitigation, benefits realisation, financial matters, communications and engagement, and the naming of both the current and new Velindre Cancer Centres.

ii. **Chief Executive Management Team meetings – 4th August and 8th September**
I attended the August and September meetings of the Chief Executive Management Team, where discussions focused on the National Cancer Programme, Workforce Negotiations, actions from the Graduate Summit (held 18th June), strategic discussions, Clinical Services and Mental Health Clinical Plans.

iii. **Cardiff Health Partners (CHP) Executive Management Board meetings – 5th August and 10th September**
I attended the August and September Executive Management Board meetings of the Cardiff Health Partners, to discuss the following:

- Governance
- Missions
- CHP Operating Framework
- Programme updates and escalations
- Next generational cancer care
- Strategic updates

iv. **National Cancer Reference Group – 19th August**
I chaired the National Cancer Reference Group, which involved a number of NHS Wales Performance and Improvement, Public Health Wales and NHS Wales Joint Commissioning Committee colleagues. Items discussed included the Cancer Improvement Plan 2023-2026, Psychological Therapies and National Optimal Pathways.

v. **NHS Wales Leadership Board meeting – 25th August**
I attended the NHS Leadership Board, held at the Welsh Government Offices, with fellow CEOs and Welsh Government Colleagues, which focused on the following areas:

- Finance and Operational Performance

- Quality and Safety
- Service / policy development
- Development of an NHS Wales 'Well-led' Framework

vi. **South-East Wales Regional Joint Committee - 3rd September**
The September Regional Joint Committee was held at the Wales Genomic Health Centre, to provide an update on the South-East Wales Regional Pathology Programme and to endorse the continued development of the Strategic Outline Case for Cellular Pathology. Additional discussions also centred around the new Velindre Hospital update and Cancer Collaboration.

vii. **South East Wales Regional Cancer Programme Board – 7th September**
The September Regional Cancer Programme Board was held at the Nevill Hall Education Centre, to discuss the next phase of the Regional Cancer Programme Board, highlights from the Regional Acute Oncology Service and nVCC Readiness Board. Workstream updates were also provided. There was also the opportunity to visit the Radiotherapy Unit following the meeting.

viii. **Health Strategic Board (HSB) quarterly meeting – 17th September**
The quarterly HSB meeting was held with Welsh Government Colleagues to review current issues regarding the nVCC project.

TRUST BUSINESS

i. **Annual General Meeting – 30th July**
The Trust's Annual General Meeting was held following the July Trust Board meeting. This publicly livestreamed meeting presented the Trust's Annual Report (including Performance, Accountability and Finance) and addressed questions from the public.

ii. **Developing our Cancer Plan - August**
Three one-hour sessions were established and hosted by NHS Horizons, inviting colleagues, patient, partners and supporters from across Velindre to take part in interactive online conversations regarding the future of cancer services at Velindre, encouraging input to help draft the new Velindre Cancer Plan. These sessions provided the opportunity to:

- Share what makes Velindre special today.
- Explore what exceptional cancer care could look like in the future.
- Connect with colleagues from across different teams and professions.
- Contribute to work that will inform the future direction of cancer services at Velindre and beyond.

iii. **NHS Wales Performance and Improvement Performance meeting – 1st September**
For NHS Wales Performance and Improvement to develop a rapid and fundamental understanding of the organisation's planning and delivery position, monthly meetings have been established to create a holistic assessment of the organisation across the four pillars (operational performance, quality and safety, finance and workforce), in line with the new operating and accountability framework. The meeting focused on the top 3 strategic priorities for 2026/27, key contracting requirements for 2026/27 and agreed actions, issues and decisions.

iv. **Developing the Velindre Cancer Plan – 2nd September**
An all-day event took place at the Village Hotel, Cardiff, which brought together key groups of people who work at Velindre, those who use its services, partners and policy makers, with a passion for improvement, innovation and change, to co-create the foundations for our strategic delivery plan. The day provided an excellent opportunity to building our existing strengths and capabilities to help deliver our ambitious cancer service goals to the people of Wales.

v. **Community by Design Transformation Programme Board – 10th September**
I attended the Community by Design Transformation Programme Board, which focused on programme arrangements, the design model, financial baseline options and Community by Design engagement event. The meeting also focused on identifying the core Digital and Data systems and foundations required to enable delivery of Community by Design.

vi. **Tackling Cancer Through Research Stakeholder meeting – 15th September**
The Tackling Cancer Through Research Stakeholder meeting took place at the Welsh Government Offices at Cathays Park, Cardiff, the aim of which was to provide an update on progress to date and to allow an opportunity to reflect on the programme and offer feedback to support the development of the Research and Innovation Chapter of the National Cancer Strategy for Wales.

vii. **Professor Tom Crosby, OBE**
I, like so many, was deeply saddened by the passing of Professor Tom Crosby OBE, whose distinguished career was defined by an unwavering commitment to improving cancer care, research and outcomes for patients across Wales. Tom was a highly respected clinical leader, colleague and friend, whose expertise, compassion and dedication made an enduring contribution to Velindre and to the wider NHS in Wales. His influence will continue to be felt through the services he helped to shape, the professionals he supported and inspired, and the many, many patients and families whose lives were touched by his work. On behalf of the Trust, I extend our heartfelt condolences to Tom's family, friends and colleagues, and record our profound gratitude for his exceptional service and legacy.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None.

3.3 LEGAL IMPLICATIONS

3.3.1 None.

3.4 PEOPLE IMPLICATIONS

3.4.1 None.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

3.6.2 Not Applicable

Risk Number	Risk title	Risk lead	Current score
N/A	N/A	N/A	N/A

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is requested to **consider** the content of the Chief Executive's Update report for **ASSURANCE** purposes.

TRUST BOARD		
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR July 2026		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Caitlin Davies, General Management Graduate Trainee.	
PRESENTED BY	1. Victoria Oxley, Director of Strategy, Planning and Performance (Interim) 2. Anne Carey, Chief Operating Officer 3. Sarah Jenkins, Executive Director of People and Organisational Development (Interim), 4. Carl Taylor, Chief Digital Officer, 5. Lauren Fear, Director of Place, Portfolio & Partnerships 6. Matthew Bunce, Executive Director of Finance	
REPORT SPONSOR	I, **Vicki Oxley, Interim Director of Strategy, Planning & Performance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	12/08/2026	WBS SLT / Performance Review
	18/08/2026	VCS OMB / Performance Review
	24/08/2026	Executive Management Board
	10/09/2026	Finance & Performance Committee
	The report has been considered and endorsed at the VCS and WBS Performance Review meetings, the Executive Management Board and the Finance & Performance Committee. It is presented to the Trust Board for assurance on the Trust's performance for July 2026.	
ONWARD SCRUTINY ROUTE	Trust Board	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 3 - AMBER (Some measurable impact evident from actions initially taken and an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement)	
	Velindre Cancer Service – Level 3 Welsh Blood Service – Level 3 Workforce & Wellbeing – Level 3 Digital Services - Level 3	

	Estates, Infrastructure and Sustainability – Level 4 Health and Safety – Level 3 Financial Performance – Level 4
EXECUTIVE SUMMARY	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 July 2026.
ACTION / DECISION	The Board/Committee is asked to: Take assurance from the Performance Management Framework for the month of July 2026.
ADDITIONAL RESOURCES	N/A

RELEVANT TRUST STRATEGIC GOALS
This report addresses the following goal(s) within the Trust's strategic plan:

- Outstanding for quality, safety, and experience

RELEVANT TRUST WELLBEING GOALS
This report addresses the following wellbeing goal(s):

- A Healthier Wales
- A Wales of Vibrant Culture and Thriving Welsh Language

QUALITY AND SAFETY IMPLICATIONS
This report impacts one or more of the following Six Domains of Quality:

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)
A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Not required - There are no specifc equality, diversity or inclusion impacts related to the activity in this report

APPENDICES	Appendix no.	Appendix title
	Appendix 1	Key Considerations
	Appendix 2	Trust-wide Scorecards & Key Issues Highlighted by Exception

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION & BACKGROUND

1.1 The attached 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 July 2026.

1.2 The PMF Scorecards are based on 'domains', namely Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP).

1.3 Performance is assessed as either ‘within standard’ or ‘outside standard’ against any particular target or best practice measure for the current month, plus an assessment of the 15 month ‘rolling data trend’ seen, as either ‘improving’ or ‘stable' or 'fluctuating or ‘declining’. The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.

2. MATTERS FOR CONSIDERATION

2.1 ASSESSMENT

2.1.1 Key issues highlighted for attention are located in appendix one in the format of PowerPoint Slides. For VCS matters of consideration, these PowerPoint slides detail Single Cancer Pathway (SCP), SACT and Radiation Services performance

2.1.2 WBS matters of consideration consist of PowerPoint slides detailing WBS Red Cell Stock Levels, WBS Incidents Reported to the Regulator, SABRE Incidents Reported and Time Expired Platelets data.

2.1.3 Furthermore, there is a spotlight on WBS sickness rates in the People & OD slides.

2.2 FINANCIAL IMPLICATIONS

2.2.1 There is no direct impact on resources as a result of the activity outlined in this report.

2.3 LEGAL IMPLICATIONS

2.3.1 There are no specific legal implications related to the activity outlined in this report.

2.4 PEOPLE IMPLICATIONS

2.4.1 There are no direct people implications in relation to the activity outlined in this report.

2.5 WELSH LANGUAGE IMPLICATIONS

2.5.1 There are no direct Welsh Language implications related to the activity outlined in this report.

2.6 RISKS / REPUTATIONAL IMPLICATIONS

2.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

2.6.2 No Applicable.

3. RECOMMENDATIONS FOR ACTION / DECISION

3.1 The Executive Management Board is asked to take ASSURANCE from the Performance Management Framework for the month of July 2026.

APPENDIX 2 – TRUST-WIDE SCORECARDS AND KEY ISSUES HIGHLIGHTED BY EXCEPTION

Quality Domain	Trust-wide Safety Scorecard			Performance as at July 2026			Compliance against Target		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**	**2 26/27**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Curative**	**Monthly**	**2.00%**	**2.00%**	**0.20% June 26**	✓	➔	
	Inpatient Mortality: Target under development/to be agreed	**Inpatient**	**Monthly**	**N/A**	**N/A**	**9**	N/A	N/A	
	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**	**-**	**1**	N/A	N/A	Pages 26-27
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	**Local**	**Monthly**	**New**	**<5%**	**7.0**	✗	↑	Pages 26-27
	Number of incidents triggering Duty of Candour	**National**	**Monthly**	**0**	**0**	**0 June 1 cum**	✓	➔	
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 July 2026			Compliance against Target		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%	13% 86%	✗	🡅	Pages 17-24
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	7% 85%	✗	🡅	Pages 17-24
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 100%	✓	🡅	Pages 17-24
	% Patients Beginning Non-Emergency (Routine) SACT within 21 days	National	Monthly						Pages 13-16
	% Patients Beginning Emergency SACT within 2 days	National	Monthly						Pages 13-16
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	92%	✓	🡅	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	94%	✓	🡇	Page 27
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%				
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating ▯ deteriorating 🡇					

Quality Domain	Trust-wide Effectiveness Scorecard			Performance at July 2026			Compliance against Target		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		N/A	→	
	Clinical demand for red cells met (% manufactured to issued) ***met clinical demand – within tolerance**	Best practice	Monthly	104%	100%	106%*	✓	↑	
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	126%	✓	↑	Page 28
	New stem cell volunteers	National	Monthly	3341	333	391	✓	↑	
	New Apheresis Donors	Local	Quarterly	21	14				
Symbols Key: In Month = Compliant ✓ Non-compliant ✗				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓					

Quality Domain	Trust-wide Efficient Scorecard			Performance at July 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 26	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	N/A	N/A	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£33k	£0	£8k	✓	→	
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£346k	£77k	£112k	✗	↓	Page 39
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 at July 2026			Compliance against Target		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%	7.91% Jun 26	✓	↑	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	7.66% Jun 26	✗	↑	
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	97.38 % Jun 26	✗	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓					

Quality Domain	Trust-wide Experience Scorecard			Performance at July 2026			Compliance against Target		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%	100%	✓	→	
	Whole blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	90.8%	✓	→	
	Resolution of WBS formal concerns within 'Putting Things Right' regulations timescale. **1 April 2026, the concerns process has transitioned to the new *Listening to People***	National	Monthly	100%	100%	N/A	N/A	→	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	78%	✗	↑↓	Pages 29-31
	% Rolling average Staff sickness levels	National	Monthly	6.22%	4.70%	5.82%	✗	↑	Pages 29-31
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	Local	Monthly	N/A	27 25/26	5 July 15 cum	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓					

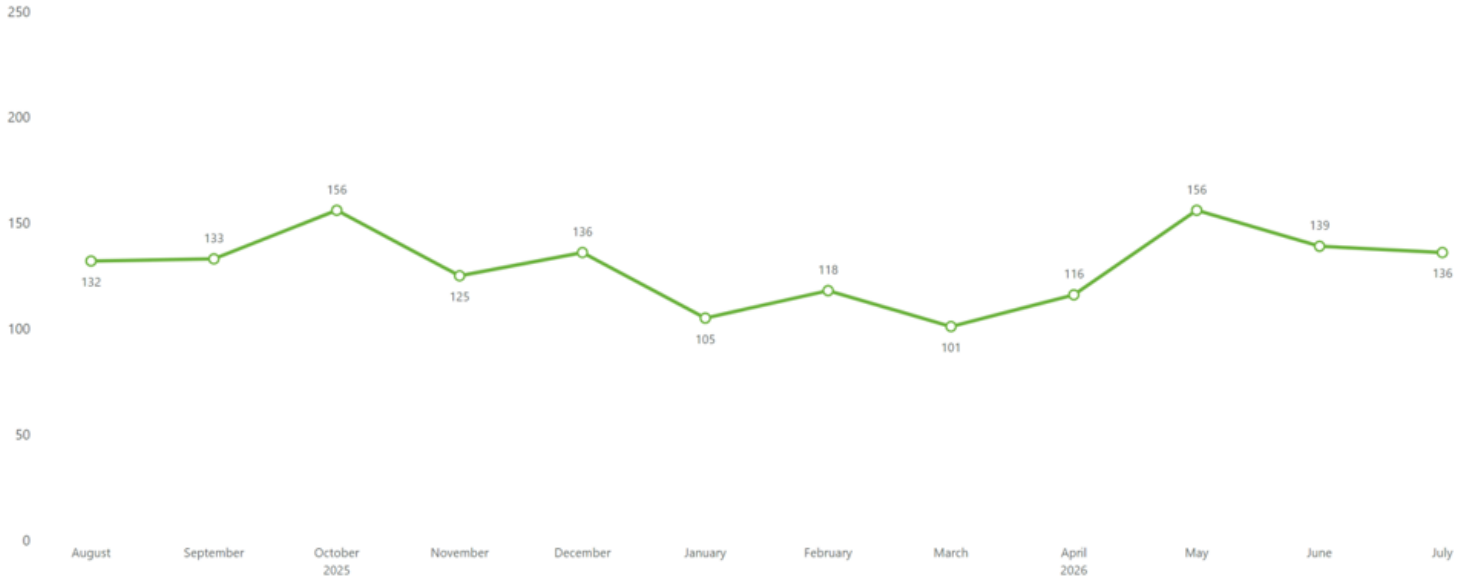
Velindre Cancer Service

SCP Referrals by Health Board

July 2026

Number of patients starting their first definitive treatment (FDT) at Velindre following SCP referral

All Orgs | All Diagnosis Types | Aug 2025 – Jul 2026



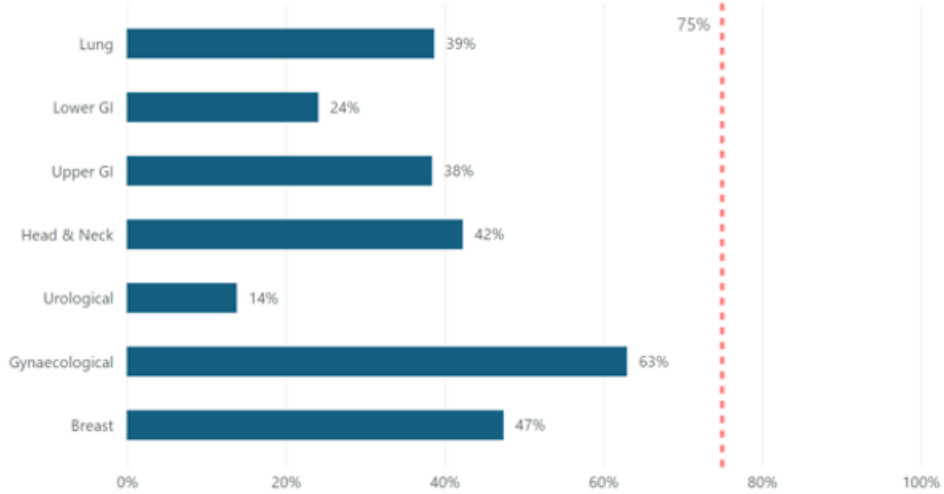
Referrals – a mean of **129** referrals per month which are linked to SCP are received by Velindre.

SCP Performance per SST

July 2026

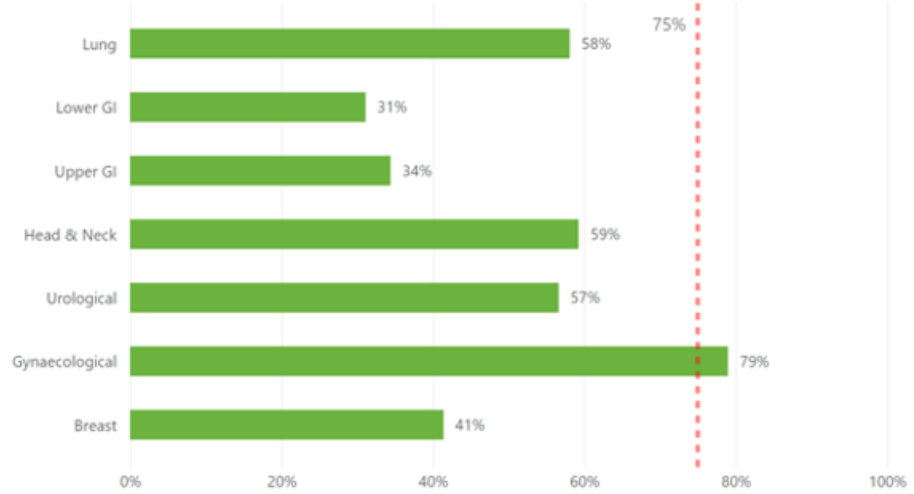
Percentage of patients starting first definitive treatment at Velindre within 62 days of SCP point of suspicion by tumour site (Ordered by most to fewest referrals)

Treatment between August 2025 - July 2026



Percentage of patients starting first definitive treatment at Velindre within 24 days of SCP referral by tumour site (Ordered by most to fewest referrals)

Treatment between August 2025 - July 2026

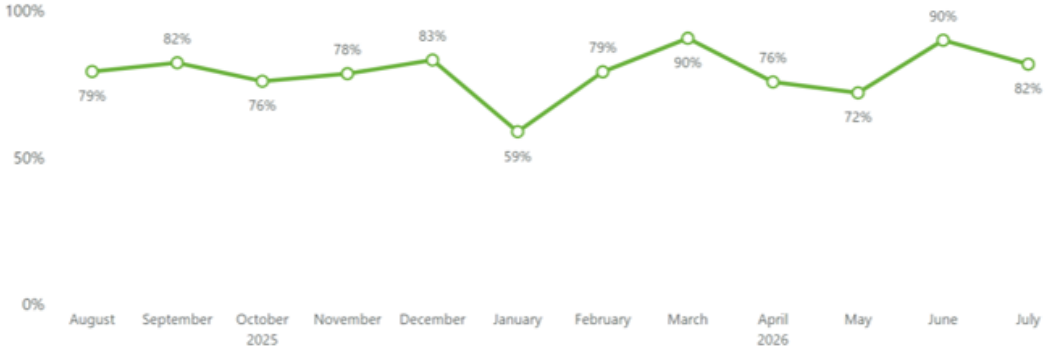


- 40% of patient FDT (first definitive treatment) within the 62-day SCP vs the 75% target (rolling average 37%).
- 49% of patients treated within 24 days (local target) from receipt of referral to VCS (rolling average 50%).

SCP Pathway Analysis (38 Day)

July 2026

Percentage of patients starting first definitive treatment at Velindre within 62 days of SCP point of suspicion where referral was received by Velindre within 38 days

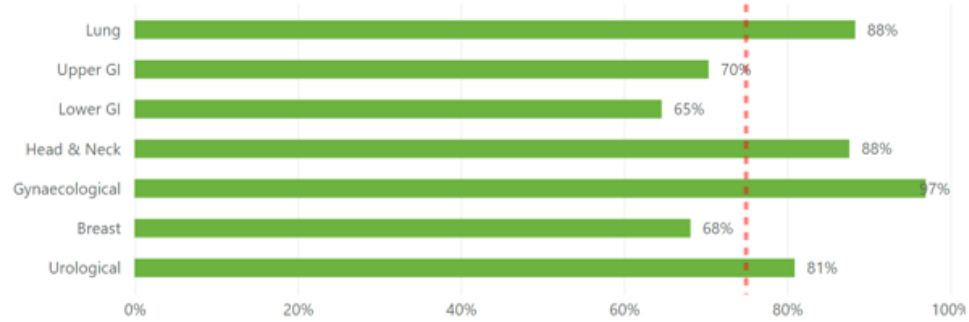


38- days (SCP patients received to VCS)

- 82% patients treated vs 75% target.
- 79% patients, 12-month position

Percentage of patients starting first definitive treatment at Velindre within 62 days of SCP point of suspicion where referral was received by Velindre within 38 days by tumour site (ordered by most to fewest referrals)

Treatment between August 2025 - July 2026



Tumour sites achieving the standard

- Lung
- Head & Neck
- Gynaecology
- Urology

SACT Performance (all treatment intents)

July 2026

Total

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	251	257	303	245	270	284	238	287	260	294	312	306
Total Breaches	136	122	159	100	121	163	127	152	139	148	151	154
% Compliance	45.8%	52.5%	47.5%	59.2%	55.2%	42.6%	46.6%	47.0%	46.5%	49.7%	51.6%	49.7%

IV First Treatment

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	217	217	252	208	223	221	198	233	214	240	251	251
Total Breaches	126	111	146	93	111	141	113	141	126	142	140	147
% Compliance	41.9%	48.8%	42.1%	55.3%	50.2%	36.2%	42.9%	39.5%	41.1%	40.8%	44.2%	41.4%

Oral First Treatment

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	34	40	51	37	47	63	40	54	46	54	61	55
Total Breaches	10	11	13	7	10	22	14	11	13	6	11	7
% Compliance	70.6%	72.5%	74.5%	81.1%	78.7%	65.1%	65.0%	79.6%	71.7%	88.9%	82.0%	87.3%

Total breaches: 154

Hospital related reasons – 35% (107)
Patient/Medical reasons – 11% (33)
Other – 5% (14)

Top hospital related breach reasons in July 2026 were as follows:

- Pharmacy Capacity – 56 compared to 31 in the previous month
- Scheduling delay – 31 compared to 25 in the previous month
- Booked in line with clinic – 5 compared to 2 in the previous month

New Validation arrangement have been introduced from July 2026 introducing a change to reported figures which involves:

- Exclusion of patients who have SACT, as part of pathway where RT is the first treatment (25 – 12 Oral and 13 IV)
- Manual revision of incorrect emergency treatment intent (1 IV)
- Manual revision of DTT where incorrect DTT assigned (4 Oral)

The Performance reported for period August 2025 to June 2026 is not based on these new validation arrangements.

SACT Performance (by treatment intent)

July 2026

P1 - Emergency - within 2 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	6	1	3	1	9	4	3	5
Total Breaches	4	1	2	1	5	2	2	
% Compliance	33.3%	0.0%	33.3%	0.0%	44.4%	50.0%	33.3%	100.0%

P2 - First definitive - 14 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	26	17	23	25	19	14	20	18
Total Breaches	18	12	14	17	15	9	14	6
% Compliance	30.8%	29.4%	39.1%	32.0%	21.1%	35.7%	30.0%	66.7%

P2 - Neo adjuvant - 14 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	52	40	32	31	39	58	49	46
Total Breaches	27	29	22	20	23	37	35	34
% Compliance	48.1%	27.5%	31.3%	35.5%	41.0%	36.2%	28.6%	26.1%

P2 - Palliative - 14 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	88	102	102	120	102	111	117	117
Total Breaches	50	67	61	76	58	71	65	82
% Compliance	43.2%	34.3%	40.2%	36.7%	43.1%	36.0%	44.4%	29.9%

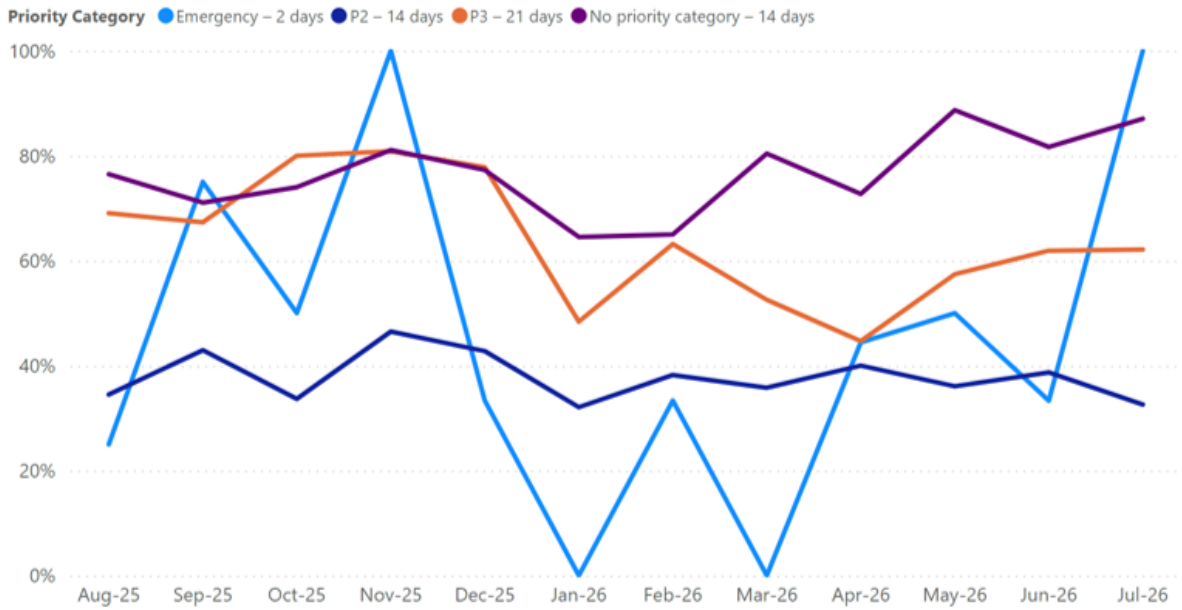
P3 - Adjuvant - 21 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	54	62	38	59	47	54	63	66
Total Breaches	12	32	14	28	26	23	24	25
% Compliance	77.8%	48.4%	63.2%	52.5%	44.7%	57.4%	61.9%	62.1%

No Priority Assigned - 14 days

	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referrals	44	62	40	51	44	53	60	54
Total Breaches	10	22	14	10	12	6	11	7
% Compliance	77.3%	64.5%	65.0%	80.4%	72.7%	88.7%	81.7%	87.0%

SACT Performance by Priority Category



All Emergency patients treated in target in month.

First definitive – 3 further patients treated between day 15 and 18 (16.6%) – 83.3% treated by day 18
Neo adjuvant – 12 further patients treated between day 15 and 18 (26.0%) – 52.1% treated by day 18
Palliative – 16 further patients treated between day 15 and 18 (13.6%) – 43.5% treated by day 18

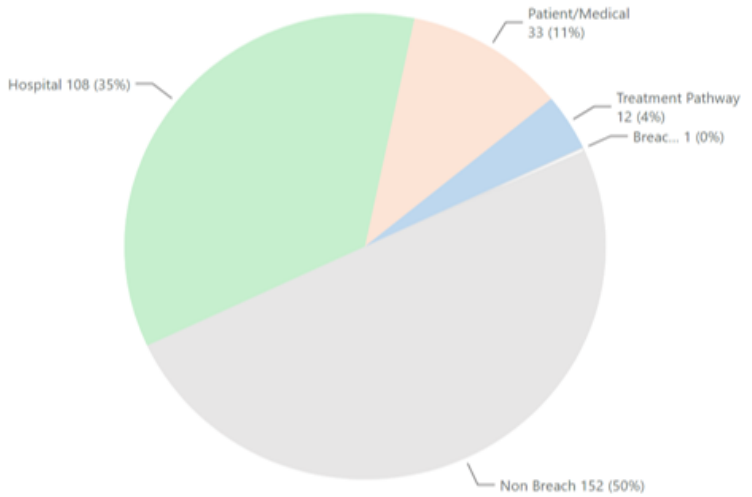
No Priority assigned are all Oral SACT. The 7 Oral Breaches relate to: Delay due to awaiting funding decision (1) Medical/ Patient reason(4) treatment interval change(1) Maintenance Chemo (1).

SACT Performance (all treatment intents) – Breach Analysis

July 2026

Waiting Reason	P1: Emergency	P2: Neo-adjuvant	P2: Palliative	P2: Primary/Definitive	P3: Adjuvant	P: No Priority	Total Referrals	% Total Referrals
Pharmacy Capacity		20	30	2	4		56	18.30%
Scheduling delay		6	19		6		31	10.13%
Daycase Capacity		1	1				2	0.65%
Pre SACT Clinic capacity		1					1	0.33%
Concurrent RT			1	2			3	0.98%
Booked in line with clinic		1	4				5	1.63%
Delay in allocation of SACT			1			1	2	0.65%
Diagnostics		1			1		2	0.65%
Muga		2	1		1		4	1.31%
Booking Error			1				1	0.33%
Pharmacy Shortage			1				1	0.33%
Medical		1	4		3	3	11	3.59%
Medical Requested start date		1	2		2		5	1.63%
Patient requested start date			9	2	5	1	17	5.56%
Change of SACT			1		1		2	0.65%
Administration Route Change (IV to SC)			1				1	0.33%
Chemocare Regimen/Programme constraint			1				1	0.33%
Interval Length Change					1	1	2	0.65%
Treatment Swap - Further Line Of Sact			4		1		5	1.63%
Maintenance						1	1	0.33%
Non breach	5	12	35	12	41	47	152	49.67%
Breach with no reason			1				1	0.33%
Total	**5**	**46**	**117**	**18**	**66**	**54**	**306**	**100.00%**

Percentage Breakdown By Category



- The first priority for available pharmacy capacity (and link to chair capacity) are patients on escalation. These are patients on SACT treatment who are awaiting their next treatment slot following medical deferral.
- To manage pharmacy capacity constraints and to reduce the waits for patients to start SACT treatment, new patients are being clinically reviewed to assess suitability to be decoupled at cycle 1 (start treatment on a different day), with a view to realigning the treatment pathway from cycle 2 onwards. Roll out of decoupling will allow treatment pathways to continue on a different day.
- New SACT referrals have reduced in recent weeks reflective of seasonal patterns, the level of New SACT referral is expected to increase in September adding further pressures to the system.

SACT Updates/Actions

July 2026

Update from last month

- Significant improvements in SACT scheduling position with patients being booked within 2 days of allocation.
- Validation of SACT Scheduling Sharepoint commenced.
- Pembro switch roll out - July 2026 actual position 27.4% against a target of 25%.
- Focus on improving the utilisation of Short procedure diaries introduced for NHH and PCH to improve utilisation at the start of the working day.
- New manual Validation Process introduced for SACT Performance. Work progressing via the PTL Group to the validation function requirements for the SACT PTL.

Actions for next period

- Sharepoint booking to be implemented by end of September 2026.
- Chair Utilisation and on-going Deep Dive functions for SACT Performance being developed into Operational Dashboards by Data and Insight.
- Biweekly Meetings with Data and Insight and Operational team in place to support development.
- Phase 2 capacity and demand modelling being progressed by Data and Insight in conjunction with SACT Operational team.
- Decoupling – progress with recruitment into the 1.5 wte posts to progress decoupling. Establish project structure for Decoupling roll out.
- Progress Home First case to Charitable Fund Committee.

Key risks/issues

- **Workforce:** Pharmacy workforce challenges with shortages across team (short term sickness/maternity leave) Bank shifts being carried out by nursing team.
- **Capacity Constraints:** capacity and demand imbalance across the SACT delivery service resulting in breaches against clinical indicators.
- **Data & Digital Gaps:** issues with data quality and digital systems hinder effective scheduling and tracking and management information to inform deep dives.

Mitigation

- **Workforce** – Prioritisation of tasks within pharmacy. Bank/overtime across nursing and admin.
- **Capacity constraints** – flexible use of trials chair capacity and opening of Rowan to address capacity/demand imbalance. Focus on escalation meetings to ensure correct information for decision making and prioritising demand.

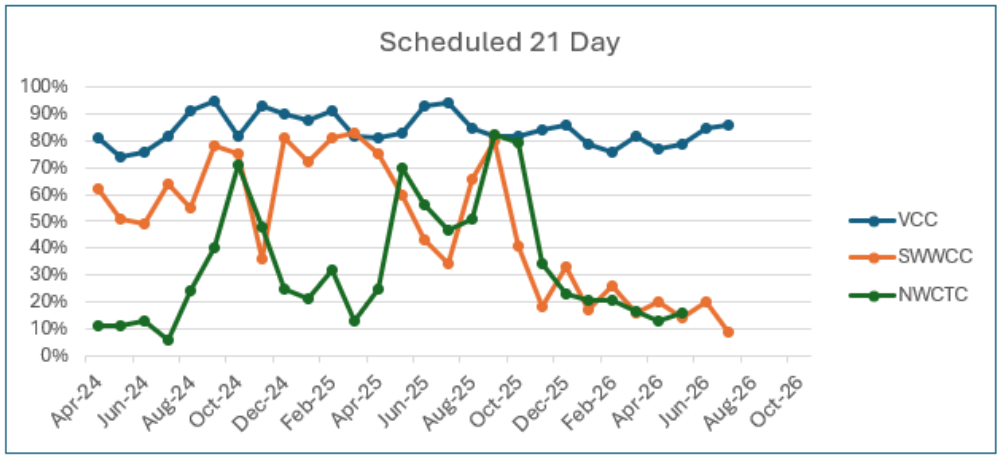
Radiation Services – COSC Mandatory and Optimal Targets

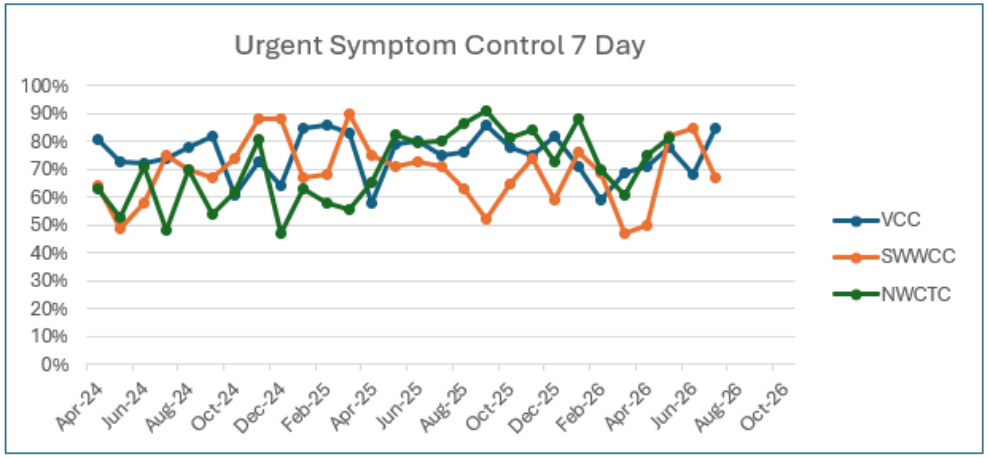
July 2026

Mandated Quality Indicator	Target	May	June	July	Movement
Scheduled radiotherapy patients to begin treatment within 21-days of decision to treat	100%	79%	85%	86%	↑
Urgent symptom control radiotherapy patients to begin treatment within 7-days of decision to treat	100%	78%	68%	85%	↑
Emergency radiotherapy patients to begin treatment within 2-days of decision to treat	100%	97%	85%	100%	↑
Elective delay radiotherapy patients to begin treatment within 14-days of decision to treat	100%	95%	100%	100%	→
Optimal Quality Indicators					
Scheduled radiotherapy patients to begin treatment within 14-days of decision to treat*	80%	14%	9%	13%	↑
Urgent symptom control radiotherapy patients to begin treatment within 2-days of decision to treat*	80%	18%	2%	7%	↑
Emergency radiotherapy patients to begin treatment within 1-day of decision to treat*	80%	97%	85%	100%	↑
Elective delay radiotherapy patients to begin treatment within 7-days of decision to treat*	80%	90%	97%	97%	→

Radiotherapy – Scheduled and USC Performance

July 2026





Performance Target: Scheduled radiotherapy

- 21 days target; 85% (184 patients out of total 214 referrals) vs 85% June
- Longest wait = 67-days the wait attributed to delays in brachytherapy treatment capacity

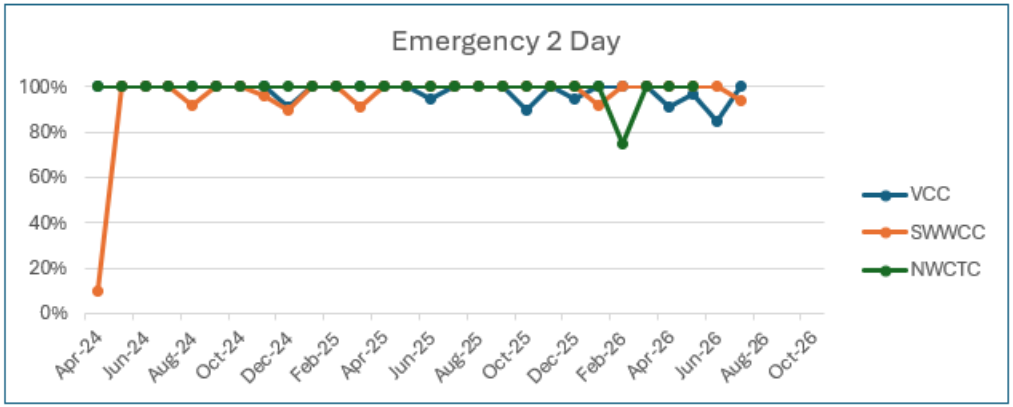
Performance Target: Urgent Symptom Control

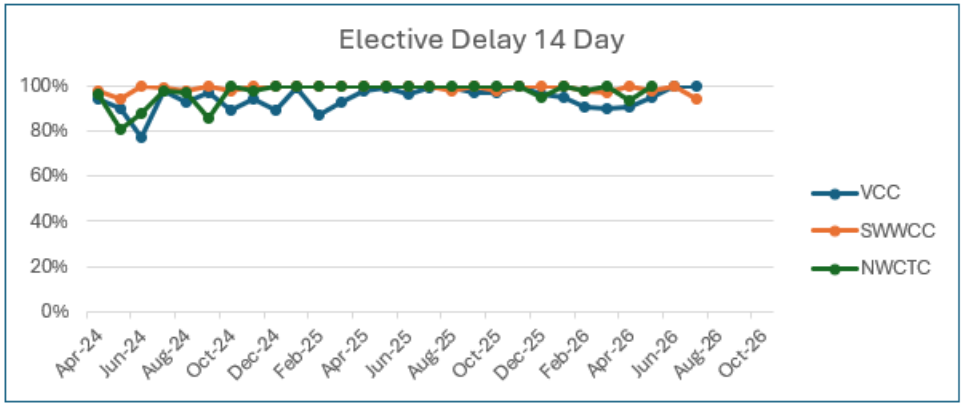
- 7-day target; 85% (47 patients out of 55 referrals) vs 68% June
- The breaches were mainly due to patient choice and patients being too unwell to attend.

Radiotherapy – Emergency and Elective Performance

July 2026

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 are not fully consistent.





Performance Target: Emergency

2 days target; 100% (18 patients)

Performance Target: Elective Delay

- 14 days standard; 100% (69 patients)

Radiotherapy – Performance Breach Analysis

July 2026

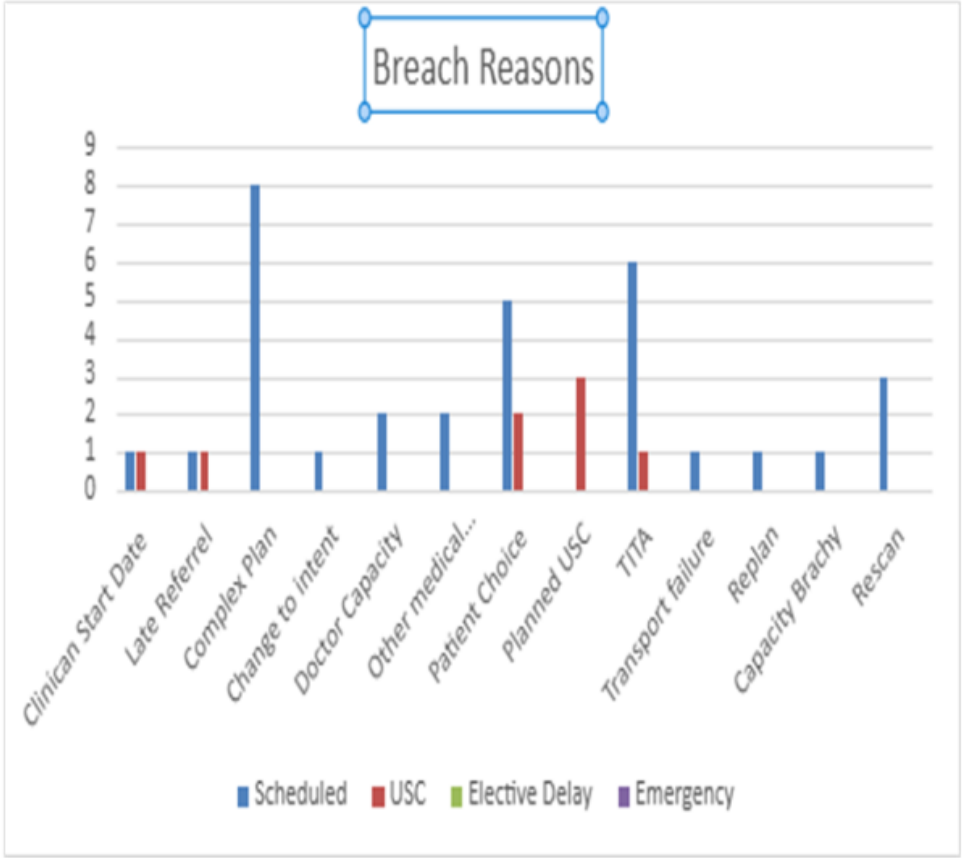
The main reasons for the 40 breaches in July were:

Scheduled (32 breaches) (14% of scheduled referrals) – the largest number of breaches were attributed to the need to develop a complex treatment plan with physics input. The longest wait to start treatment was reported as 67-days. This was attributed to a lack of brachytherapy treatment capacity.

USC (8 breaches) (15% of USC referrals) – three breaches were attributed to patient choice. The longest wait to start treatment was reported as 26-days. This wait was due to the patient being too ill to intend the scheduled treatment start

Elective (0 breaches) (0% of Elective delay referrals) – all patients began treatment within the 14-day target.

Emergency (0 breaches) (0% of emergency referrals)– all patients prescribed emergency radiotherapy began treatment within the 2-day target.



Radiotherapy Breaches: definitions

July 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

Radiotherapy Updates/Actions

July 2026

Updates from last month

- **Varian upgrades** commenced 5th June 2026, planned completion 9th September 2026.
- **Capacity and Performance** - CT capacity remained stable. Overall schedule performance 82%; Emergency 100% within 2 days. Ongoing data warehouse issues affected June reporting.
- **Pathway and Technology –** Extreme Hypo-Fractionated RT prostate now live (reduction from 20 fractions to 5 fractions).
- **Business continuity plans** are in place to utilise V@NHRU to mitigate loss of activity through Varian upgrades planned over the coming months.

Actions for next period

- **Capacity and Performance** - Resolve data issues and continue V@NHRU ramp-up, including Urgent Symptom Control.
- **Pathway and Technology** - respiratory gating to be available on all Varian equipment (rollout from 14/08/2026 to 09/09/2026).
- **Activity, reporting and assurance** - complete RT and brachytherapy reporting, and progress benchmarking and Aria Core Insights readiness.

Key risks/issues

- **Demand/capacity imbalance and data issues** limiting full performance assurance – USC & Emergency pathways
- **Activity reporting and assurance –** gaps in activity and income reporting reduce assurance and benchmarking capability
- **Breakdowns in old linacs (Elekta)** - adversely affected by extreme temperatures and humidity causing disruption.
- **Head & Neck pathway** - workforce constraints; posts pending scrutiny outcome.

Mitigation

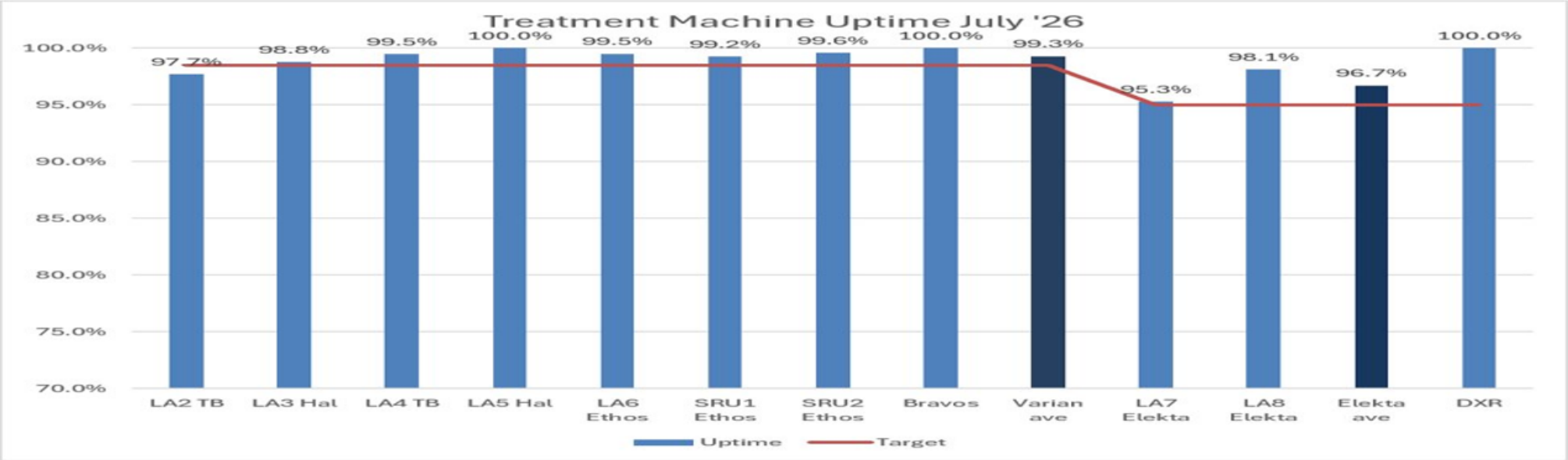
- **Demand/capacity –** escalation and clinical prioritisation in place
- **Activity reporting and assurance –** joint work with data and insights, finance and physics to strengthen Aria data and reporting
- **Utilise capacity across VCS** (incl. V@NHRU) to mitigate any service disruption in VCC.

Assurance

- ✓ Weekly capacity meetings review potential breach patients and assess any risk of clinical harm from delay.
- ✓ Patients are prioritised according to clinical urgency, individual need and the Access to Treatment Procedure.
- ✓ Where demand exceeds capacity, referrals are escalated for prioritisation and clinical harm assessment.
- ✓ Breaches against Welsh Government radiotherapy targets are reviewed at pathway level to identify wait times and reasons for delay.
- ✓ Breach themes are used to inform service improvement.
- ✓ A finalised radiotherapy improvement plan is in place to address the key causes identified through breach analysis.

Radiotherapy – treatment machine (Linac) uptime

July 2026



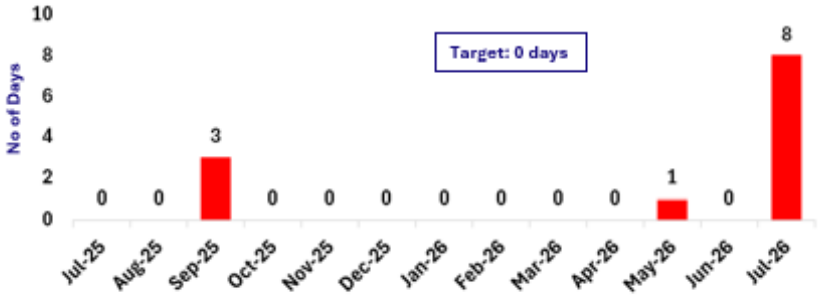
- Uptime' relates to the time a Linac machine is available for radiotherapy treatment over standard operating hours.
- The Varian average uptime across both sites was 99.3% which is above the target of 98.5% for the IRS contract.
- The Elekta average uptime was 96.7%. This was above the in-house target of 95%. LA7 was the worst performing machine largely due to an intermittentissue with the MLC camera.
- The combined Linac, Flexitron, DXR and Bravos uptime was 98.9% which is above the in-house target of 95%.

1.1 Welsh Blood Service

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

July 2026



Key Issues / Risks:

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

Updates on last month:

- All clinical demand for O, A & B+ groups was met.
- Red cell manufacturing exceeded demand (106%), resulting in an improved stock position.
- A pre-amber advisory for Group 0+ blood was issued to hospitals on 13/07/2026 following extreme heat related disruption to donation clinics. The advisory was lifted on 04/08/2026 following stock recovery, supported by receipt of 100 units O+ blood through mutual aid.

Action / Mitigation Underway:

- Daily Resilience meetings to manage immediate stock pressures and operational risks.
- Enhanced Blood Supply Chain Planning Group oversight of blood supply resilience.
- Strengthened monitoring of demand, collections and stock.
- Focus on achieving required stock build ahead of winter and WLIMS.
- Review of collection capacity constraints, including workforce, venues and donor attendance.

Forecast / Next Month:

- Stock position has improved; however, further disruption to collection activity from extreme heat could impact resilience.

WBS Incidents Reported to Regulator / Licencing Authority

Gwasanaeth Gwaed Cymru
Welsh Blood Service

July 2026



One new Serious Adverse Blood Reactions and Events (SABRE) event was reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in July 2026.

No new adverse event reports were submitted to the Human Tissue Authority (HTA) in July 2026.

Incident Details:

SABRE 163: HLA-matched platelets required for a planned surgery could not be released due to an outstanding malaria test result, resulting in cancellation of the procedure. A details action plan has been developed to address the underlying process issues and reduce reoccurrence.

Ongoing Action / Mitigation Underway:

- Historically, most SABRE events relate to donor eligibility assessments or transcription errors, both of which involve complex processes.
- Actions are in place to reduce reoccurrence; however, some longer-term solutions remain in development, and further events may occur while these are implemented.

Quality Assurance – Incidents & Audits

July 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
⬆	**7%** overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

⬆	**2** exceeding target date for closure (in reporting month)	Target: 0
➡	**4** that remain overdue at month end	Target: 0
	Age of oldest open overdue incident – **94 days**	No target set

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

	1 from internal audits in the last month	No target set
	8 from external audits in the last month	No target set
⬇	**12.2** overdue actions from open audit action plans	Target: <5%

Key: ⬆ Increase in performance ➡ Performance remained the same ⬇ Decrease in performance

Action / Mitigation underway:

- Performance has improved in the management and closure of incidents reported to the regulator / licencing authority; however, quality incidents and audit actions remain significantly overdue.
- A review has identified underlying processes, governance and system issues affecting action management and closure.
- A Service Improvement project has been established to undertake a full root cause analysis and inform longer-term improvements, including process redesign, SOP review and staff training – *expected to be completed in Q3 with benefits being realised in Q4.*

Time Expired Platelets

Gwasanaeth Gwaed Cymru
Welsh Blood Service

July 2026



Updates on Last Month:

- July performance remained close to the 10% target and broadly consistent with June 2026.
- Average weekly demand reduced from 176 to 172 units; however, overall performance remained stable.
- The underlying challenge remains balancing production with variable clinical demand given the short shelf like of platelets.

Key Issues / Risks:

- Forecasting is challenging due to short shelf life and real-time clinical demand; reducing production to limit waste risks shortages and greater impact on patient care.

Action / Mitigation Underway:

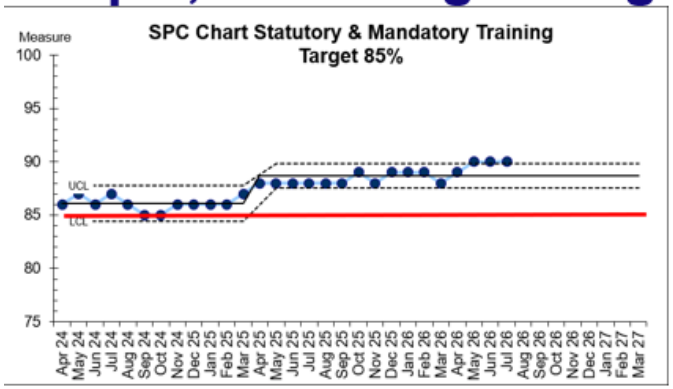
- Ongoing focus on balancing platelet production and demand to minimise wastage while maintaining supply resilience.
- Exploration of separating pooled and apheresis platelets within targets, to better reflect true wastage (KPI review).
- Continued development of planning tools and operational controls to improve forecasting and decision-making where possible.

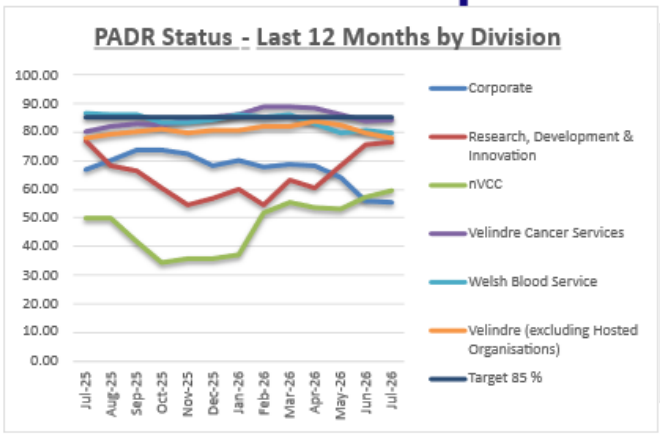
Forecast / Next Month:

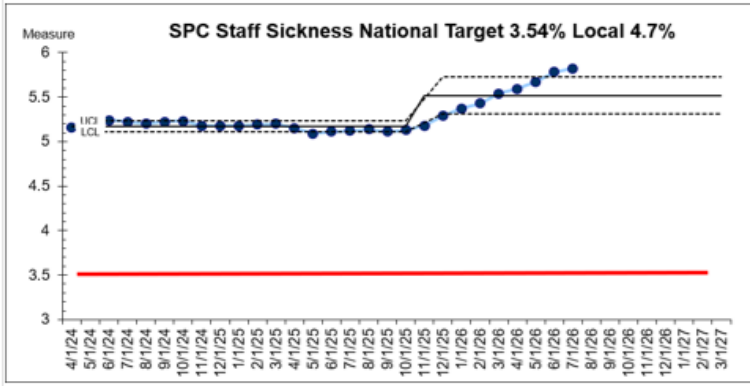
- Performance is expected to remain close to target, although some moth to month variation is likely due to the challenges of balancing production with variable clinical demand.

People, Wellbeing & Organisational Development

July 2026







Action / Mitigation Underway:

- Fundamentals of Management Training (FOMs) package has been offered to all managers and supervisors across the Trust
- In VCS a Deep dive analysis has been undertaken into sickness absence rates and underlying causes within VCS to inform the development of a targeted action plan aimed at supporting managers, reducing absence levels and improving workforce wellbeing and support
- Working in partnership with managers to identify key areas of focus, bringing together initiatives and business areas to ensure a coordinated and effective approach to delivery.
- July into August will see the finalisation of a targeted action plan to support absence management is underway, with an update to be provided to the Leadership Team. The plan is focused on supporting managers and colleagues through enhanced coaching and guidance,
- WBS have commenced a sickness deep dive comparing our sickness stats with the Celtic nations and reviewing their measures to reduce sickness absence to share lessons
- Please note these actions will not yield improvement in month. Action plans will be ongoing over the next 3-6 months to improve sickness trends, hence narrative remainst similar to last month

Forecast / Next Month:

- **PADR** – as systems for completion of PADR's improves we forecast an improving trend towards the KPI target of 85%
- **Sickness** –as noted divisional action plans and SMART objectives agreed aligning to the detailed data analysis.

Key Issues / Risks:

- Capacity of management time to undertake effective people management activities alongside clinical workload, meaning that only 50% of managers have attended FOMS.
- Capability and confidence of managers to effectively undertake people management activities

Updates on Last Month:

- **PADR** – Ongoing management of action plans and highlights to managers where compliance has not been met
- **Sickness** – Trust action plans following detail absence analysis are ongoing and progress towards target is being monitored and discussed with senior management teams

People KPIs Heatmap

July 2026

	PADR	Sickness Absence FTE Rolling	Stat & Mand	Welsh Language Awareness	Anti Racism	Turnover FTE Rolling	Job Plan
Corporate	55.46	4.89	85.82	81.68	90.48	11.77	N/A
Research, Development & Innovation	76.67	4.24	88.87	81.69	92.96	13.97	N/A
Velindre Cancer Services	84.48	5.99	89.68	82.42	90.96	7.95	78.13
Welsh Blood Service	79.95	6.64	93.53	88.03	96.58	8.44	100.00
nVCC	59.46	1.09	88.81	69.05	90.48	3.00	N/A
Velindre Organisations	78.12	5.82	90.03	83.39	92.36	8.77	79.00
Target	85%	3.54%	85%	90%	85%	7%	90%

People, Wellbeing & Organisational Development – WBS Spotlight

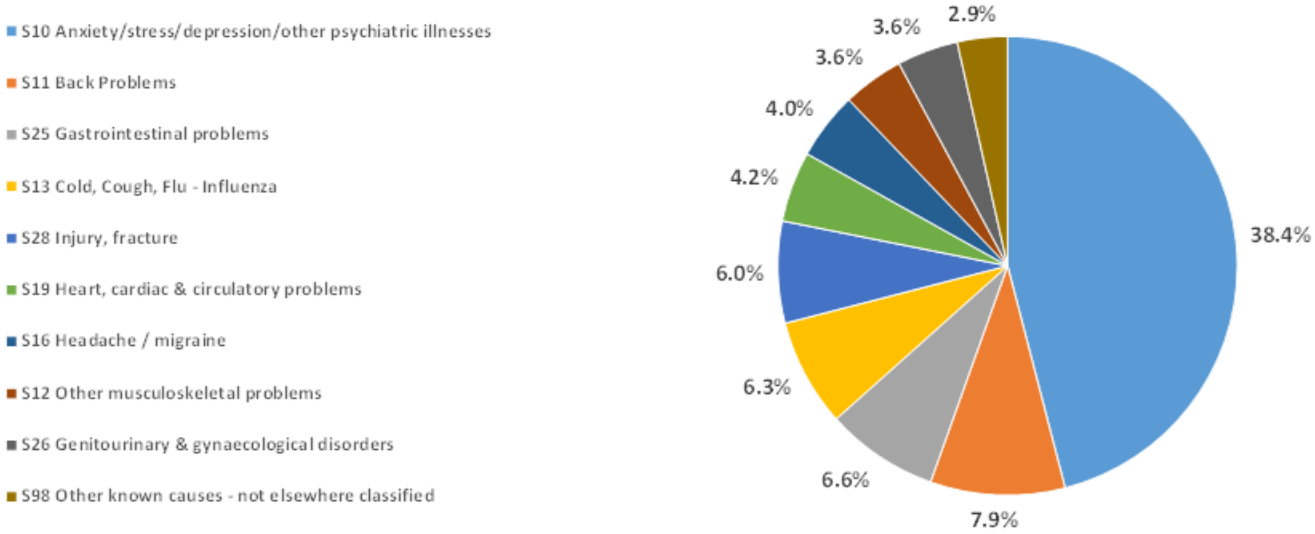
July 2026

Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)	Absence % (FTE)
Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
6.00%	5.90%	5.93%	6.03%	6.11%	6.07%	5.98%	5.97%	5.97%	6.14%	6.39%	6.64%

Sickness absence rates for the last 12 months:

- Sickness absence rates have remained volatile throughout the year
- Rates fell to 5.90% in September 2025, peaking in July 2026 at 6.64%
- Focus is on reducing reoccurring spikes and achieving a downward trend
- A deep-dive on sickness absence and comparisons with the Celtic nations blood services is underway

Top Ten Sickness Absence Rates in the last 12 months



People - NHS Staff Survey Culture Metrics – 2024 and 2025

July 2026

	Response Rate %		Staff Engagement Index %		We are able to speak up %		We are compassionate and inclusive %		We are continuously learning and improving %	
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Velindre University NHS Trust	33.7	41.3	77	75.7	71.8	70.7	77.5	78	68.7	67.9
Corporate Services	59	54	79.5	76.6	74.7	72.6	80.5	78.6	74.9	70.8
Research Development and Innovation	22.6	22.2	74	80.1	68.6	77.5	79	74.6	69.8	77.9
Transforming Cancer Services	34.8	76.7	82.4	84.5	<10	78.9	<10	89.8	<10	86.3
Velindre Cancer Service	29.5	32.3	74.5	74	70.8	67.9	77.2	77.2	66.9	65.6
Welsh Blood Service	31.1	53.2	77.1	76.2	69.6	71.7	73.1	77.6	64.6	66.1
NHS Wales	21.9	30	71.67	70.8	66.2*	65.6*	70*	69.6*	64*	66.1*

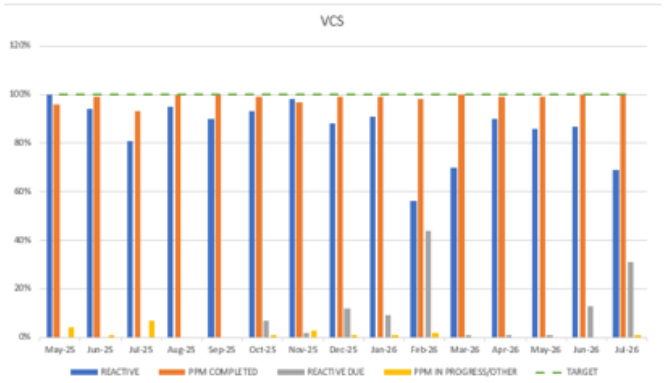
This data is from the NHS Wales Staff Survey 2025.

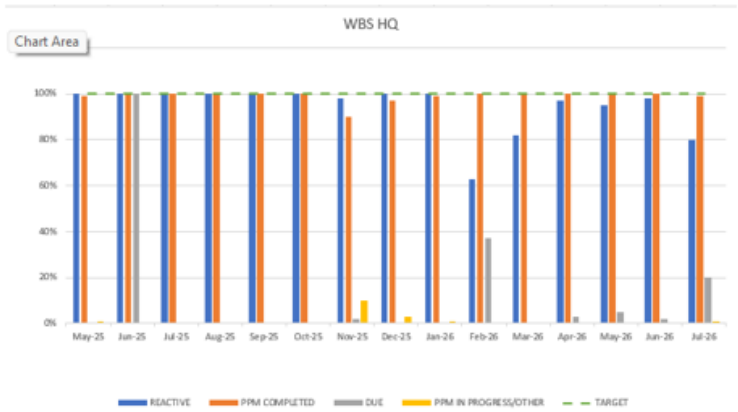
- The green represents percentages higher than the NHS Wales average and the pink represents a percentage lower than NHS Wales average.

*benchmarking average for Health Boards

Estates and Infrastructure

July 2026





Updates on Last Month:

VCS – PPM = 100% - Reactive = 69 %
Trust HQ – PPM = 100% - Reactive = 50 %
WBS HQ - PPM = 99% - Reactive = 80%
Dafen – PPM = 100% - Reactive = 100%
Wrexham – PPM = 100% - Reactive = 100 %
Bangor – PPM = 100% - Reactive = 50%

Action / Mitigation in Progress:

- VCS – July: During the month, the Estates team experienced staff sickness absence and pre-booked annual leave. An action plan was implemented to secure external labour support from contractors; however, due to seasonal resource constraints, only two days of contractor support per week could be secured. Internal labour resources were prioritised towards statutory and compliance-related activities to ensure compliance obligations continued to be met while mitigation measures were implemented. Estates continues to seek suitably qualified contractor resources to provide additional support and help address the increase in reactive maintenance activity.
- Trust HQ – July – 2 jobs on the system, 1 complete (Non-Compliance tasks)
- Bangor– July – 2 jobs on the system, 1 complete, 1 Contractor.

Forecast / Next Month: August 2026

- PPMs July planned for VCS - 772
- PPMs July planned for Trust HQ - 22
- PPMs July planned for WBS sites - 155

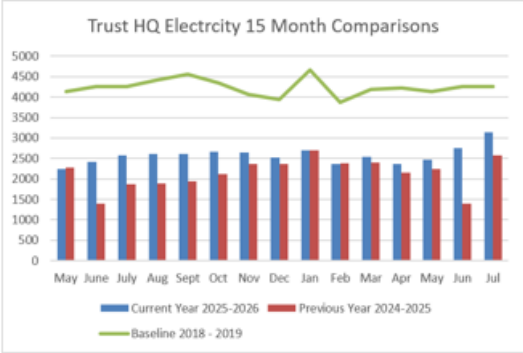
Main Issues / Risks:

- CAFM System: Issues with the current CAFM system continue. Estates has completed all required governance approvals and is currently awaiting purchase order (PO) approval to proceed with the new system. The existing CAFM supplier is currently operating outside of contract, and any further delays in awarding the contract may increase the risk of access to the current system being withdrawn. This could impact the Estates team's ability to access maintenance, asset, and compliance records during the transition period.

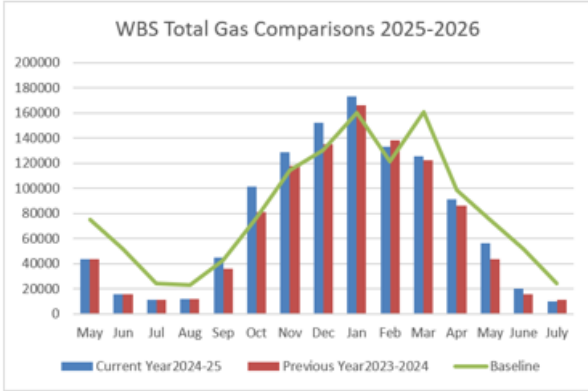
Estates Sustainability

July 2026

Elec – Trust HQ



Gas – VCC All Sites



Updates on Last Month:

- **Gas consumption:** Gas consumption down across all sites to reflect the warmer weather and switching off of heating. VCC gas meter AMR fault in reading – skewing data for this month.
- **Electricity use:** Increase in electricity use due to the increased use of air conditioning – particularly noted in Trust HQ.

Action / Mitigation Underway:

- **Energy Management:** Deliver internal audits, BMS monitoring, and monthly Estates reviews to identify inefficiencies, and track ongoing energy reductions. To be completed monthly.
- **LED Lighting:** Install LED lighting with motion/daylight sensors across all planned areas using procured materials, completing rollout by Q4 2026 and monitoring energy savings.
- **Renewable Energy:** Submitted Ynni grant application for WBS North Wales and, if approved, implement renewable installations within 18 month.
- **Waste & Recycling:** Roll out WBS waste upgrade projects: complete audits across all Wales sites by Q2 2026, with improvement actions implemented by Q1 2027 while maintaining VCS BAU before nVCC.

Forecast / Next Month:

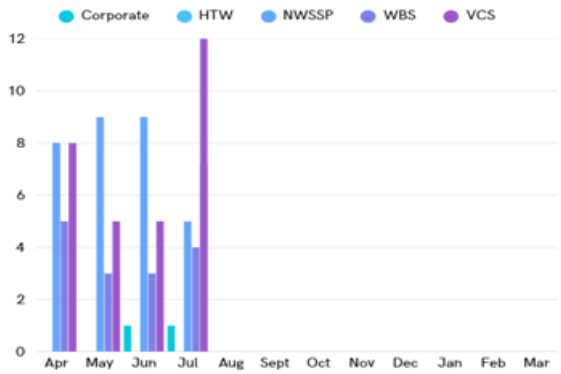
- Bin replacements across WBS are expected to increase recycling rates.
- Energy costs continue to be monitored via WEOG, with potential price increases linked to Middle East geopolitical factors. April marked the start of NHS Wales contract move to Variable 30 contract.
- LED lighting project awaiting further audit to check progress inline with budget.
- Focus on EV chargers to promote and increase staff use – policy currently going through
- WBS satellite sites waste and energy audit.
- Trust Staff Travel Survey currently collecting responses.
- ISO14001:2025 audit prep underway ready for external audit 28th– 1st October.
- nVCC transitions planning making good progress.

Key Issues / Risks:

- None to note.

Health & Safety

Incidents by Division 26/27



July 2026

Updates on Last Month: Total of incidents

- NWSSP – 5
- VCS - 12
- WBS – 4
- Corporate - 1
- MIM (Trust Managed) - 0
- RIDDOR – 0

Forecast / Next Month:

•Continued focus on nVCC operational readiness, including development of the Health & Safety Management System and readiness assurance activities.
•Progress implementation of Work Wallet to strengthen contractor management and assurance arrangements.
•Monitor incident themes, investigation outcomes and training compliance, with particular focus on violence and aggression and workplace environment risks.

Action / Mitigation Underway:

•Continued review of incident trends and support to managers to identify learning and preventative actions.
•Estates and local management actions progressed to address environmental and equipment-related hazards.
•Ongoing support provided for violence and aggression reporting, staff wellbeing and stress-related investigations.

Key Issues / Risks:

•18 incidents reported during July, all classified as low or no harm, with the main themes relating to violence and aggression, slips/trips/falls, contact with objects and work-related stress.
•Several work-related stress concerns associated with resource pressures within Palliative Medicine have been reported and are currently being reviewed locally.
•Discussions are ongoing regarding the most appropriate recording and management arrangements for work-related stress concerns, recognising these are both workforce and health & safety matters. Further review will be undertaken once key stakeholders return from annual leave.

Health & Safety

July 26

Incident Severity - Heinrich's Triangle

Use this scale to classify the most serious outcome of an incident.
Enter the total number of incidents for each severity level.

0	1	2	3	4	5
Negligible / No harm	Minor / First aid	Moderate / Medical treatment	Severe / Lost time injury / Serious but recoverable	Major / Single fatality	Catastrophic / Multiple fatalaties

WELSH BLOOD SERVICE

	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	0
2	0	2
1	3	11
0	1	4
Total Incidents:	4	15

VELINDRE CANCER SERVICE

	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	1
2	0	1
1	8	13
0	4	15
Total Incidents:	12	30

VUNHST - TRUST TOTAL

Total of all

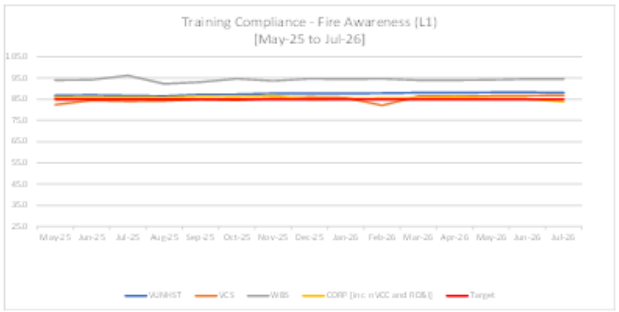
	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	1
2	0	3
1	6	30
0	6	19
Total Incidents:	18	47

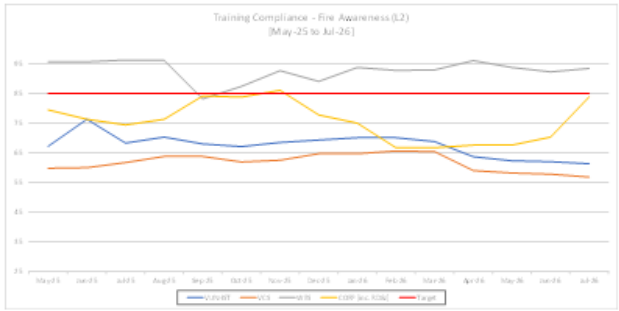
Notes:
Corp (CTU) July - 1 x Accident, injury incident (minor)

PMF LINK

Fire Safety

July 2026







Updates on Last Month:

STRATEGIC
- Continuation with development of fire safety protocols – need to align with new Firecode Management document [HTM 05-01].
- Training compliance remains static with minor changes; Non-clinical compliance shows minor improvement but Clinical has continued to fall.

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. Plan agreed to achieve 85% benchmark for Clinical [L2] training compliance by end of ***AUGUST 2026***, but current compliance has shown further decline. Several VCS departments have been in contact to arrange training, and consideration should be given to achieving compliance by the end of ***SEPTEMBER 2026***.

WBS
- 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.

Action / Mitigation Underway:

STRATEGIC
- Revise strategy for delivery of fire safety and other emergency response training to focus on essential information and record participation in drills & exercises on ESR to support improvement in training compliance.

VCS
- Action developed to address poor compliance in [L2][Clinical fire training – revised target of **SEPTEMBER 2026.**
- Engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved – **NOVEMBER 2026**
- Schedule evacuation exercises for clinical areas – **NOVEMBER 2026**

WBS
- Engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved – **NOVEMBER 2026**
- Work with Evacuation & Security T&F group ongoing..

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

Forecast / Next Month:

STRATEGIC
- Continuation of 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
- Anticipate improvement in training compliance but currently not on target to achieve agreed benchmark by end of August 2026; agree revised target of ***SEPTEMBER 2026***
- 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 and transition to nVCC.

WBS
- Commence delivery of Evacuation Warden training

CORPORATE
- Further work on FRA actions.

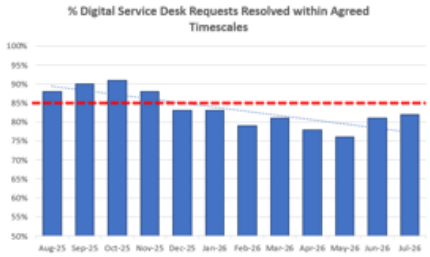
Key Issues / Risks:
- Continued low compliance for fire safety training; especially VCS Clinical [L2]; Service needs to develop and execute plan to achieve benchmark by end of ***SEPTEMBER 2026.*** Progress towards compliance is at risk due to limited engagement from relevant service areas despite requests for input. The issue has been escalated and will be discussed at the next Cynefin Group meeting to agree actions and support delivery of the planned approach.
- 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 and transition to nVCC; this will include additional training burden which the Trust need to consider.

Digital Services

July 2026









Updates on Last Month:

- Service performance remains above the agreed percentage; Incidents performance remained stable in July. Factors to consider is Windows 11 migration project and seasonal variations on Requests.
- One Major Incidents recorded:
  - Compromised CTM account - PDF Attachment (National Issue) – User account sent multiple emails in attempt to compromise additional NHS Wales accounts. Blocked at source and potential impacted accounts/devices quarantined and subsequently restored.
- 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:

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

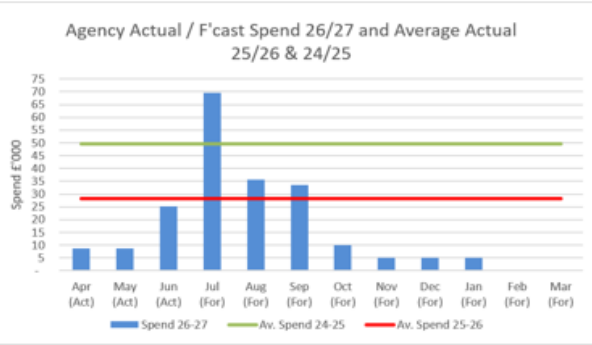
Key Issues / Risks:

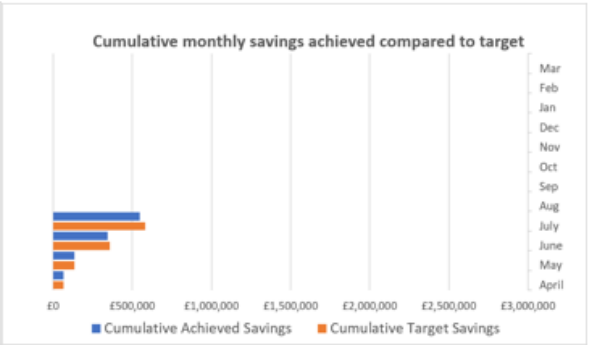
- Capacity v Demand of requests on the IMTP.

Financial Performance

July 2026

Trust Revenue Position (core)	25/26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual Cum £k	33	2	3	6	8								
Target		0	0	0	0								
Trust Capital Position	**25/26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**
Actual Cum £m	20.593	0.395	1.938	2.534	6.542								
Target £67.659m CEL		0.395	1.938	2.534	6.542								





Updates on Last Month:

- The Trust has reported a small underspend up to 31st July 2026 of £0.008m which is in line with the 2026-27 IMTP planning assumptions.
- The Trust has met the Public Sector Payment Performance (PSPP) target of paying 97% of Non-NHS invoices within 30 days for June 2026.
- The Trust is on track to achieve the Capital Expenditure Limit (CEL) for 2026-27.
- All saving schemes for 2026-27 have been identified and are now rated green. They will require close monitoring as the year progresses.

Forecast Year End Position:

- The Trust is currently on track to achieve its forecast breakeven position, albeit it is early in the year and there are a number of challenges to manage.
- The Trust is in discussions with WG regarding capital allocations but currently expects to meet its CEL target.
- Savings plans now all rated green, need to deliver as planned / be replaced by alternative schemes in year.

Action / Mitigation Underway:

- Urgent action required from Divisional / Executive Directors and SLT / SMT to ensure that saving schemes for 2026-27 start / continue to deliver as expected; and RD&I Directorate either turn two remaining amber schemes green or replace with alternative schemes by the end of July.

Key Issues / Risks:

- Non delivery of full saving plans for 2026/27
- Commissioners not supporting Service investments above 1.11% core uplift funding
- VCS Service Transformation Investment
- Ability for Divisions to manage new / emerging cost pressures
- Potential issue in relation to removal of Same Day Emergency Care recurrent funding being discussed with WG due to impact on future financial years

TRUST BOARD		
Finance Report: Month 4 (July 2026) 2026/27		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Claire Bowden, Head of Financial Planning & Reporting & Steve Coliandris, Deputy Director of Finance	
PRESENTED BY	Claire Bowden, Head of Financial Planning & Reporting Matthew Bunce, Executive Director of Finance	
REPORT SPONSOR	I, **Matthew Bunce, Executive Director of Finance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	24/08/2026	Executive Management Board
	10/09/2026	Finance & Performance Committee
	The paper was noted.	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR DISCUSSION	
	• Long term agreement (LTA) financial values, contract rebase & VCS LTA financial performance • Integrated Medium Term Plan (IMTP) financial plan / forecast • Key financial targets / performance indicators	
EXECUTIVE SUMMARY	The attached report sets out the Trust's financial position and performance for the period ended 31 July 2026. It highlights the key issues affecting delivery of the 2026-27 financial plan: LTA financial values and contract rebase, the IMTP financial plan and forecast, and performance against key financial targets and KPIs. The three main issues are highlighted below: **<u>1. Long Term Agreement (LTA) financial values, contract rebase & VCS LTA financial performance</u>** **LTA Financial Values:**	

- The Trust has agreed LTAs with all Commissioners including the 1.11% uplift.

- Commissioners have not agreed additional funding above the 1.11% general uplift, for either WBS or VCS. The Trust continues to manage capacity pressures across outpatients, ambulatory care, SACT and imaging to meet rising demand and cancer waiting times.

Contract Rebase:

- All Wales DoFs have agreed to establish an LTA / commissioning group to review historical LTAs across NHS Wales and make recommendations on how they should be updated to reflect current activity and cost. This will include recommendations on the principles for managing the financial impact, including gains and losses, of LTA re-basing. The Trust continues to participate in this group with the intention of moving to an activity-based NICE drug cost recovery methodology through the 2027-28 LTAs; however, this remains subject to collective commissioner agreement, which has not yet been reached.

VCS LTA Financial Performance:

- The IMTP planned overperformance against 2019/20 baseline contract levels in 2026-27 is £10.590m. This represents an increase in contract income of £0.112m against the 2025-26 outturn and the plan set through the IMTP. The forecast marginal income overachievement is being held to support the underachievement on radiotherapy activity and underlying cost pressures within VCS.

2. Integrated Medium Term Plan (IMTP) – Financial Plan / Forecast

- A balanced three-year IMTP financial plan covering 2025-28 was approved by Welsh Government. The 2026-29 plan was submitted to Welsh Government on 31 March 2026 and is awaiting formal sign-off.

- The Trust has achieved a minor underspend of £0.008m for the four-month period ended 31 July 2026 and is currently forecasting a breakeven position at 31 March 2027.

- Maintaining a balanced underlying position remains challenging because of the significant cost pressures and risks facing the Trust. Despite this, the 2026-29 IMTP reflected a balanced brought-forward position, which is expected to be maintained over the course of the plan.

	3. Key Financial Targets / KPIs • Revenue Balance: The Trust has reported a year-to-date underspend of £0.008m at 31st July 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 is forecasting achievement of its CEL in 2026-27. • Savings Target: All schemes are now rated green. It is important that these are closely monitored and if fully delivery is not deemed achievable, they are replaced with alternative schemes.
ACTION / DECISION	The Committee are asked to note the contents of the July 2026 financial report and, in particular: • The year-to-date and forecast revenue and capital outturn position, and Public Sector Payment Performance (PSPP). • The latest position on VCS LTA income for 2026-27 from the Trust's commissioners. • The position with commissioners on the contract rebase agreement, noting that the LTA issue with Hywel Dda UHB has now been resolved. The current position of the Trust savings plans.
ADDITIONAL RESOURCES	N/A
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:	
• Outstanding for quality, safety, and experience	
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):	
• A Prosperous Wales	
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:	

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specifc equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Trust Finance Report – July 2026
	Appendix 2	nVCC Finance Report – July 2026

KEY CONSIDERATIONS

1. SITUATION

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

2. BACKGROUND

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

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 The table below summarises the performance against key financial targets at this point in the financial year, together with the year end forecast position:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.008	6.542	67.907
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	97.1%	95.0%

3.2 FINANCIAL IMPLICATIONS

The core Trust has reported a minor underspend of £0.002m for July 2026, leading to a year-to-date underspend of £0.008m. This is in line with the IMTP planning assumptions and supports the current year-end forecast of breakeven. However, delivery remains challenging given the cost and service pressures outlined in the plan, together with the additional commissioner funding required for service developments that has not been secured.
The Trust's financial plan includes Commissioner uplift funding of 1.11% agreed in its Long-Term Agreements (LTAs). This, together with a 2.5% savings target, is fundamental in enabling the Trust to develop and deliver its balanced financial plan for 2026-27.

Savings

The overall Trust savings performance at July 2026 shows that in-month planned savings of £0.223m were underachieved by £0.020m, with £0.203m delivered.

All schemes are now rated green, with close monitoring required to ensure full delivery, or replacement schemes are put in place to ensure the full savings requirement for 2026-27 is delivered.

LTA Income

The Trust has agreed 2026-27 LTAs with Commissioners for VCS and WBS. Signed agreements have been received from all organisations.

LTA Contract Position

Commissioners agreed no additional funding in 2025-26 above the 1.77% uplift for WBS or VCS, and no additional funding above the 1.11% uplift has currently been agreed for 2026-27. The Trust continues to manage capacity pressures across outpatients, ambulatory care, SACT and imaging to meet rising demand and cancer waiting times.

Although the Velindre Collective Commissioning Group for Cancer planned a further review of the SACT business case, no commitment was made in 2025-26. The financial risk of the additional implemented capacity therefore remains with the Trust. Growth investments were resubmitted on 22 October 2025 for 2026-27, but all Commissioners confirmed that no funding support would be provided.

LTA Contract Rebase

To ensure Commissioners fund the current cost of Velindre cancer services, there needs to be collective agreement to move from historic shares based on 2004-05 activity and NICE consumption to a baseline based on current activity and NICE consumption. Commissioners will need to agree how any financial gains or losses are managed across Wales. Without that collective agreement, the dispute between the Trust and Hywel Dda UHB may simply transfer into disputes between the Trust and other Health Boards.

3.3 PSPP Performance

During July 2026 the Trust (core) achieved a compliance level of **97.9%** (June 97.9%) of non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including NWSSP) is **97.1%** compared to the target of 95%.

3.4 Reserves

The financial strategy for 2025-26 and previous years included an emergency reserve of £0.500m, established on the assumption that expected income would be received, planned savings schemes would be delivered, and emerging cost pressures would be managed. As part of the 2026-29 IMTP planning process, Welsh Government directed the Trust to use this reserve recurrently to support the underlying position. As a result, the reserve is no longer available from 2026-27 onwards.

Use of money held in the reserve position from the IMTP will continue to be closely monitored during 2026-27 and will be considered alongside several key factors such as the VCS marginal income risk, LTA contract rebase risk, achievement of the 2026-27 savings target and a review of currently committed support towards Trust investment, transformation and delivery programmes.

3.5 Financial Risks & Opportunities

The risks outlined in section 7 of the attached report are listed below:

- Commissioners not supporting Service Investment / Growth in VCS and WBS - *likelihood: medium, value £TBC*
- Radiotherapy Activity Income Underachievement – *likelihood: medium, value £0.300m*
- Management of Operational Pressures – *likelihood: medium, value £0.500m*
- Non-Delivery of Savings - *likelihood: medium, value £0.500m*
- Removal of Same Day Emergency Care (SDEC) Funding - *likelihood: medium, value £0.867m*

Opportunities discussed, also in section 7, are summarised below:

- Vacancy Turnover - *likelihood: low, value £0.200m*
- Overachievement of Bank Interest - *likelihood: low, value £0.200m*

3.6 Capital

All Wales Programme

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended 31st March 2027 is currently £67.659m (2025-26 £20.603m). This includes All Wales Capital funding of £65.413m, and discretionary funding of £2.246m. The increase since June 2026 relates to additional funding added to the CEL for EPMA and WBMDR software.

A further £8.688m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as and when required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. The nVCC project team has requested a £0.250m drawdown against this contingency fund (Quantified Risk Assessment). While approval is awaited, the year-end forecast is reporting an overspend, as shown in the table above.

Some further changes are expected as 2026-27 award letters are issued, and new funding requests are considered.

The funding letter for the 2026-27 discretionary capital allocation of £2.246m has been received from Welsh Government, signed and returned. It is anticipated that this will be fully committed and spent in 2026-27, with the plan being ratified by the Capital Planning & Delivery Group and approved by the Executive Management Board in May 2026. The allocation of £2.246m represents an increase of 12.3% on the £2.000m provided during 2025-26 which was fully spent.

3.7 LEGAL IMPLICATIONS

3.7.1 There are no specific legal implications related to the activity outlined in this report.

3.8 PEOPLE IMPLICATIONS

3.8.1 There are no specific people implications related to the activity outlined in this report.

3.9 WELSH LANGUAGE IMPLICATIONS

3.9.1 There are no Welsh language implications related to the activity outlined in this report.

3.10 RISKS / REPUTATIONAL IMPLICATIONS

3.10.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

04 - Finance

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 04).

Individual risks will be managed within the 2026-27 financial envelope. The overall financial sustainability risk will continue to be reported and managed through the BAF, with progress reviewed through routine financial governance during the year.

The key barriers to implementation are the availability of resources to deliver required work or changes, and the successful conclusion of negotiations with Commissioners.

Operational Risks

3.10.2 There are no risks noted in Datix for Finance that score 15+.

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board are asked to note the contents of the July 2026 financial report, in particular:

4.1.1 The year-to-date and forecast revenue and capital outturn position, and PSPP performance.

4.1.2 The latest position on Velindre Cancer Service LTA income for 2026-27 from our commissioners.

4.1.3 The position with commissioners on the contract rebase agreement, noting that the LTA issue with Hywel Dda has now been resolved.

4.1.4 The current position of the Trust savings plans.

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Gwasanaeth Canser Felindre Velindre Cancer Service

Welsh Blood Service Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 JULY 2026

TRUST BOARD
24 SEPTEMBER 2026

1. Introduction

This report summarises the Trust's financial position for 2026-27 to 31 July 2026. It highlights performance against the revenue, capital, cash and savings targets; sets out the key risks to delivery of the breakeven forecast; and identifies the actions being taken to manage those risks through divisional plans, Trust reserves and engagement with Commissioners and Welsh Government.

2. Background / Context

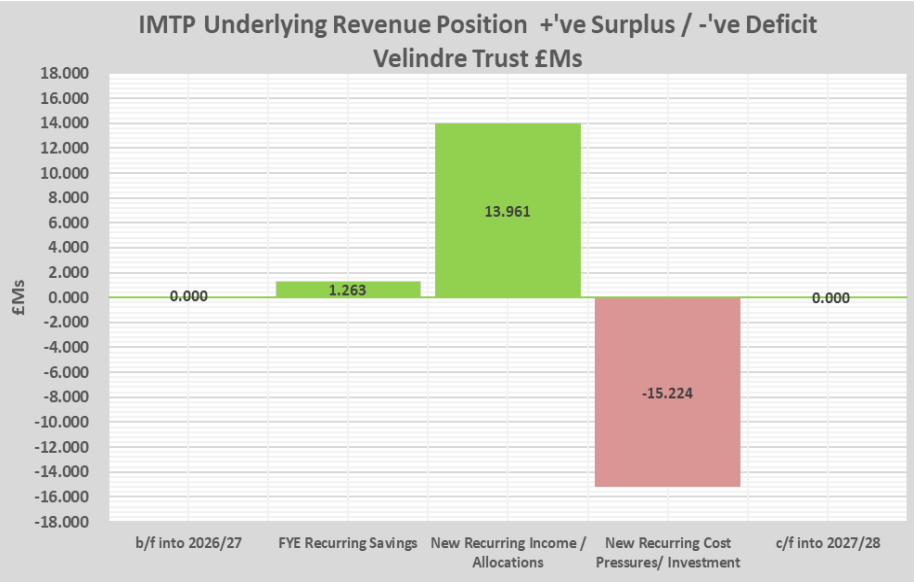
The Trust IMTP Financial Plan for 2026-29 was developed in the following context:

- The Trust submitted a balanced three-year IMTP covering 2026-27 to 2028-29 to Welsh Government on 31 March 2026.

- For 2026-27 the Plan included:
  - A balanced position brought forward from 2025-26;
  - Full-year effect of new cost pressures and investment of **£15.224m;**
  - Offset by **new recurrent income of £13.961m;**
  - Recurrent full-year effect **savings schemes of £1.263m;**
  - Enabling a **balanced position** to be carried forward into 2027-28.

- The 1.11% core discretionary uplift 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 deliver a balanced financial position, the Trust must achieve the 2026-27 savings target, secure all anticipated income, and ensure that any emerging cost pressures are either mitigated at divisional level or managed through Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2026/27	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2027/28
Velindre NHS Trust	0.000	1.263	13.961	-15.224	0.000

3. Executive Summary

Key messages: the Core Trust is reporting a small year-to-date underspend of £0.008m and continues to forecast breakeven at year end. Delivery remains dependent on achieving the £2.647m savings target, securing anticipated income, and managing emerging cost pressures through divisional plans or Trust reserves. The main risks requiring Committee oversight are savings delivery, commissioner funding for service growth, radiotherapy activity income, capital delivery before 31 March 2027, and confirmation of recurrent SDEC funding.

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	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.008	6.542	67.907
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	97.1%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to Date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.020)	(0.035)	0.000

Revenue

The core Trust reported a small underspend of £0.002m in July 2026 and a year-to-date underspend of £0.008m. This remains consistent with the IMTP assumptions and supports the current breakeven forecast. Delivery will remain challenging because planned cost and service pressures still need to be managed and additional Commissioner funding for service development has not yet been secured.

The Trust's financial plan includes Commissioner uplift funding of 1.11% agreed in its Long-Term Agreements (LTAs). This, together with a 2.5% savings target, is fundamental in enabling the Trust to develop and deliver its balanced financial plan for 2026-27.

Capital

The approved Capital Expenditure Limit (CEL) for 2026-27 is £67.659m, comprising £65.413m of All-Wales capital funding and £2.246m of discretionary funding. The forecast year-end spend is £0.248m higher than the current CEL, reflecting the nVCC QRA Contingency drawdown request described later in the report. Capital expenditure to 31 July 2026 was £6.542m, and all approved funding is expected to be fully utilised during 2026-27.

A significant volume of equipment and deliveries, valued at approximately £30m and relating to the nVCC project, are scheduled for receipt during the final quarter of the year. These items will require close management to ensure all assets are received by 31 March 2027, enabling funding

to be recognised within the 2026-27 financial year in line with Welsh Government funding availability.

Some All-Wales scheme funding remains subject to Welsh Government confirmation. The nVCC project team has also requested a £0.250m drawdown from the QRA contingency held by Welsh Government.

The Trust's current CEL is broken down as follows:

	Opening CEL £m	Movement £m	Current CEL £m
All Wales Capital:			
Integrated Radiotherapy Solution	17.115	0.000	17.115
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.000	1.142
nVCC - Project	37.825	0.000	37.825
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.000	0.059
nVCC - Enabling Works	0.393	0.000	0.393
Welsh Blood Service Fleet Replacement Programme 2025-26	0.882	0.000	0.882
Fees to develop the OBC/FBC for the PET at the nVCC	0.256	0.000	0.256
Digital Resource for the nVCC Project	0.550	0.000	0.550
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000
DPIF - Medicines and Prescribing: ePMA	0.025	0.000	0.025
DPIF - Transforming WBMDR software	0.000	0.166	0.166
Total All Wales Capital Programme	**65.247**	**0.166**	**65.413**
Discretionary Capital	**2.246**	**0.000**	**2.246**
Total CEL	**67.493**	**0.166**	**67.659**

PSPP

During July 2026 the Trust (core) achieved a compliance level of **97.9%** (June 97.9%) of non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including NWSSP) is **97.1%** compared to the target of 95%.

Efficiency / Savings

An in-depth review of the Trust's savings plans was undertaken during the IMTP process. For 2026-27, a savings target of £2.647m was set and allocated across the Trust's core divisions as follows:

Savings Plan by Division	Target £m	Identified (Green) £m	Savings Target Gap £m
Welsh Blood Service	0.879	0.879	-
Velindre Cancer Service	1.303	0.500	0.803
Corporate Services	0.178	0.078	0.100
Research, Development & Innovation	0.287	-	0.287
Total	2.647	1.457	1.190

Savings schemes were identified post submission of the IMTP to cover the gap and the financial year commenced with plans (some green, some amber) for the full £2.647m.

Commented [MB1]: I've been reporting to Board and NHSW P&I that the £2.6m savings target had schemes identified which are all green apart from one scheme rated as Amber. This table is saying the Trust has a savings target gap of £1.2m i.e. we have a £1.2m deficit in our financial plan?

Commented [CB2R1]: This was the position when the IMTP was submitted. Have added a line for clarity. What you're saying to the Board and NHSW P&I is correct - although the amber scheme is not expected to deliver at all and is covered by the increase in another green scheme.

As at July 2026, the Trust's overall savings performance indicates that in-month planned savings of £0.223m were not fully achieved, with a shortfall of £0.020m, resulting in savings delivered of £0.203m.

One VCS scheme previously rated as amber is no longer forecast to deliver any savings in the current financial year. The associated savings value is instead expected to be delivered through an existing, green-rated scheme, which is forecast to overachieve against its original savings target.

Two other schemes were reported last month as amber-rated, despite having passed the Welsh Government requirement to achieve green-rated status within three months of being added to the Trust plan. These recurrent RD&I schemes have this month been reported as green-rated. The division needs to ensure they are tightly monitored and, if they start to underachieve, replaced with alternative recurrent schemes.

Revenue Position

Cumulative Breakeven				Forecast Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(91.845)	(92.174)	0.329	(284.871)	(285.794)	0.924
Pay	38.808	38.019	0.789	116.284	115.479	0.805
Non Pay	53.037	54.148	(1.111)	168.586	170.317	(1.731)
Total	**0.000**	**(0.008)**	**0.008**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of July 2026 is a minor underspend of £0.008m, with a year-end outturn forecast of breakeven.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

The Trust submitted a balanced IMTP Financial Plan for 2026-29 and is expected to maintain financial balance across the three-year planning period. The plan identified significant financial risks and challenges, particularly in 2026-27, due to uncertainty about the income required to support committed capacity investment in Velindre Cancer Services.

The Trust's income planning assumptions are reflected in the respective Commissioner Long-Term Agreements for 2026-27, which include agreed planning principles and a 1.11% general uplift.

To maintain a balanced position in 2026-27, the Trust must manage all current and emerging financial risks, deliver the agreed savings target, and mitigate or remove cost pressures as they arise.

Income

The table below analyses Trust income. Commentary on significant variances is provided below the table or in the relevant sections of this report.

Cumulative (£0.329m overachieved)			
Type	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)
Core Income - HB / JCC	39.418	39.446	- 0.028
Nice/ High Cost Drugs	24.590	24.590	- 0.000
WBS Wholesale Blood Products	10.476	10.383	0.093
WBS Transplantation Services	0.017	0.017	- 0.000
WBS Blood Components	0.017	0.316	- 0.300
Home Care Drugs	0.441	0.472	- 0.030
Private Patient	0.447	0.170	0.277
VCS Over Activity	3.530	3.590	- 0.060
Radiotherapy Activity Income	1.088	0.877	0.211
IRS Programme	0.387	0.387	-
Radiation Protection	0.296	0.310	- 0.014
Staff Recharges	0.483	0.479	0.004
One Wales Palliative and EOL Care	0.435	0.437	- 0.001
Velindre Charity	1.418	1.523	- 0.105
Other Charity	0.036	0.012	0.024
RD&I*	2.042	1.872	0.170
HTW	0.606	0.527	0.078
Other Operating Income	6.117	6.766	- 0.648
Total	91.845	92.174	-0.329

*RD&I full year budget includes £2.398m of income from the Velindre Charitable Fund

The £0.093m underachievement in WBS Wholesale income relates to reporting issues following the eProgressa outage at year end, which created an imbalance in charges to Health Boards. This non-recurring impact will be addressed through non-recurrent mitigations during the financial year.

The £0.277m underachievement in Private Patients income is a timing issue linked to remedial accounting transactions in the period. Income for the remainder of the year is forecast to overachieve, supported by the agreed additional tariffs.

The variance reported against Radiotherapy Activity income is partially offset by vacancies, non-recurrent funding support, contract performance income for wider services, and non-pay reductions. These are non-recurring mitigations to address the underperformance against planned contract income levels set out in the IRS business case. The income underperformance will be recurrently offset in part through the allocation of contract income from wider cancer services and anticipated growth in future financial years.

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

Commissioners are expected to pass through the 2025-26 Agenda for Change, Medical and Senior Manager staff costs through LTAs in line with the Welsh Government pay award matrix. The 2026-27 pay inflation is expected to be funded by Welsh Government and passed to the Trust through the Health Board commissioning model once the allocation is confirmed, based on actual staff in

post. Any shortfall, including staff increments or bank staff costs, will need to be met through the discretionary uplift, further savings, or divisional absorption.

No additional funding above the agreed uplifts was provided for WBS or VCS in 2025-26, and no additional funding above the 1.11% uplift has been agreed for 2026-27. The Trust continues to manage capacity pressures across outpatients, ambulatory care, SACT and imaging to meet rising demand and cancer waiting times. The financial risk associated with unfunded service growth therefore remains with the Trust, as Commissioners have confirmed that no additional funding support will be provided for the 2026-27 growth investments submitted on 22 October 2025.

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

VCS Long Term Agreement (LTA) Contract Performance

All LTAs with Commissioners in 2025-26 were signed. However, to agree LTA principles and value with Hywel Dda UHB, the Trust accepted a recurrent reduction in NICE/HCD income of c.£0.825m to reflect resources consumed rather than historic shares. Hywel Dda had also been challenging the Welsh Government direct allocations passed via LTAs, including capital charges, pay award, energy and national discretionary uplift, totalling £0.605m in 2024-25. The 2026-27 LTA has now been signed and returned to the Trust. The finance team will work with Welsh Government this year to reallocate the baseline cash allocations from Hywel Dda to the other Health Boards to mitigate any potential future challenge and risk.

The Trust has also agreed LTAs with all other Commissioners for VCS and WBS. Signed agreements have now been received from all organisations.

To ensure Commissioners fund the full cost of Velindre cancer services from 2026-27 onwards, Commissioners will need to agree a change in commissioning principles from historic shares, based on 2004-05 activity and NICE consumption, to a current activity and NICE consumption baseline. The way Commissioners manage the resulting financial impact is for them to determine; however, this should not prevent the Trust from moving to charging based on current activity and consumption from 2026-27. Without collective agreement on how the financial impact will be managed across Wales, the current dispute between the Trust and Hywel Dda is likely to transfer to a dispute between the Trust and other Health Boards.

The tables below set out the June 2026 LTA income performance for 2026-27 by Commissioner and main service delivery areas (*note the data supplied is one month behind the rest of this report due to reporting timelines*). The increase in marginal income represented activity performance in excess of 2019/20 baseline contracted activity volumes.

The IMTP planned performance against 2019/20 baseline contract levels for 2026-27 is £10.590m (Av. £1.5m p.a.) split across commissioners as shown below:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda (7A2)	0.749	0.010	0.759	1%	-0.019	0.028
Swansea Bay (7A3)	0.512	0.002	0.547	0%	0.007	-0.004
Cardiff & Vale (7A4)	17.707	3.655	22.278	21%	3.516	0.139
Cwm Taf Morgannwg (7A5)	15.997	2.719	19.681	18%	2.688	0.031
Aneurin Bevan (7A6)	22.177	3.893	27.390	18%	3.779	0.113
Powys (7A7)	1.210	0.312	1.594	25%	0.312	-0.000
NHS Wales Joint Commissioning Committee	2.438	0.180	2.753	7%	0.306	-0.126
Total	**60.791**	**10.771**	**75.002**	**18%**	**10.590**	**0.181**

The marginal income overachievement largely in outpatients and SACT preparation is being 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	6.588	0.491	7.079	0.075	0.319	0.171
Radiotherapy Delivery	15.071	0.068	15.139	0.005	0.007	0.061
Nuclear Medicine	1.150	-0.050	1.101	-0.043	-0.046	-0.003
Radiology Imaging	3.513	0.758	4.271	0.216	0.745	0.014
Preparation for Systemic Anti-Cancer Therapy	3.255	1.192	4.448	0.366	1.147	0.045
Delivery of Systemic Anti-Cancer Therapy	7.680	2.213	9.893	0.288	2.333	-0.120
Ambulatory Care Services	1.567	0.554	2.121	0.353	0.521	0.033
Outpatient Services	11.665	5.043	16.707	0.432	5.043	-0.001
Inpatient Admitted Care	6.875	0.502	7.377	0.073	0.520	-0.018
Contract Adjustments	3.426	0.000	6.867	0.000	0.000	0.000
Total	**60.791**	**10.771**	**75.002**	**18%**	**10.590**	**0.181**

The following table provides an analysis on the same contract currency / service area 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	4,052	136	3%	3,957	94
Radiotherapy Delivery	53,586	50,688	- 2,898	-5%	49,781	908
Nuclear Medicine	1,738	1,551	- 187	-11%	1,563	- 12
Radiology Imaging	9,103	14,998	5,895	65%	14,991	8
Preparation for Systemic Anti-Cancer Therapy	25,262	41,686	16,424	65%	41,049	638
Delivery of Systemic Anti-Cancer Therapy	31,867	50,170	18,303	57%	51,087	- 917
Ambulatory Care Services	7,874	11,640	3,766	48%	11,291	349
Outpatient Services	59,960	99,219	39,259	65%	100,180	- 961
Inpatient Admitted Care	9,072	10,463	1,391	15%	10,530	- 67
Contract Adjustments	-	-	-	0%	-	-
Total	**202,378**	**284,467**	**82,089**	**40%**	**284,429**	**39**

Radiotherapy delivery remains a key area of focus and is being reviewed alongside the financial risk associated with radiotherapy under-activity performance.

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	1,267	65	5%	1,127	140
Swansea Bay (7A3)	1,200	1,235	35	3%	1,379	-143
Cardiff & Vale (7A4)	60,809	89,522	28,713	47%	88,916	606
Cwm Taf Morgannwg (7A5)	59,964	79,364	19,400	32%	79,199	166
Aneurin Bevan (7A6)	74,098	105,115	31,017	42%	105,584	-468
Powys (7A7)	3,619	5,910	2,291	63%	5,915	-4
NHS Wales Joint Commissioning Committee	1,486	2,054	568	38%	2,310	-256
Total	**202,378**	**284,467**	**82,089**	**40%**	**284,429**	**39**

Although now resolved through the agreed and signed 2026-27 LTA, Hywel Dda UHB requested a recurrent reduction in LTA value from 2026-27, citing reduced activity where patients had been redirected to Swansea Bay UHB. The Trust challenged this position. While activity from Hywel Dda

reduced between 2019-20 and 2024-25, activity levels have now returned to 2019-20 levels and represent only a 13% reduction against the baseline. On this basis, moving to an actual charge basis should result in minimal, if any, loss of income from Hywel Dda.

The following VCS cost pressures and service developments were communicated to Trust Commissioners as part of the IMTP process. No funding support has currently been provided:

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 continues to manage financial risks affecting supply chain sufficiency, demand, and patient safety. Following publication of the Infected Blood Inquiry (May 2024), the service must strengthen transfusion safety where possible. The Trust submitted six business cases to JCC covering key areas to maintain or improve the safety of the supply chain for the transfused patients in Wales.

These cases were:

Area	Cost Pressure	2026/27 £k	Recurrent/ Non-Recurrent
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. *Note: Presently intended to be financed as a deduction: cost of delivery offset against the benefits of wholesale pricing*	See note	R
Red Cell Immuno-Haematology Laboratory	Additional capacity 24/7 for the Red Cell Immuno-Haematology Laboratory	251,000	R
Haemoglobin S Screening	Implementation of Haemoglobin S (HbS) testing to comply with national guidance	52,000	R
Blood Component Development	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	703,000	R
Buccal Swab Pathway	Introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel	259,000	R (excl £45k implementation costs)
Blood Donation Team Resilience	Additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.	266,000	R
	Total	1,531,000	

JCC has not approved additional funding for the six WBS cases. This creates a significant financial risk because some investments are required to maintain and improve quality and safety, and the Trust has therefore made some investments at financial risk. The cases were resubmitted to JCC on 8 October 2025 for consideration in the 2026-29 IMTP process, but no funding was provided. Funding will therefore need to be sought from Welsh Government following the Infected Blood Inquiry recommendations. Recent discussions with JCC have agreed closer working with the Trust during 2026-27 to improve engagement and commissioning arrangements.

The Trust Medical Director has briefed the Deputy Chief Medical Officer on the Infected Blood Inquiry recommendations, and WBS colleagues are progressing the transfusion-related actions.

NWJCC and WBS met in June 2026 to discuss commissioning arrangements for the service and the business cases submitted for 2026-27 funding. NWJCC indicated that WBS had been identified as one of its top four priorities for considering how the commissioning model should be designed in future, with proposal options to be developed by NWJCC for discussion over the coming months. While funding continues to be discussed, WBS is non-recurrently offsetting the financial pressures through mitigations such as vacancy management, temporary income sources and service curtailment.

WBS have commissioned a specialist consultant to prepare a business case in respect of addressing the recommendations from the Infected Blood Inquiry (IBI). Additionally, WBS has commissioned a workforce review on behalf of BHNOG (Blood Health National Oversight Group) to review and identify work pressures within Health Boards, the findings are currently under review.

Pay Highlights / Key Issues

As referenced above, Commissioners are expected to pass through, as additional income to the LTAs, the 2025-26 Agenda for Change, Medical and Senior Manager (VSM) staff costs, in line with the Welsh Government pay award matrix. The 2026-27 pay inflation is expected to be funded directly by Health Boards following Welsh Government confirmation of the allocation based on

actual staff in post. Any shortfall, such as staff increments or use of bank staff, will need to be met through the discretionary uplift, additional savings, or absorption by Divisions. The current expectation is that funding will be provided in September.

Several VCS posts were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments, without certainty over LTA income from activity undertaken or FBC funding approval by Welsh Government and Commissioners. Most of these posts were funded recurrently through the 2024-25 and 2025-26 IMTP processes. The remaining unfunded posts continue to be reviewed alongside LTA cancer activity, to align activity demand forecasts and associated income to mitigate financial risk exposure. Funding was ringfenced in the 2026-27 IMTP to support unfunded posts; however, this is subject to the review and alignment of posts to vacancies.

On top of the savings plans and the shortfall in pay award VCS, WBS and Corporate divisions hold a recurrent vacancy factor target which is expected to be achieved to support a balanced financial position for 2026-27.

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 2026-27 has been set at VCS £1.303m, WBS £0.879m, RD&I £0.287m and Corporate £0.178m.

The Trust reserves are held in month 12 and will be released into the position to match pre-approved spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

As of 31st July 2026, the current staff in post is 1,742 WTE (June '26 = 1,735). The number of vacancies is 96 WTE (June '26 = 100), which represents a vacancy rate of 5.21% (5.44% June '26) against the budget of 1,838 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.

The largest number of vacancies are within VCS: 60 WTE. Significant vacancies include medical records, 4 WTE; medical physics, 6 WTE; Radiation Protection Services (RPS), 6 WTE; radiotherapy satellite unit, 7 WTE; radiotherapy, 3 WTE; programme management office, 3 WTE; service planning, 3 WTE; and estates and ancillary services, 4 WTE. Agency hours are offsetting AHP vacancies in occupational therapy. The vacancies reported include 30 WTE unfunded posts, 21 WTE of which are recurrent.

WBS currently are reporting -1 WTE vacancy overall. This is a net position as there are 3 WTE admin and clerical vacancies, 1 WTE medical & dental vacancy and 7 WTE additional clinical service vacancies which are being offset by over establishments in nursing (3 WTE), healthcare scientists (8 WTE) and estates staff (1 WTE) linked to business cases submitted to JCC that have not yet been approved. The vacancies reported include 21 WTE unfunded posts, 14 WTE of which are recurrent.

The graph and information below includes unfunded posts and therefore shows a net position:

Commented [MB3]: The VCS analysis of vacancies is described in terms of Departments the WBS in terms of Staff Group - consistency would be better

Commented [CB4R3]: Will amend for future reports

Commented [MB5]: Is it the balance of 60WTE less the other figures quoted? Why don't we just say the numbers or even better just have a table with the narrative explaining?

Commented [CB6R5]: It would be 90 vacancies without the unfunded posts. Will insert table in future, agree would be better presented that way

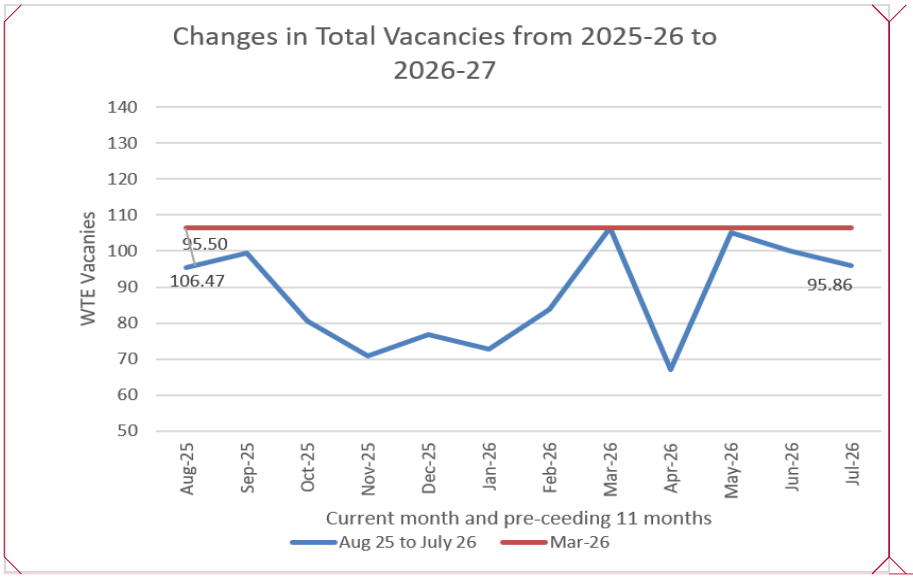
Commented [MB7]: Steve - we have 13WTE RT but also have 25.7wte already recruited post with no recurrent funding as part of business cases - so do we need to move 50% of the posts into those vacancy budgets? I get that the VCS wont then be achieving its vacancy factor, but the finance reporting would be clearer?

Commented [MB8]: Is this service planning or physics planning?

Commented [CB9R8]: I suspect service as it's an A&C post mentioned in the context of the PMO by the division but will check if still applicable next month.

Commented [MB10]: So a 1WTE Over-establishment? So for the WBS narrative we've combined vacancies and over-establishments but for VCS we've just talked about vacancies. We should be consistent and clear on both services.

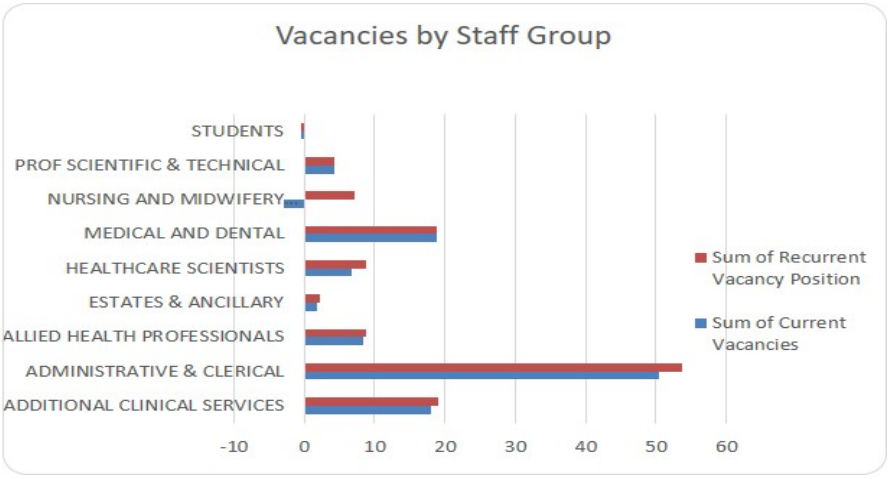
Commented [CB11R10]: There are 20 vacancies offsetting 21 unfunded posts. I think this is consistent? Appreciate may not be clear though, apols, will reconsider presentation next month

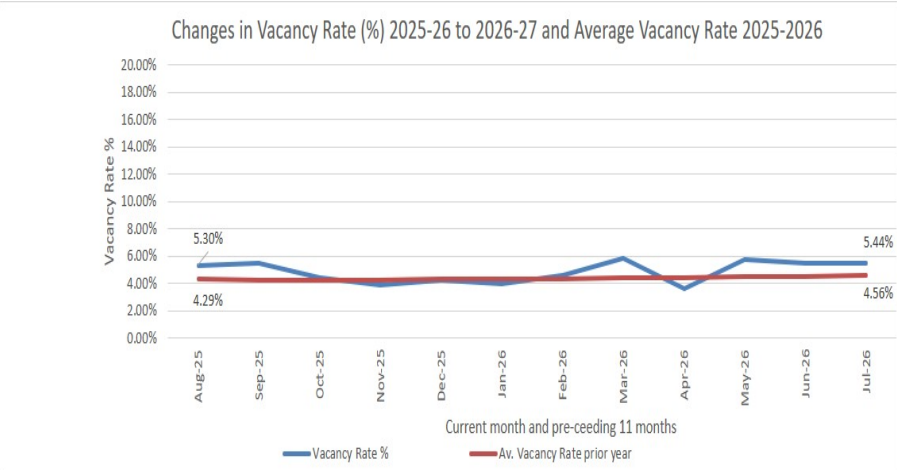


Commented [MB12]: Dint understand the key for red line - I assume it's the average of 2025-26 financial year as a comparator so it needs to say Av. Apr '25 - Mar '26 or something similar

Commented [CB13R12]: Red line is the March 2026 position

The total Trust vacancies as of July 2026 are 96 WTE (June 100 WTE): VCS (60 WTE), WBS (-1 WTE), Corporate (21 WTE), R&D (13 WTE), nVCC (0 WTE) and HTW (3 WTE).

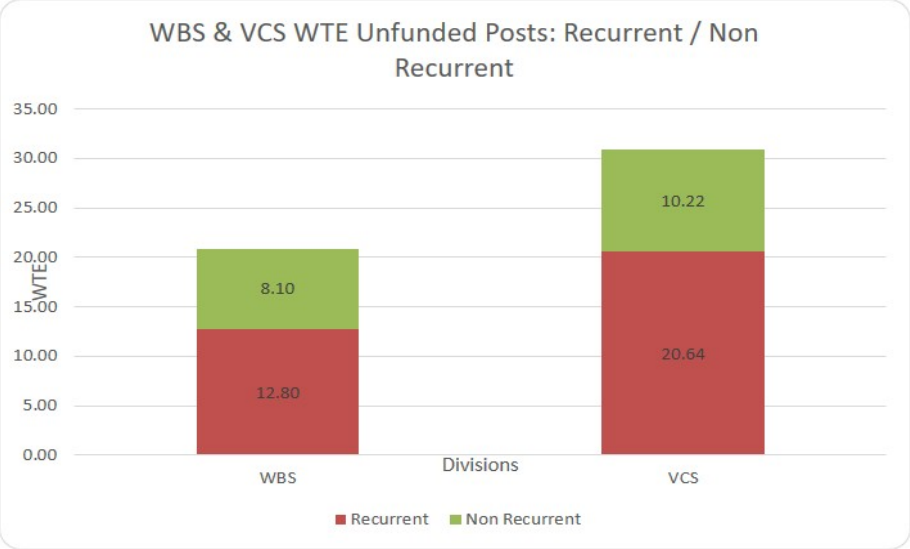


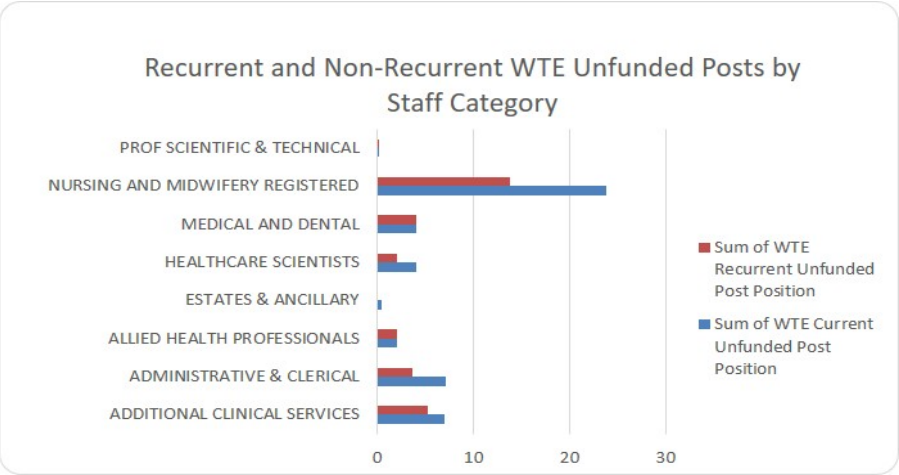


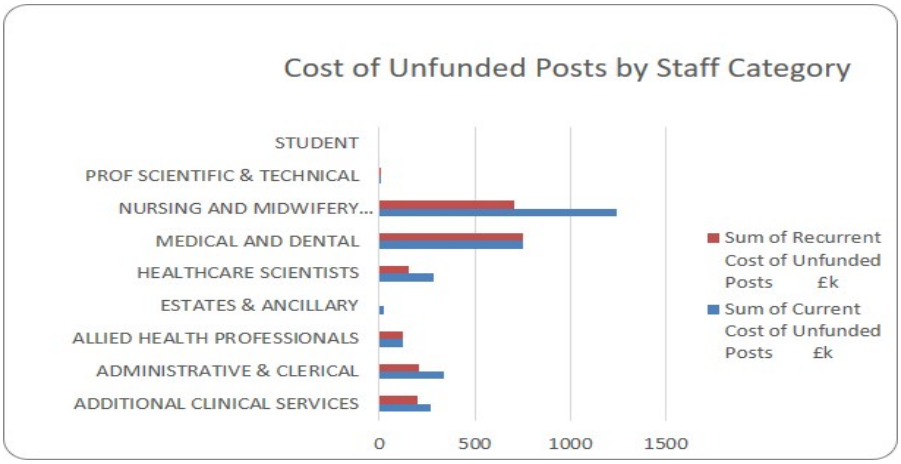
Unfunded posts are shown in more detail below for WBS and VCS. The total unfunded posts as at 31 July 2026 is 51 WTE (June '26 = 51 WTE) at a cost of £3.296m, with 33 WTE (£2.304m) being recurrent. For WBS the staff category with the highest number of recurrent unfunded posts is additional clinical services (5.0 WTE) and in VCS it is nursing and midwifery registered (9.5 WTE).

	WBS					VCS				
Staff Category	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts
ADMINISTRATIVE & CLERICAL	2.7	3.6	6.3	1.0	5.3	9.6	4.1	13.8	3.7	10.0
MEDICAL AND DENTAL	0.9	-	0.9	-	0.9	14.4	4.1	18.4	4.1	14.4
NURSING AND MIDWIFERY REGISTERED	(2.7)	4.4	1.7	4.4	(2.7)	(3.5)	18.5	14.9	9.5	5.5
PROF SCIENTIFIC & TECHNICAL	-	-	-	-	-	6.5	0.1	6.6	0.1	6.5
ADDITIONAL CLINICAL SERVICES	6.7	6.0	12.7	5.0	7.7	10.3	1.0	11.4	0.2	11.2
ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	9.5	2.1	11.6	2.1	9.5
HEALTHCARE SCIENTISTS	(8.2)	5.9	(2.3)	2.4	(4.7)	8.4	1.0	9.4	1.0	8.4
ESTATES & ANCILLARY	(0.7)	1.0	0.3	-	0.3	5.2	-	5.2	-	5.2
STUDENTS	-	-	-	-	-	(0.4)	-	(0.4)	-	(0.4)
PAY BUDGET ADJUSTMENTS	-	-	-	-	-	-	-	-	-	-
Total	(1.1)	20.9	19.6	12.8	6.8	60.0	30.9	90.9	20.6	70.2

	Trust Total			
Staff Category	WTE Current Unfunded Post Position	Current Cost of Unfunded Posts £k	WTE Recurrent Unfunded Post Position	Recurrent Cost of Unfunded Posts £k
ADMINISTRATIVE & CLERICAL	7.11	362.65	4.71	273.36
MEDICAL AND DENTAL	4.07	751.60	4.07	751.60
NURSING AND MIDWIFERY REGISTERED	22.85	1,199.63	13.85	715.15
PROF SCIENTIFIC & TECHNICAL	0.10	7.60	0.10	7.60
ADDITIONAL CLINICAL SERVICES	7.62	304.15	5.20	198.22
ALLIED HEALTH PROFESSIONALS	2.11	122.63	2.11	122.63
HEALTHCARE SCIENTISTS	6.90	504.19	3.40	235.49
ESTATES & ANCILLARY	1.00	43.79	-	-
STUDENT	-	-	-	-
TOTAL	51.76	3,296.24	33.44	2,304.05



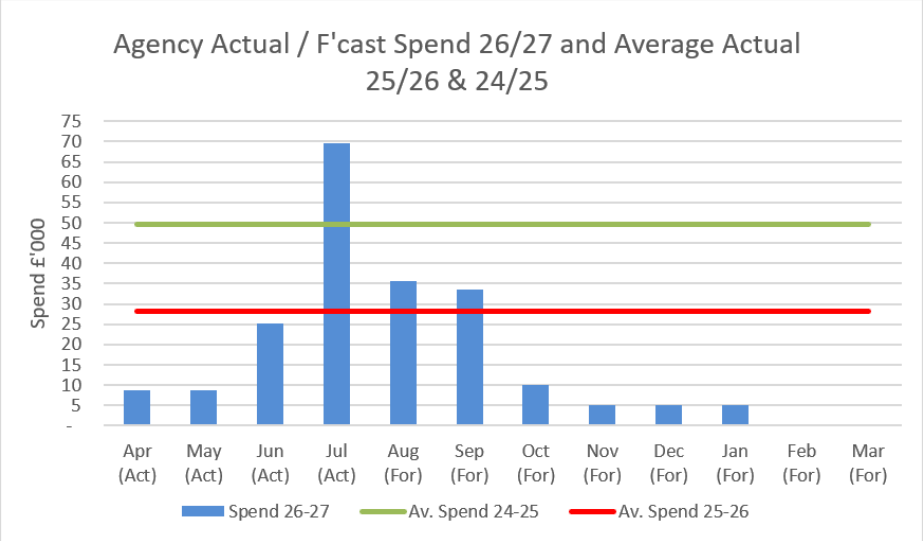




The spend on agency staff for July 2026 was **£0.069m** (June '26 = £0.025m) with a year-end forecast currently of **£0.206m** (£0.337m 2025/26). The in-month charges are higher than planned and largely relate to spend in the Corporate division where there have been issues with recruitment via other routes.

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.

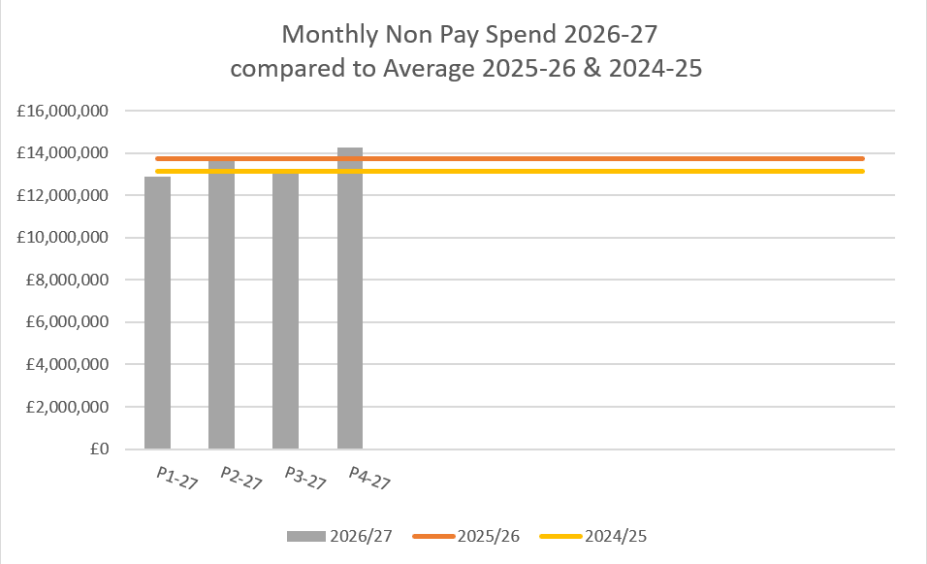


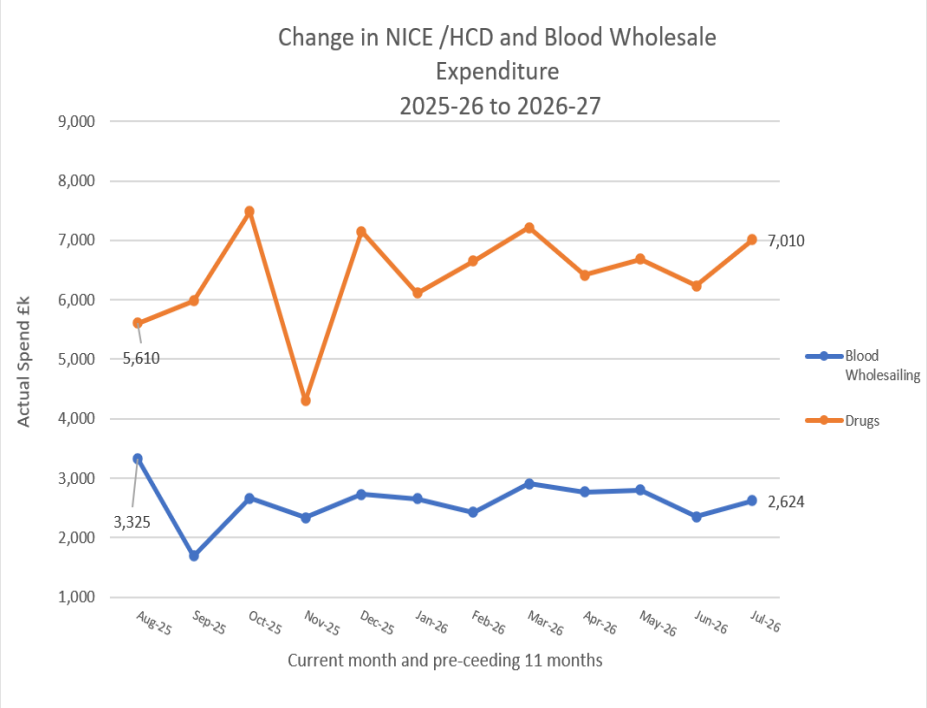
4.3 Non Pay

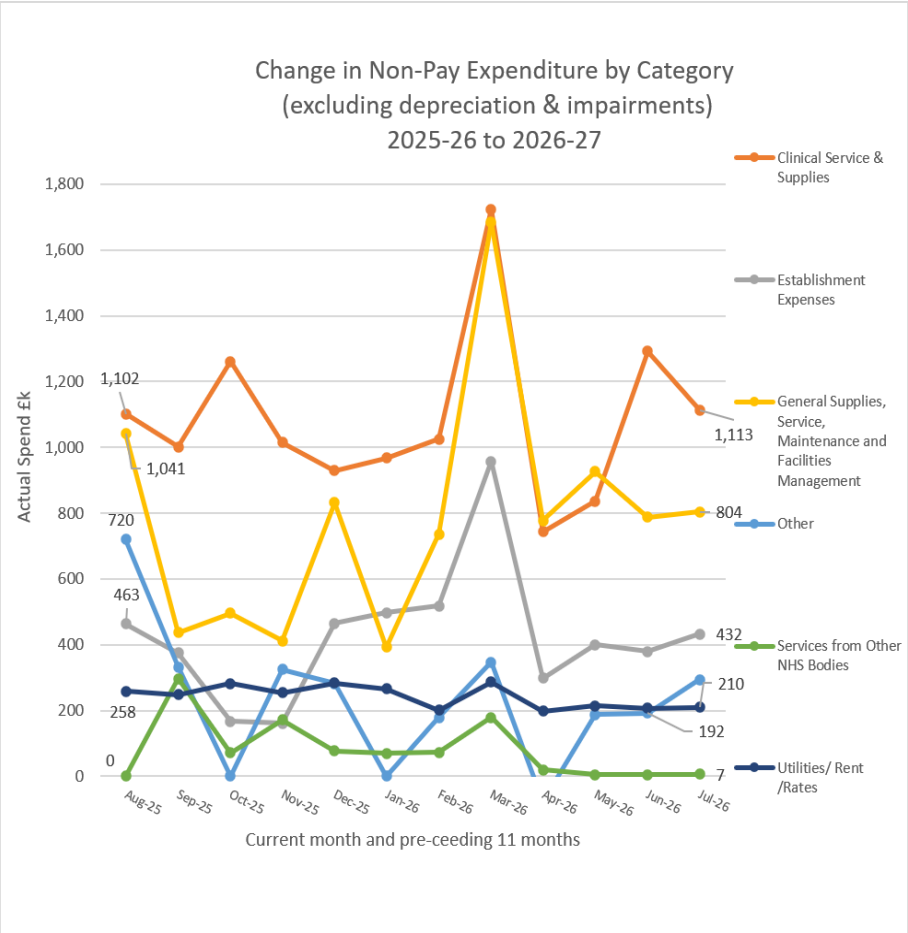
Non-Pay average spend for 2025/26 was £13.741m per month which was a £0.603m increase from the previous financial year. The largest movement was in relation to NICE and HC drugs that saw an increase in average monthly spend of £0.620m, and which were offset by income recharges to Health Boards. Non-cash capital charges decreased as the impairment charges associated with the nVCC works reduced in 2025-26, resulting in a reduction in average spend of £0.435m per month (although notably they are recognised in month 12 as seen in the relevant graph below). Average monthly blood wholesale costs increased by £0.165m which, as drugs, were offset by income recharges to Health Boards. Other smaller movements included an increase in Clinical Services & Supplies (£0.157m) and General Supplies, Service, Maintenance & Facilities (£0.082m). All other costs remained fairly static when compared with the year-on-year average.

The non-pay average monthly spend for 2026-27 currently stands at £13.537m. NICE and HCD drugs have increased since April by £0.410m and blood wholesale costs have increased by £0.032m, which again will be offset by an income increase for recharges to Health Boards.

The graphs provided below show the change in non-pay spend split by expenditure category over the period from August 2025 to July 2026 compared to the average spend across the financial year 2024/25 and 2025/26.


Monthly Non Pay Spend 2026-27
compared to Average 2025-26 & 2024-25
£16,000,000
£14,000,000
£12,000,000
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0
P1-27
P2-27
P3-27
P4-27
2026/27
2025/26
2024/25


Change in NICE /HCD and Blood Wholesale Expenditure
2025-26 to 2026-27
Actual Spend £k
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
5,610
7,010
3,325
2,624
Blood Wholesailing
Drugs
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26
Jun-26
Jul-26
Current month and pre-ceeding 11 months



Clinical Services & Supplies saw a sharp decrease in spend from March 2026 to April 2026. Spend was significantly higher in the following divisions & areas in March: Excess Treatment Costs in RD&I of £192k (full 2025-26 year spend reported in one month that will be phased in future); HPC collection costs in WBS of £166k, Blood bags, harnesses & labels in WBS of £156k, laboratory reagents in WBS of £100k, and M&SE maintenance contracts in VCS of £262k. The increase seen in June 2026 relates to contractual clinical service costs for clinical trials within the R&DI division that are invoiced on a quarterly basis.

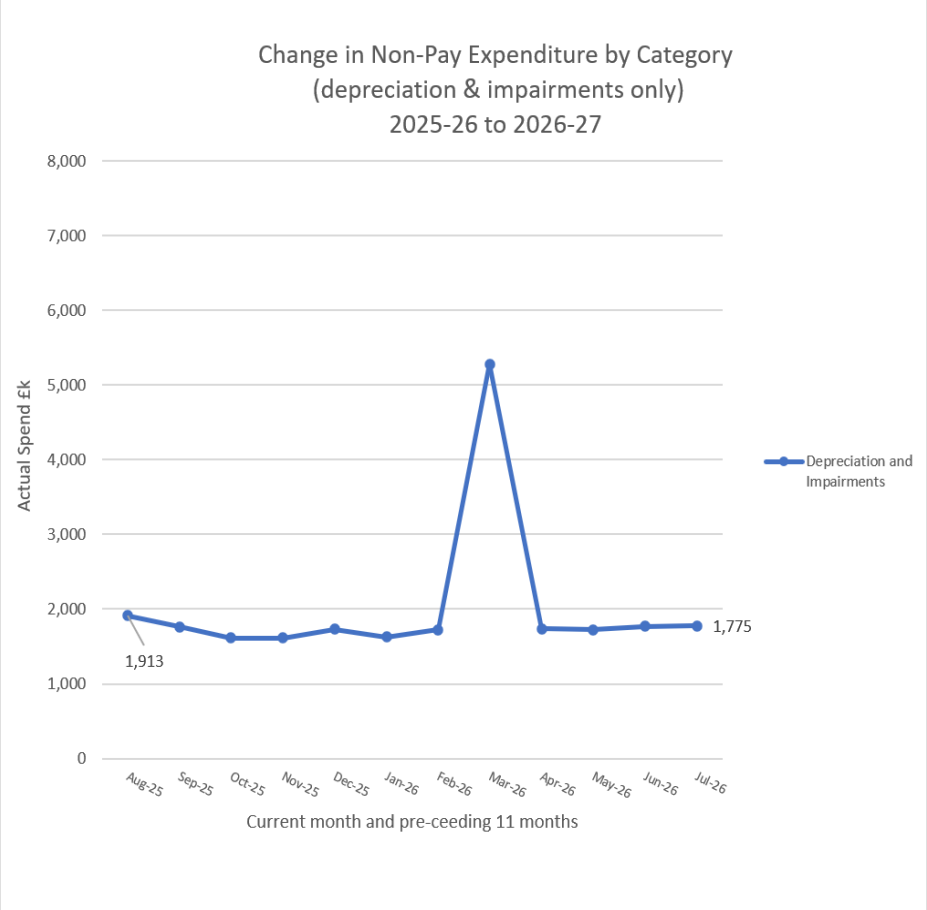
Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure. These costs saw a reduction in October 2025 due to recovery of some VAT (£0.173m) previously paid to HMRC as a result of an annual review exercise. This has been treated as a reduction in expenditure. November also saw a temporary reduction in spend across a number of categories including postage, travel, and other transport costs. Costs (£0.267m) for the statutory financial audit for 2025-26 were fully charged in March 2026 but will be accrued on a monthly basis during 2026-27, and spend on digital licences were high in March, with £0.261m payable to Trust Marque Solutions

Ltd for various items. Currently postage costs are above that budgeted in VCS and therefore a review is required in terms of ongoing spend and plans to take advantage of digital capabilities.

Other costs in May 2025 were lower than usual due to a provision for legal costs of £1.184m which was made in error in April 2025 and 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 resulted in the spike seen in the graph.

Spend on services from other NHS bodies is low in the first quarter of this year and predominantly relates to WBS intraoperative cell salvage reimbursement. WBS reimburse Health Boards based on evidence spend invoiced to the Trust. The Health Boards do not generally start invoicing until the end of quarter two / start of quarter 3, with the majority of the reimbursement occurring in quarter 4. WBS are unable to accrue for these costs without the information provided by the Health Boards.

Depreciation and impairment charges have been excluded from the graph above given their significant value in March 2026. For clarity, these are shown separately below.



*The Depreciation value shown in the above graph includes the charge recognised in March 2026 for the impairment of the nVCC Enabling Works of £3.433m.

4. Savings

As part of the IMTP Financial Plan, the Trust established a 2026-27 savings requirement of £2.647m. This equates to 2.5% of the Trust's core LTA income and is required to support planned investment and manage cost pressures within the system.

Of the revised £2.647m total savings target, £1.262m is recurrent and £1.385m is non-recurrent. £1.405m is categorised as savings schemes, with the remaining £1.242m to be delivered through income generation.

The divisional allocation of the revised Trust savings target is VCS £1.303m (49%), WBS £0.879m (33%), RD&I £0.287m (11%) and Corporate £0.178m (7%).

One VCS scheme that was previously rated amber is no longer forecast to achieve any savings in the current year. The equivalent amount is now expected to be delivered via an existing green scheme that is anticipated to overachieve against the original value set.

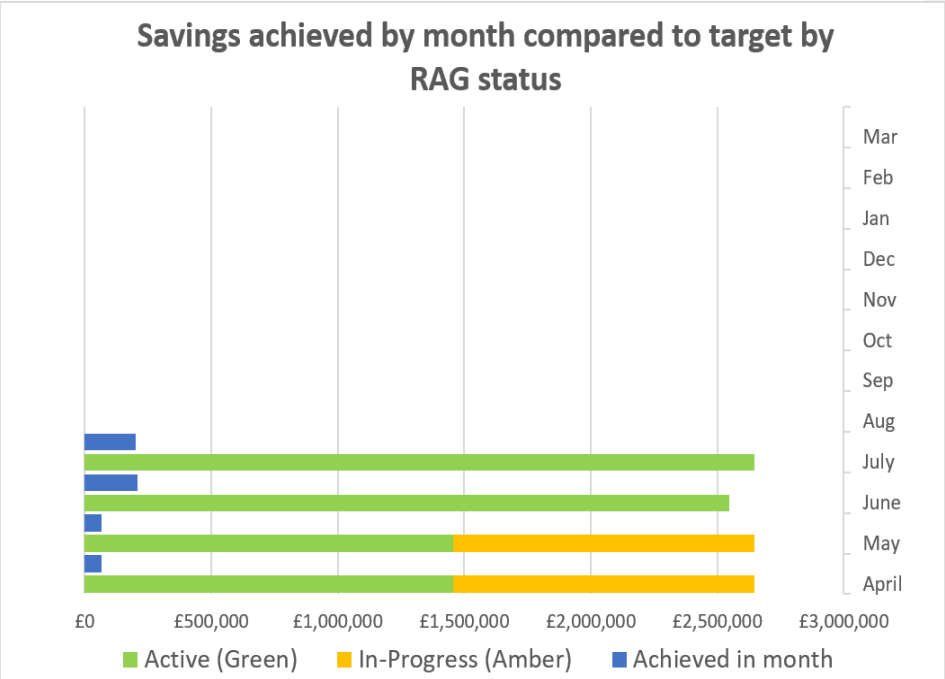
Two other schemes were reported last month as amber-rated, despite having passed the Welsh Government requirement to achieve green-rated status within three months of being added to the Trust plan. These recurrent RD&I schemes have this month been reported as green-rated. The division must ensure these schemes are closely monitored and, if they begin to underachieve, replaced with alternative recurrent schemes.

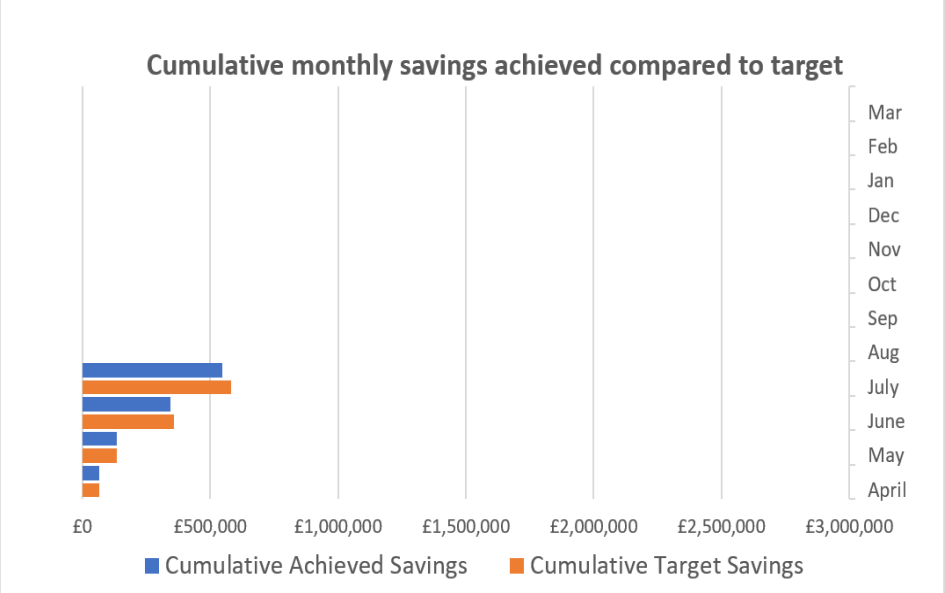
Performance

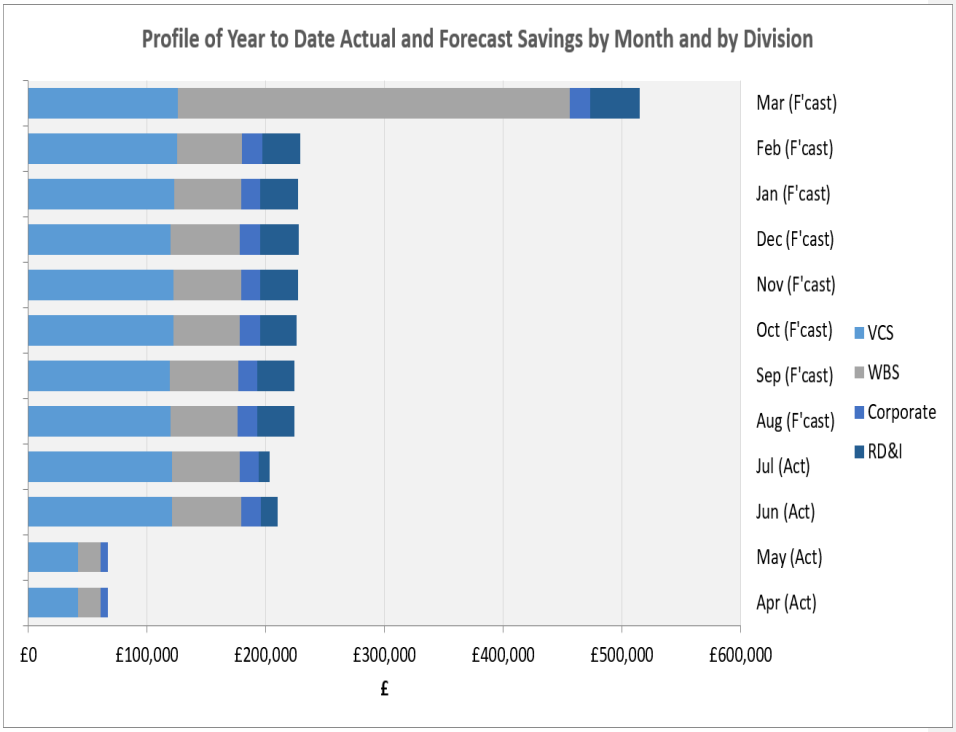
The Trust's savings performance at 31 July 2026 is £0.547m against a plan of £0.582m, resulting in a year-to-date underachievement of £0.035m. The annual target is still expected to be achieved, but delivery remains at risk and requires continued divisional grip.

Divisions must continue to review current savings schemes and, where delivery is at risk, identify and implement alternative recurrent schemes to ensure the 2026-27 savings target is achieved on a recurrent basis.

Scheme Type	Division	Recurrent / Non-Recurrent	RAG Rating	TOTAL £000	YTD Planned £000	YTD Actual £000	Variance £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Capacity management - improve efficiency prior to recru	VCS	R	Green	56	10	10	0	56	0
Capacity management - improve efficiency prior to recru	VCS	NR	Green	516	102	102	0	516	0
Reduce spend on postage	VCS	R	Green	10	2	0	(2)	10	0
Procurement supply chain	VCS	R	*Not forecast to deliver*	50	10	0	(10)	0	(50)
WBS Establishment Control	WBS	R	Green	40	13	13	0	40	0
Stock Control - Optimised level of stock retention	WBS	R	Green	100	20	20	0	100	0
Stock Control - Optimised level of stock retention	WBS	NR	Green	150	30	30	0	150	0
Nucleic Acid Testing new managed service contract	WBS	R	Green	127	43	43	0	127	0
Omnichannel contact centre solution	WBS	R	Green	3	1	1	0	3	0
Omnichannel contact centre solution	WBS	NR	Green	28	9	9	0	28	0
WBS Demand Planning - Processing volumes - Transfusio	WBS	R	Green	30	6	6	0	30	0
WBS Demand Planning - Processing volumes - Transfusio	WBS	NR	Green	50	10	10	0	50	0
WBS Demand Planning - Apheresis - Donation Services	WBS	NR	Green	40	8	8	0	40	0
Establishment vacancy control	Corporate	R	Green	80	16	16	0	80	0
Establishment vacancy control	Corporate	NR	Green	20	4	4	0	20	0
Corporate HQ savings	Corporate	R	Green	5	1	1	0	5	0
Capacity management - improve efficiency prior to recru	RD&I	R	Green	50	10	0	(10)	40	(10)
Capacity management - improve efficiency prior to recru	RD&I	NR	Green	50	10	15	5	60	10
Total Saving Schemes				**1,405**	305	288	(17)	1,355	(50)
Income Generation									
Maximise profit share	VCS	R	Green	100	32	30	(2)	100	0
Maximise profit share	VCS	NR	Green	50	16	16	0	50	0
Private patient income optimisation	VCS	R	Green	200	68	68	0	200	0
Private patient income optimisation	VCS	NR	Green	150	52	60	8	150	0
Contract Income Overperformance	VCS	R	Green	171	34	40	6	221	50
Sales of Plasma	WBS	NR	Green	171	0	0	0	171	0
Ethylenediaminetetraacetic acid (EDTA) Testing Income	WBS	R	Green	40	13	13	0	40	0
Plasma For Medicines (Recovered Plasma)	WBS	R	Green	100	0	0	0	100	0
Bank Interest	Corporate	NR	Green	73	24	24	0	73	0
Commercial Income Generation	RD&I	R	Green	100	20	-10	(30)	100	0
Commercial Income Generation	RD&I	NR	Green	87	18	18	0	87	0
Total Income Generation				**1,242**	277	259	(18)	1,292	50
TRUST TOTAL SAVINGS				**2,647**	**582**	**547**	**(35)**	**2,647**	**0**
						94%		**100%**	


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
£3,000,000
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



Two savings schemes in WBS currently rated green are not forecast to deliver savings until March 2027. These relate to:

- Sales of plasma £171k; and
- Plasma for medicines £100k

These schemes should be monitored closely so that, if delivery risk emerges, alternative schemes can be identified and implemented well before March 2027.

5. Reserves

The financial strategy for 2025-26 and previous years 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. As part of the IMTP planning process for 2026-2029 Welsh Government directed the Trust to utilise this reserve to support the underlying position on a recurrent basis and therefore is not available from this financial year onwards.

Use of IMTP reserve funding will continue to be monitored during 2026-27 alongside VCS marginal income risk, LTA contract rebase risk, delivery of the 2026-27 savings target, and the review of committed support for Trust investment, transformation and delivery programmes.

6. Cost Pressures / Investment Decisions

National and local cost pressures included in the submitted IMTP 2026-29 are shown in the table below, split by division and analysed between recurrent and non-recurrent impacts.

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**

The majority of these cost pressures have been allocated to divisional budgets, except for WRP, BMA pay negotiations and the SACT closed system, which will be funded based on actual costs incurred.

Updated SACT Closed system costings are being finalised but expected to be lower than that shown above.

Information to support the costing of the new BMA contract has recently been received from POD colleagues and the financial impact is currently being calculated and will be matched against actual payment in August in order for funding to be released.

The £707k for unfunded posts support is expected to be fully allocated to divisions, once a review of the decisions made and full impact of these commitments has been completed.

7. End of Year Forecast / Risk & Opportunity Assessment

Although the Trust submitted a balanced three-year financial plan, significant risks and challenges remain, particularly in 2026-27, due to uncertainty over the income required to support committed capacity investment in Velindre Cancer Services.

The Trust recognises these risks and is taking the actions set out below to manage and mitigate them. All delivery areas are risk assessed, and identified risks are recorded within the Trust Assurance Framework and Trust-wide Risk Register where appropriate.

The risks below should be read alongside the current breakeven forecast. They do not currently change the reported forecast outturn, but they identify the areas where further slippage, delayed funding confirmation, or non-recurrent mitigation could weaken the Trust's ability to maintain financial balance on a recurrent basis.

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

Several service growth investments were presented to the Trust Commissioners as part of the 2025-28 process; however, no funding was provided. These were re-submitted as part of the 2026-29 process and again the Trust was informed that no funding would be allocated in 2026-27 to support these investments. Funding will therefore need to be requested from Welsh Government following recommendations from the IBI report.

No formal actions have been undertaken to date to request this funding from Welsh Government with the Trust's position per the IMTP being that there will be no service investment without secured funding. It is appreciated that this approach removes financial risk from the Trust's 2026-27 financial plan, however the lack of investment / growth on a continued basis will impact the services provided and potential benefits for Commissioners and patients / donors. Potential benefits for Commissioners could be financial hence the retention of this item within the monthly monitoring report to WG.

Radiotherapy Activity Income Underachievement – *likelihood: medium, value £0.300m*

A risk emerged, and crystallised in part in 2025-26, 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. £0.500m was allocated by holding marginal income growth recurrently, which impacts on the Trust's ability to invest further in cancer services during 2026-27. It is currently anticipated that any shortfall in 2026-27 will be managed via overachievement of wider activity which will be subject to close monitoring.

Management of Operational Pressures – *likelihood: medium, value £0.500m*

Cost pressures may emerge during the year that cannot be mitigated or are beyond divisional control. As in 2025-26, the Trust expects to manage these cost pressures non-recurrently during 2026-27; however, a residual risk remains due to the wider financial pressures facing the Trust.

Non-Delivery of Savings - *likelihood: medium, value £0.500m*

The Trust has identified £2.647m of savings and income generation to be achieved during 2026-27 as part of the IMTP. This savings target has been set to ensure that the Trust can mitigate the significant cost pressures within the service.

Commented [MB14]: Should this be £2.647m?

Commented [CB15R14]: Yes apologies, typo

Although all schemes are now rated green, not all are without risk. Schemes should therefore be closely monitored, with additional schemes developed where required to replace any underachieving schemes in-year.

Removal of Same Day Emergency Care (SDEC) funding – *likelihood: medium, value £0.867m*

The need for SDEC funding to continue on a recurrent basis was raised as one of the key issues in the Trust IMTP 2026-29 meeting on 28th November 2025 with WG colleagues, as without it the Trust would not be able to submit a balanced financial plan.

The Trust understood that WG colleagues were supportive of the need to make the funding recurrent given the permanent staff that were employed delivering the services and the benefits that the services provided in relieving pressure in Health Board EDs and admissions.

The recurrent SDEC funding was clearly identified in the allocation letter issued by Welsh Government on 19 December 2025, which the Trust assumed reflected its representations to Welsh Government colleagues at the meeting on 28 November 2025.

The Trust included the recurrent funding in its draft IMTP Financial Plan presented to WG colleagues on 3rd February 2026 and the final version submitted to WG by the required deadline.

Via a Health Board on 22nd May 2026, the Trust has received a message suggesting that the funding allocated to the Trust was a mistake. If this is the case it will have implications for the Trust financial plans recurrently. The Trust is currently waiting on formal clarification from WG regarding this matter.

However, as signed LTAs, including the appropriate SDEC elements, are in place with relevant Health Boards, and with payments being made in line with those LTAs, the Trust does not consider this to be a risk to delivery of financial balance in 2026-27. It has therefore been removed from the monthly monitoring financial tables sent to WG but is included within this report until recurrent funding is confirmed.

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.

Opportunities

Vacancy Turnover - *likelihood: low, value £0.200m*

Further vacancy turnover savings above the vacancy factor held in divisions.

Overachievement of Bank Interest - *likelihood: low, value £0.200m*

The overachievement this year is likely to be less than in previous years as interest rates have stated to reduce, and the income generation target for bank interest within the savings target has been increased from 2025-26 to support the overall Trust position.

8. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL 2026/27 £m	YTD Spend £m	Budget Remaining @ M4 £000s	Forecast Spend 2026/27 £m	Forecast Year End Variance 2026/27 £m
All Wales Capital Programme					
Integrated Radiotherapy Solution	17.115	0.147	16.968	17.115	0.000
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.017	1.125	1.142	0.000
nVCC - Project	37.825	5.314	32.511	38.073	(0.248)
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.059	0.000	0.059	0.000
nVCC - Enabling Works	0.393	0.000	0.393	0.393	0.000
Welsh Blood Service Fleet Replacement Programme 2025-26	0.882	0.000	0.882	0.882	0.000
Fees to develop the OBC/FBC for the PET at the nVCC	0.256	0.028	0.228	0.256	0.000
Digital Resource for the nVCC Project	0.550	0.000	0.550	0.550	0.000
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000	7.000	0.000
DPIF - Medicines and Prescribing: ePMA	0.025	0.000	0.025	0.025	0.000
DPIF - Transforming WBMDR software	0.166	0.000	0.166	0.166	0.000
Total All Wales Capital Programme	65.413	5.565	59.848	65.661	(0.248)
Discretionary Capital	2.246	0.977	1.269	2.246	0.000
Total	**67.659**	**6.542**	**61.117**	**67.907**	**(0.248)**

** Requesting funding from QRA budget held by WG. Approved funding will increase on CEL once confirmed & agreed by WG.*

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended 31 March 2027 is currently £67.659m (2025-26: £20.603m). This includes All-Wales capital funding of £65.413m and discretionary funding of £2.246m. The increase since June 2026 relates to additional CEL funding for EPMA and WBMDR software.

A further £8.688m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. The nVCC project team has requested a £0.250m drawdown against this contingency fund from Welsh Government. While approval is awaited, the forecast year-end variance is reported as an overspend, as shown in the table above.

Some further changes are expected as 2026-27 award letters are issued, and new funding requests are considered.

The funding letter for the 2026-27 discretionary capital allocation of £2.246m has been received from Welsh Government, signed and returned. It is anticipated that this will be fully committed and

spent in 2026-27, with the plan being ratified by the Capital Planning & Delivery Group and approved by the Executive Management Board in May 2026. The allocation of £2.246m represents an increase of 12.3% on the £2.000m provided during 2025-26 which was fully spent.

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital 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 have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m: £1.000m of which was awarded and spent in 2025-26, with a further allocation on the 2026-27 CEL. It is currently anticipated that the OBC/FBC will be submitted to WG in May 2027.

A request for c. £1.500m is to be sent to Welsh Government in the form of an SBAR to request funding for the development of an OBC/FBC for the decommissioning of the existing Velindre Cancer Centre site.

In relation to the Blood Establishment Computer System (BECS), a separate case has been provided to Welsh Government for the Implementation and Delivery Capital requirements for 2026/27 & 2027/28. There is a potential further requirement for additional functionality and upgrades, but this will likely form a request into DPIF (c. £2.215m revenue 2028-2033). The costs for BECS are currently being absorbed within the discretionary capital allocation until such a time that funding is confirmed (c. £0.830m).

A backlog maintenance request totalling £1.464m has been submitted for consideration split between Estates requirements for blast freezers & air conditioning units (£0.400m) and Digital requirements (£1.064m). WG have asked for confirmation that these items can be delivered post 31st March 2027, with funding to be released by the end of August if the Trust are able to confirm.

The CEL will be fixed by WG at the end of October, after this point the Trust will be expected to internally manage any slippage on the Capital programme.

Performance to date

Actual expenditure to 31 July 2026 on All-Wales Capital Programme schemes was £6.542m. This comprises £5.401m on nVCC schemes, £0.147m on the IRS, and £0.017m on WBS HQ business case fees.

Spend on the Discretionary Capital Programme was £0.977m. As schemes have now been approved, they should be progressed as early as possible in the financial year to reduce the risk of later-year delivery pressures. **This is particularly important given the expected requirement for Procurement colleagues to support nVCC equipment procurement, which is predominantly scheduled for the final quarter and will require close monitoring to ensure deliveries are received before 31 March 2027. Additional short-term staffing resource may be required to support equipment delivery.**

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 included in the IMTP for 2026-27 and beyond are shown in the table below:

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**
Discretionary Assumptions	**2.000**	**2.000**	**2.000**	**2.000**	**2.000**	**10.000**
IFRS16 Assumptions	**0.345**	**0.331**	**0.000**	**0.000**	**0.000**	**0.676**
Total Funding Capital IMTP Requirement:	**90.829**	**29.366**	**17.032**	**16.500**	**10.001**	**163.728**

Updates on All Wales and Discretionary Schemes are discussed at the monthly Capital Planning & Delivery Group meetings.

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 sets out the Trust's assets and liabilities. Under the Trust's SFIs, movements in working capital must be reported.

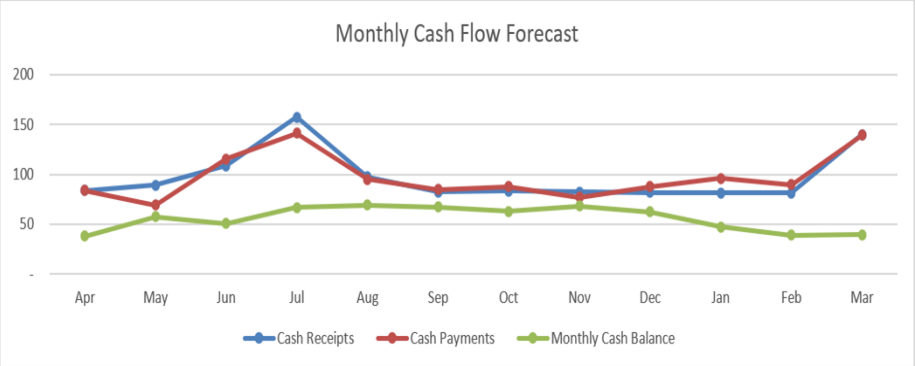
	Beginning of Apr-2026	End of Jul-26	from 1st April Jul-26	Balance End of Mar 27
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	437.115	342.290	(94.825)	342.290
Intangible assets	10.585	10.585	0.000	10.585
Trade and other receivables	1,530.778	1,530.678	(0.100)	1,530.678
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,978.478	1,883.553	(94.925)	1,883.553
Current Assets				
Inventories	33.680	33.252	(0.428)	33.252
Trade and other receivables	678.791	884.407	205.616	884.407
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	34.330	50.295	15.965	35.014
Non-current assets classified as held for sale	0.009	0.009	0.000	0.009
Current Assets sub total	746.810	967.963	221.153	952.682
TOTAL ASSETS	2,725.288	2,851.516	126.228	2,836.235
Current Liabilities				
Trade and other payables	(289.098)	(415.326)	(126.228)	(400.045)
Borrowings	(1.637)	(1.637)	0.000	(1.637)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(445.825)	(445.825)	0.000	(445.825)
Current Liabilities sub total	(736.560)	(862.788)	(126.228)	(847.507)
NET ASSETS LESS CURRENT LIABILITIES	1,988.728	1,988.728	0.000	1,988.728
Non-Current Liabilities				
Trade and other payables	(3.555)	(3.555)	0.000	(3.555)
Borrowings	(228.064)	(228.064)	0.000	(228.064)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,532.537)	(1,532.537)	0.000	(1,532.537)
Non-Current Liabilities sub total	(1,764.156)	(1,764.156)	0.00	(1,764.156)
TOTAL ASSETS EMPLOYED	224.572	224.572	0.000	224.572
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	39.789	39.789	0.00	39.789
PDC	164.484	164.484	0.000	164.484
Retained earnings	20.299	20.299	0.000	20.299
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	224.572	224.572	0.000	224.572

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.

	Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
RECEIPTS													
Income from other Welsh NHS Organisations	71.087	55.921	84.089	55.758	64.091	56.542	56.542	56.042	56.042	55.542	55.542	53.042	720.242
WG Revenue Funding	3.983	26.209	9.079	80.625	24.845	17.199	17.933	17.973	17.533	17.133	17.573	17.133	267.216
Short Term Loans													0.000
PDC												61.387	61.387
Interest Receivable	0.186	0.182	0.212	0.250	0.140	0.140	0.140	0.140	0.140	0.140	0.140	0.140	1.949
Sale of Assets													0.000
Other	8.246	6.592	15.307	20.689	8.425	8.500	8.500	8.250	8.250	8.250	8.000	8.000	117.009
TOTAL RECEIPTS	**83.502**	**88.903**	**108.687**	**157.322**	**97.502**	**82.382**	**83.115**	**82.405**	**81.965**	**81.065**	**81.255**	**139.702**	**1,167.803**
PAYMENTS													
Salaries and Wages	31.491	45.082	44.920	46.845	44.893	44.892	44.892	44.892	44.892	44.892	44.892	44.892	527.473
Non pay items	49.829	22.744	70.002	90.844	46.008	35.860	39.810	30.730	29.780	37.700	37.700	69.650	560.658
Short Term Loan Repayment													0.000
PDC Repayment	0.214											0.000	0.214
Capital Payment	2.208	1.214	0.650	3.517	4.112	3.685	3.014	1.420	13.145	13.480	6.911	24.632	77.988
Other items													0.000
TOTAL PAYMENTS	**83.743**	**69.039**	**115.572**	**141.207**	**95.013**	**84.437**	**87.716**	**77.042**	**87.817**	**96.072**	**89.503**	**139.174**	**1,166.333**
Net cash inflow/outflow	(0.241)	19.863	(6.886)	16.115	2.489	(2.055)	(4.601)	5.363	(5.852)	(15.007)	(8.248)	0.528	
Balance b/f	37.929	37.689	57.552	50.666	66.781	69.270	67.215	62.614	67.977	62.125	47.119	38.871	
Balance c/f	37.689	57.552	50.666	66.781	69.270	67.215	62.614	67.977	62.125	47.119	38.871	39.399	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCS	(17.631)	(17.625)	0.006	(52.510)	(52.510)	0.000
RD&I	0.057	0.058	0.001	0.350	0.350	0.000
WBS	(8.194)	(8.194)	0.000	(24.446)	(24.446)	0.000
Sub-Total Divisions	**(25.767)**	**(25.761)**	**0.007**	**(76.606)**	**(76.606)**	**0.000**
Corporate Services Directorates	(6.265)	(6.254)	0.011	(18.869)	(18.869)	0.000
Delegated Budget Position	**(32.032)**	**(32.015)**	**0.017**	**(95.475)**	**(95.475)**	**0.000**
nVCC	(0.058)	(0.067)	(0.009)	(0.173)	(0.173)	0.000
Health Technology Wales	(0.091)	(0.091)	0.000	(0.272)	(0.272)	0.000
Trust Income / Reserves	32.180	32.180	0.000	95.920	95.920	0.000
Trust Position	**0.000**	**0.008**	**0.008**	**0.000**	**0.000**	**0.000**

The position at close of month 4 is an **underspend of £0.008m.**

The year-end forecast position for the core Trust is **breakeven**, although there are some risks to achieving this.

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**36.089**	**36.245**	**0.156**	**112.103**	**112.103**	**0.000**
Expenditure						
Staff	22.999	22.531	0.468	68.653	67.719	0.934
Non Staff	30.722	31.339	(0.617)	95.960	96.893	(0.934)
Sub Total	**53.720**	**53.870**	**(0.150)**	**164.612**	**164.612**	**0.000**
Total	**(17.631)**	**(17.625)**	**0.006**	**(52.510)**	**(52.510)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services at the end of July 2026 was an **underspend of £0.006m**. The expected outturn position at this stage is **breakeven**, although some associated risk remains.

Income at month 4 was £0.156m above plan, largely due to pharmacy drugs and activity income overperformance, partly offset by radiotherapy activity income underperformance.

The pay position is **underspent by £0.468m** at the close of month 4. This reflects the impact of the current vacancies within the division, offset by unfunded roles. There is also a divisional CIP required to address the net impact of the VCS restructure.

Non-staff expenditure at month 4 was overspent by £0.617m. This is predominantly due to an overspend on NICE/HCD drugs expenditure of £0.282m, which will be corrected next month, general drug costs of £0.248m and private patient drug costs of £0.153m, offset by smaller underspends across the service.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**12.348**	**12.723**	**0.375**	**38.537**	**39.662**	**1.125**
Expenditure						
Staff	7.066	7.291	(0.225)	21.423	22.098	(0.675)
Non Staff	13.475	13.626	(0.151)	41.560	42.012	(0.450)
Sub Total	**20.541**	**20.917**	**(0.376)**	**62.983**	**64.110**	**(1.125)**
Total	**(8.194)**	**(8.194)**	**0.000**	**(24.446)**	**(24.446)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of July 2026 was **breakeven**, with the current expected outturn position also forecast as **breakeven**.

WBS reported a **£0.375m overachievement** of income to date. This is primarily due to additional non-recurrent plasma income of £0.300m and smaller in-month overachievements, including WBMDR income of £0.036m.

The staff overspend of **£0.225m** is due to an increased CIP savings target and unfunded posts appointed at risk, largely offset by pay vacancies across the service. The unfunded posts will be reviewed with a view to securing funding that is ringfenced in the Trust IMTP.

The WBS non-staff position was overspent by £0.151m in month 4. Non-recurring activity and volume-related benefits from performance below demand planning targets continue to offset some supply chain cost pressures. The service is recovering from the eProgressa outage at the end of March and has also seen fluctuations in activity-driven spend due to recent excessive temperatures.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.517**	**1.537**	**0.020**	**4.553**	**4.574**	**0.020**
Expenditure						
Staff	6.317	5.870	0.447	18.744	18.297	0.447
Non Staff	1.465	1.921	(0.456)	4.679	5.146	(0.467)
Sub Total	**7.781**	**7.791**	**(0.009)**	**23.423**	**23.443**	**(0.020)**
Total	**(6.265)**	**(6.254)**	**0.011**	**(18.869)**	**(18.869)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of July 2026 was an **underspend of £0.011m**, with the current expected outturn position forecast as **breakeven**.

The Trust is continuing 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 we can expect to see this benefit reduce as the year progresses. In addition, an increased income generation target within the divisional savings plan for 2026-27 will reduce the opportunity for additional gains above those planned.

Several vacancies within the division resulted in the in-month underspend, particularly within the Data and Insights, ATW, Digital and Finance teams. These underspends offset overspends in the Estates team, which will be investigated in-month, as well as the use of agency staff and the divisional savings target.

Non-pay overspend largely relates to divisional CIP target, the increased running costs associated with the hospital estate and corporate management costs including those relating to the governance review and other consultancy costs. Expenditure this month relating to the nVCC readiness project is also included in the position, with income to be drawn and the variance removed in month 5.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**2.042**	**1.872**	**(0.170)**	**6.409**	**6.239**	**(0.170)**
Expenditure						
Staff	1.714	1.650	0.064	5.328	5.264	0.064
Non Staff	0.270	0.164	0.107	0.731	0.625	0.106
Sub Total	**1.984**	**1.813**	**0.171**	**6.059**	**5.889**	**0.170**
Total	**0.057**	**0.058**	**0.001**	**0.350**	**0.350**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of July 2026 was **breakeven**, with the current expected outturn position also forecast as **breakeven**.

Clinical Trials and Charitable funds income is expected to fluctuate during the year and is drawn down in line with expenditure.

The staff **underspend** to date is due to several vacancies that have not yet been recruited to.

The non-staff **overspend** to date relates to study-related costs, audit and miscellaneous expenditure, and higher laboratory equipment costs.

nVCC – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.016**	**0.043**	**0.027**	**0.048**	**0.074**	**0.027**
Expenditure						
Staff	0.074	0.101	(0.028)	0.221	0.249	(0.028)
Non Staff	0.000	0.008	(0.008)	0.000	(0.001)	0.001
Sub Total	**0.074**	**0.110**	**(0.036)**	**0.221**	**0.247**	**(0.027)**
Total	**(0.058)**	**(0.067)**	**(0.009)**	**(0.173)**	**(0.173)**	**0.000**

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of July 2026 is a small overspend of **£0.009m.**

A fuller financial analysis, including capital expenditure and programme forecasts, is attached at Appendix 2.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.606**	**0.527**	**(0.078)**	**1.817**	**1.739**	**(0.078)**
Expenditure						
Staff	0.639	0.575	0.063	1.916	1.853	0.063
Non Staff	0.058	0.043	0.015	0.173	0.158	0.015
Sub Total	**0.696**	**0.618**	**0.078**	**2.089**	**2.011**	**0.078**
Total	**(0.091)**	**(0.091)**	**0.000**	**(0.272)**	**(0.272)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of July 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.

nVCC Project Finance Report For July 2026

DATE OF MEETING	TBC
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kate Evans Senior Finance Business Partner
PRESENTED BY	Mark Ash Assistant Project Director
EXECUTIVE SPONSOR APPROVED	Matt Bunce, Executive Director of Finance
REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the new Velindre Cancer Centre (nVCC) Project Board outlining spend to date against the Welsh Government (WG) approved/indicative budget as of **July 2026**.

1.2 The nVCC, PET CT and Enabling Works Project financial positions are continually monitored and updated, and an update will be provided to the nVCC Project Board and Trust Board on a monthly basis.

2. PART A – ENABLING WORKS & NVCC

2.1 FINANCIAL SUMMARY FOR 2026-27

2.1.1 Key matters are outlined below:

- **Capital funding** has been provided by WG for the nVCC Project resources.
- The **financial position** for the overall Project as of **July 2026** is set out below:

New Velindre Cancer Centre
Finance

Programme	Project Director	Report Period
nVCC	David Powell	Jul-26

	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Total Costs	54.90M	10.91M	1.57M	56.46M	20.75M	16.18M	19.48M	56.40M	9.40M

- The in-year **financial position** for **July 2026** is:
    - **CAPITAL** in-year spend to date of **£4.641m**, against a total budget of **c£36.575m.** The outturn is displaying an overspend position of £0.250m.

nVCC Project Capital Budget & Spend Summary 2026-27

	Year to Date			Financial Year		
	Budget Jul-26	Spend Jul-26	Variance Jul-26	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
EW FBC Project	0	0	0	393,000	393,000	0
nVCC Project Delivery	1,183,890	1,183,890	0	5,193,523	5,193,523	0
nVCC MIM (Construction Costs)	32,563	32,563	0	55,200	55,200	0
nVCC Equipment Procurement	3,424,217	3,424,217	0	30,933,163	31,183,113	-249,950
	4,640,670	**4,640,670**	**0**	**36,574,887**	**36,824,836**	**-249,950**

- **REVENUE** in-year spend to date of **£0.065m**, against a total budget of **c£0.193m.** The outturn is displaying a breakeven position.

REVENUE

	Year to Date			Financial Year		
	Budget Jul-26	Spend Jul-26	Variance Jul-26	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
Enabling Works						
Project Delivery Support Costs	0	0	0	0	0	0
Enabling Works Revenue Total	**0**	**0**	**0**	**0**	**0**	**0**
New Velindre Cancer Centre						
nVCC Pay	57,667	57,667	0	173,000	173,000	0
Project Delivery Support Costs	7,841	7,725	115	20,000	20,000	0
nVCC Revenue Total	**65,507**	**65,392**	**115**	**193,000**	**193,000**	**0**
REVENUE TOTAL	**65,507**	**65,392**	**115**	**193,000**	**193,000**	**0**

2.2 FUNDING – EW & nVCC

WG funding relates to the period 1 April 2024 to 31 March 2028 and must be claimed in full by 31 March 2028 otherwise any unclaimed part of the funding will cease to be available to you.
The funding made available in the approved FBC is **£78.662m capital** and **£2.412m revenue** for the nVCC Project.

A summary breakdown of funding is shown below:

Capital Budget: £69.719m consisting of:

	£m
Deep Clinical Clean	0.272
Project (nVCC) capital expenditure – Equipment	32.540
Stage 3 and 4 delivery costs (Phase 2)	14.508
IRS Implementation costs (Phase 3 nVCC Implementation)	5.071
MIM Quantified Risk Assessment	8.496
Trust Quantified Risk Assessment	8.832

Revenue Budget: £2.412m consisting of:

Dual Running Costs (non-recurrent) currently due to be required in 2027-28 financial year.	2.412

Enabling Works Budget: £8.943m consisting of:

	£m
Water Main Diversion / Delays (Planning & Highways)	4.659
Scope changes	0.506
Unforeseen activities	2.003
Inflation	0.408
Quantified Risk Assessment	1.367

2.2.1 The funding includes IRS implementation costs of £5.071m, which is not managed by the nVCC Project. In respect of the QRA, all QRA budgets are subject to drawdown according to the agreed QRA process. The QRA of c£18.695m will be held by WG until funding has been agreed.

2.2.2 In respect of the original FBC funding and QRA drawdown, the nVCC project will now be responsible for **c£56.215m**.

2.2.3 For clarity, it is the Welsh Government's expectation that this capital allocation is the final funding ask prior to the new Velindre Cancer Centre opening.

2.2.4 As a result of the Trust and Welsh Government reassessment of the QRA allocation, the capital funding has been **reduced to £70.875m.** It should be noted that the QRA is reviewed on a quarterly basis.

2.2.5 A summary breakdown of the estimated revised funding is shown below:

EW Project	
FBC Addendum	£7,575,600
Original FBC	£0
QRA Called	£917,879
	£8,493,479
nVCC Project	
Equipment	£32,540,286
Transactions(Resource Costs)	£14,507,885
MIM Construction Costs	
PROW Diversions	
Deep Clean	£272,000
QRA Called	£650,982
	£47,971,154
	£56,464,633

2.3 FINANCIAL POSITION – EW & nVCC

2.3.1 Overall the status of the financial position of the Project is a RAG rating of GREEN.

2.3.2 The Project overall has an agreed funding of c£56.464m. The projected spend is £56.401m leading to an overall underspend position of £0.063m. The spend forecast is made up of actual spend of c£20.745m, contractual commitments of c£16.178m and projected spend to completion of c£19.478m. The projected spend element of c£19.478m is primarily equipment (c£18.793m).

2.3.3 It should be noted that as at July 2026 the Trust has commitments of c£8.9m for major medical equipment, with £8.1m purchase orders raised in September 2025. In addition, there is Network infrastructure c£0.9m and Digitisation of Records c£0.586m and digital c£0.307m. The residual relates to committed pay costs and equipment advisory costs.

2.3.4 The Project had reserves as per the FBC of c£18.7m and into the second year of the construction phase and to date has only called down £1.569m of the QRA, which represents 8.39% of the agreed reserves. In addition. the Trust reviewed the QRA in September 2025 and reduced the risk exposure by c£7.8m. Therefore, the Project retains reserves of c£9.344m.

2.3.5 The risk exposure was reduced in respect of major equipment; design elements and disruption of works. The retained reserve reflects a prudent provision for the remainder of the contract term. However, a further review of the risk exposure and QRA will be undertaken in September 2026.

2.3.6 The further breakdown of the overall Project financial position is set out below:

New Velindre Cancer Centre
Finance

Programme	Project Director	Report Period
nVCC	David Powell	Jul-26

	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Costs	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Enabling Works	7.58M	1.37M	918K	8.49M	8.07M	0	393K	8.46M	481K
Equipment	32.54M	2.58M	250K	32.79M	3.84M	10.16M	18.79M	32.79M	2.33M
Transactions (Resource Costs)	14.51M	5.18M	0	14.51M	8.49M	6.02M	0	14.51M	5.18M
MIM (Construction Costs)	272K	156K	0	272K	0	0	272K	272K	156K
Deep Clean	0	1.63M	401K	401K	350K	0	19K	369K	1.26M

EW Project – **as of July 2026**

2.3.7 The overall financial position is an approval to spend of c£8.493m, which is set out below:

	FBC Funding	Costs Incurred 2024-25	Costs Incurred 2025-26	Costs Incurred 2026-27	Commitments 2026-27	Projected Costs 2026-27
EW Project						
Pay	£153,116	£153,116	£0	£0	£0	
6MVA Supply - National Grid	£576,000	£480,000	£98,089	£0	£0	
Supply Chain Fees	£645,800	£323,268	£219,614	£0		£81,000
Non Works Costs	£0	-£113,202	£0	£0	£0	
Asda Works	£1,776,000	£2,008,269	£0	£0	£0	
Walters Design & Build	£0	£116,260	£9,873	£0	£0	
S278 works on Longwood Drive	£3,610,628	£288,858	£3,144,580	£0	£0	
Offsite Habitat Creation (SW Corner)	£717,335	£434,292	£364,125	£0	£0	
HV Intake Room	£627,600	£161,286	£370,756	£0	£0	
Rural Path	£75,000	£0	£0	£0		£40,000
TCAR Habitat	£72,000	£0	£0	£0		£72,000
Revised Emergency Access	£240,000	£0	£0	£0		£200,000
Enabling Works FBC Reserves	£0	£9,921	£0	£0	£0	
TOTAL EW PROJECT	**£8,493,479**	**£3,862,068**	**£4,207,037**	**£0**	**£0**	**£393,000**
QRA funding	£1,367,400					£1,367,400
HV Intake Room Drawdown	-£160,800					-£160,800
Asda Final AccountDrawdown	-£368,000					-£368,000
Sacrificial Cable	-£96,000					-£96,000
S278 Works	-£293,079					-£293,079
Addn funding						£0
	£449,521	**£0**	**£0**	**£0**	**£0**	**£449,521**
TOTAL nVCC EW FUNDING	**£8,943,000**	**£3,862,068**	**£4,207,037**	**£0**	**£0**	**£842,521**

2.3.8 The overall financial position of the EW Project is spend to date is c£8.069m, with projected costs of c£0.843m.

2.3.9 The QRA available for the EW Project is c£0.450m and reflects the unallocated resources for the Project. It should be noted that the QRA has recently been reviewed and adjusted to reflect the current risks within the Enabling works.

Financial Risks

2.3.10 The QRA reflects the risks being managed by the EW Project as at July 2026.

***nVCC Project* – as of July 2026**

2.3.11 The overall financial position is an approval to spend of c£47.971m, which is set out below:

	FBC Funding	Costs Incurred 2024-25	Costs Incurred 2025-26	Costs Incurred 2026-27	Commitments 2026-27	Projected Costs 2026-27
nVCC MIM Activties						
Project Management Office	£3,325,884	£1,181,156	£1,091,450	£327,563	£725,715	£0
Design & Construction Workstream	£2,606,271	£629,664	£881,905	£187,893	£906,810	£0
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£748,474	£249,859	£2,188,329	£162,692
Digital Workstream	£1,935,417	£113,756	£328,524	£141,313	£1,351,824	£0
Engagement & Communications Workstream	£380,688	£159,689	£143,399	£52,718	£24,882	£0
Commercial Activity Group	£2,242,432	£621,540	£717,962	£209,575	£693,356	£0
Strategic Reserves				£0		£0
Project Delivery	£295,000	£117,988	£194,460	£14,971	£130,273	-£162,692
Major Medical Equipment	£10,676,400	£0	£0	£0	£8,107,612	£2,568,788
Other Equipment	£12,385,200	£0	£167,737	£127,050	£215,000	£11,875,413
Strategic Reserves(2)						
IM&T infrastructure	£5,609,752	£0	£247,811	£2,442,393	£941,560	£1,977,988
Digital	£433,415	£0	£0	£0	£307,040	£126,375
Digitisation of Health Records	£3,685,469	£0	£0	£854,774	£585,570	£2,245,125
Non Works Costs	£272,000	£0	£0	£0	£0	£272,000
MIM Construction Costs	£342,032	£130,434	£187,004	£32,563		-£7,969
PROW Diversions	£59,000			£0		£27,000
TOTAL nVCC PROJECT	**£47,971,153**	**£3,327,065**	**£4,708,726**	**£4,640,670**	**£16,177,971**	**£19,084,720**
QRA funding	£11,471,000					£11,471,000
Asda Traffic Management Drawdown	-£225,000					-£225,000
PROW Diversions	-£59,000					-£59,000
PA Changes	-£63,218					-£63,218
Fibre Divergence	-£53,814					-£53,814
Network Install & Supply	-£249,950					-£249,950
Adjustment	-£1,929,999					-£1,929,999
	£8,890,019	**£0**	**£0**	**£0**	**£0**	**£8,890,019**
TOTAL nVCC MIM FUNDING	**£56,861,172**	**£3,327,065**	**£4,708,726**	**£4,640,670**	**£16,177,971**	**£27,974,739**

2.3.12 The overall financial position of the nVCC Project is spend to date is c£12.676m, with commitments of c£16.178m and projected costs of c£27.975m.

2.3.13 The QRA available for the nVCC Project is c£8.890m and reflects the unallocated resources for the Project. It should be noted that the QRA has recently been reviewed and adjusted to reflect the current risks within the project.

Financial Risks

2.3.14 The QRA reflects the risks being managed by the nVCC Project and there are no additional financial risks reported as of July 2026.

2.4 Financial Position – EW & nVCC in year position for 2026-27

2.4.1 The in-year financial position for **July 2026** is reporting an overspend position.

- **CAPITAL** in-year spend to date of **£4.641m**, against a budget of **c£36.575m.**

The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2026-27

CAPITAL	Year to Date			Financial Year		
	Budget Jul-26	Spend Jul-26	Variance Jul-26	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
Enabling Works						
6MVA Supply - National Grid	0	0	0	0	0	0
Supply Chain Fees	0	0	0	81,000	81,000	0
Rural Path	0	0	0	40,000	40,000	0
TCAR Habitat	0	0	0	72,000	72,000	0
Revised Emergency Access	0	0	0	200,000	200,000	0
Enabling Works FBC Reserves	0	0	0	0	0	0
Enabling Works Capital Total	**0**	**0**	**0**	**393,000**	**393,000**	**0**
nVCC Project Delivery						
Project Management Office	342,534	342,534	0	1,134,524	1,134,524	0
Design & Construction	187,893	187,893	0	837,297	837,297	0
Equipment, Commissioning and Migration	249,859	249,859	0	1,121,473	1,121,473	0
Digital	141,313	141,313	0	861,421	861,421	0
Engagement & Communications	52,718	52,718	0	181,184	181,184	0
Commercial Activities Group	209,575	209,575	0	720,713	720,713	0
Strategic Reserves	0	0	0	336,910	336,910	0
Project Delivery Capital Total	**1,183,890**	**1,183,890**	**0**	**5,193,523**	**5,193,523**	**0**
MIM (Construction Costs)						
MIM (Construction Costs)	32,563	32,563	0	55,200	55,200	0
MIM Reserves	0	0	0	0	0	0
MIM (Construction Costs) Total	**32,563**	**32,563**	**0**	**55,200**	**55,200**	**0**
Equipment Procurement						
Medical and Other Equipment Procurement	127,050	127,050	0	19,472,585	19,472,585	0
IM&T & Digital Procurement	3,297,167	3,297,167	0	9,068,725	9,318,675	-249,950
Strategic Reserves 2	0	0	0	2,391,853	2,391,853	0
nVCC Capital Total	**3,424,217**	**3,424,217**	**0**	**30,933,163**	**31,183,113**	**-249,950**
CAPITAL TOTAL	**4,640,670**	**4,640,670**	**0**	**36,574,887**	**36,824,836**	**-249,950**

2.4.2 The key **EW CAPITAL** areas of spend to date are explained as follows:

Work Packages are outlined below:

- **Supply Chain Fees** – **no spend -** costs associated with Legal advisory support provided by DLA Piper.
- **Asda Works** – **no spend -** costs associated with the Asda car park works costs c£0.000m. The final account is being finalised.

- **S278 Works Longwood Drive** – **no spend -** costs associated with the highway improvement works on Longwood Drive agreed with Cardiff County Council. The final account is being finalised.
- **Off-site Habitat** – **no spend -** costs associated with the offsite habitat creation required as part of the EPSL.
- **HV Intake Room – no spend** - costs associated with the design and build of the HV intake room. Internal Emergency lighting works costs.
- **Reserves** – **no spend -** costs are c£0.000m – no spend to date.

2.4.3 The key **nVCC CAPITAL** areas of spend to date are explained as follows:

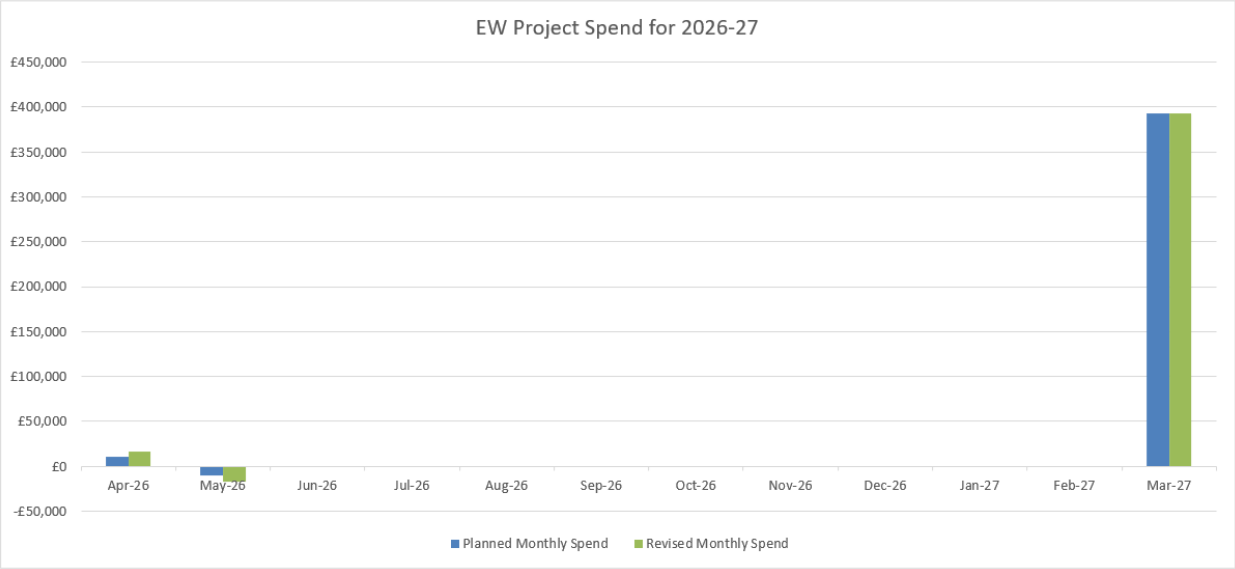
- **Staffing** - WG funded posts **spend of £0.928m.** Reflects the Project posts and a run rate of c£0.232m per month.

Work Packages are outlined below:

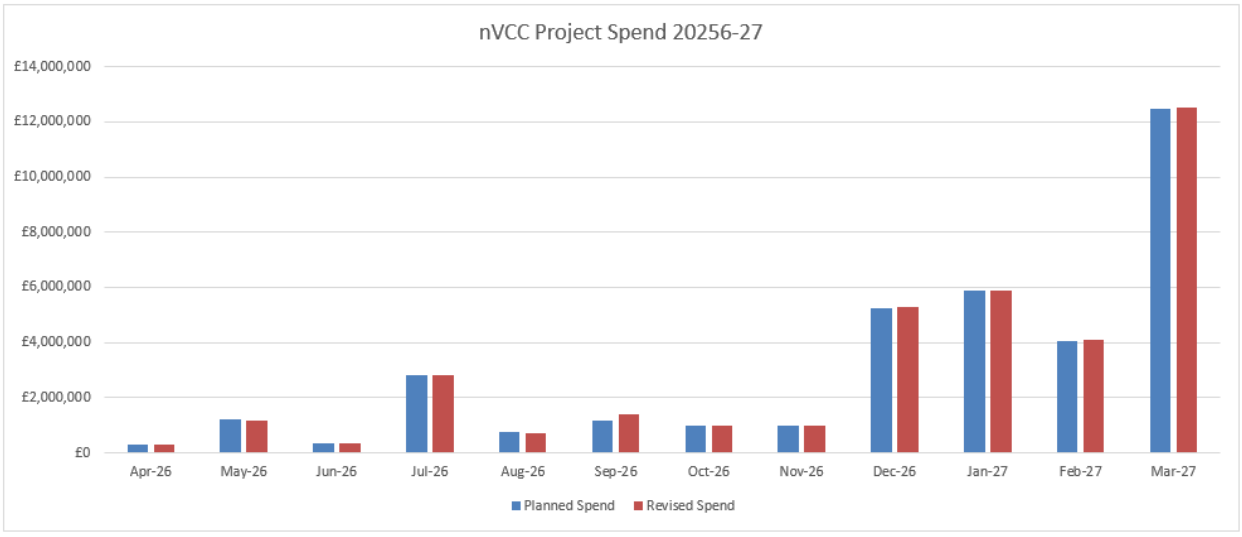
- **Project Delivery –** costs associated with the running of the Project Office and spend is **£0.015m.**
- **Capability Review – no spend.**
- **RDD Process** – **spend of £0.017m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase – spend of £0.052m** for the services provided by the Authority Construction Surveyor.
- **Equipment Advisers & purchases – spend of c£0.007m** for Specialist Equipment advice.
- **Digital and IM&T Equipment procurement – no spend –** costs associated with Network engineers, Digitalisation of Health records programme and Hardware procurement and Patient Engagement.
- **Engagement and Communications – spend of £0.001m.** Costs are for engagement events.
- **Project Management Advisors – spend of c£0.103m** for the SRO; Project Planning & Control and Technical advisory support.
- **Professional Advisors – spend of £0.062m** for legal advice on the PA and changes, and range of commercial matters; commercial support.
- **Reserves – spend of £0.000m –** no spend to date.

2.4.4 **Cashflow**

The graph below outlines the Enabling works actual capital spend to date for **July 2026 is NIL**. A review of the spend profile is required once plans are confirmed.



The graph below outlines the nVCC actual capital spend to **July 2026 is £4.641m**. The actual run-rate is **in-line** with planned spend. The spend profile has now been rephased to reflect estimated delivery dates for the Major Medical equipment and the Network infrastructure installation.



2.4.5 **Capital Resource Limit -** the CRL for the EW and nVCC Project(s) was **agreed with WG in March 2026**:

- For **July 2026** the capital spend outturn is **£36.825m**
- WG have **approved** the CRL for the Project(s).

2.4.6 The CRL position is outlined below:

EW Project

Period 2026-27	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-26	0.010	0.017	-0.007
May-26	-0.010	-0.017	0.007
Jun-26	0.000	0.000	-0.000
Jul-26	0.000	-0.000	0.000
Aug-26	0.000	0.000	0.000
Sep-26	0.000	0.000	0.000
Oct-26	0.000	0.000	0.000
Nov-26	0.000	0.000	0.000
Dec-26	0.000	0.000	0.000
Jan-27	0.000	0.000	0.000
Feb-27	0.000	0.000	0.000
Mar-27	0.393	0.393	0.000
TOTAL	**0.393**	**0.393**	**0.000**

nVCC Project

Period 2026-27	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-26	0.301	0.314	-0.013
May-26	1.195	1.182	0.013
Jun-26	0.339	0.339	0.000
Jul-26	2.805	2.805	-0.000
Aug-26	0.759	0.716	0.044
Sep-26	1.152	1.379	-0.226
Oct-26	0.997	0.974	0.023
Nov-26	0.965	0.982	-0.017
Dec-26	1.862	5.268	-3.406
Jan-27	1.475	5.882	-4.407
Feb-27	4.067	4.081	-0.014
Mar-27	20.264	12.510	7.753
TOTAL	**36.182**	**36.432**	**-0.250**

3. QUANTIFIED RISK ASSESSMENT (QRA)

3.1.1 The **Original QRA position was £18.7m** as per the FBC and approved by Welsh Government. The revised position is now **c£10.908m** following the bi-monthly review conducted with Welsh Government. This reduction of £7.8m reflects the negating of the risks to the project, particularly in the procurement of the Category 2c equipment allocation.

3.1.2 The Project has utilised **c£1.569m** of the QRA and the funding has been provided by WG.

3.1.3 The remaining QRA is **c£9.340m with the profiling set out in the below:**

REVISED QRA (JUN 26)	2024-25	2025-26	2026-27	2027-28		Total
REVISED NVCC QRA - MIM (JUN 26)			£3,268,782			£3,268,782
REVISED NVCC QRA - TRUST (JUN 26)			£2,536,036	£3,085,200		£5,621,236
REVISED NVCC EW - TRUST (JUN 26)			£449,521			£449,521
TOTAL QRA	**£0**	**£0**	**£6,254,339**	**£3,085,200**		**£9,339,539**

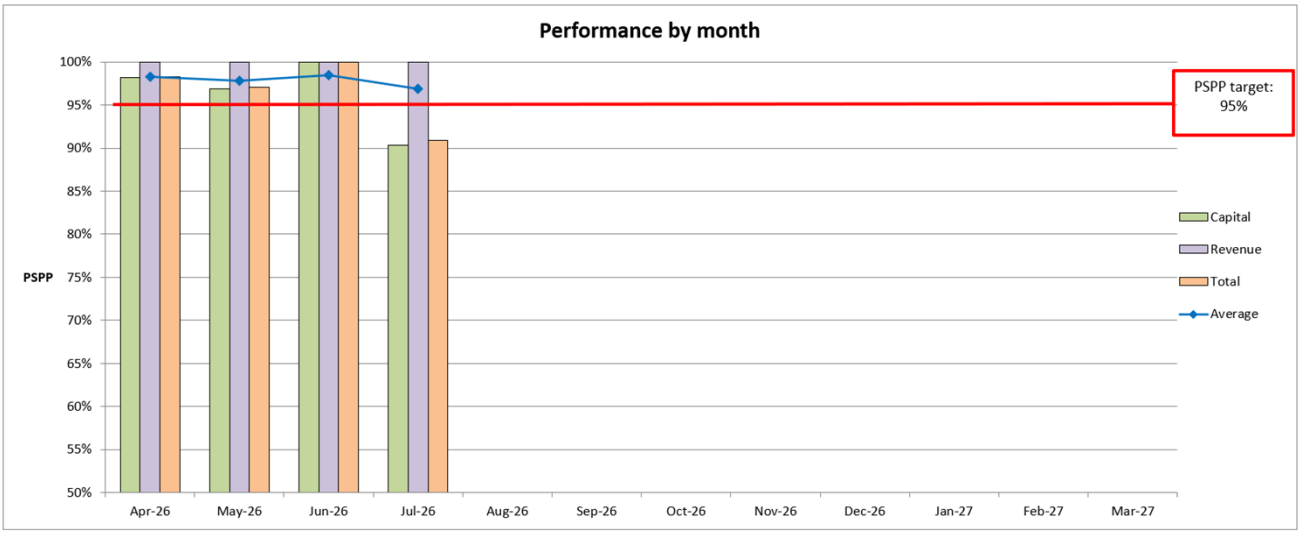
3.1.4 The Project reviews the QRA on a quarterly basis and the risks quantification re-assessed. The next review will take place in September 2026.

4. PUBLIC SECTOR PAYMENT POLICY

4.1.1 For **July 2026,** the PSPP performance was **91%** and the PSPP target was **not achieved**. Of the 33 invoices for payment, 30 invoices were processed within the 30-day deadline.

4.1.2 The average PSPP performance to date for 2025-26 is **97%**.

4.1.3 The Project(s) PSPP monitoring report is outlined below:



5. PART B – PET CT

5.1 FUNDING – PET CT

WG funding relates to the period 1 April 2024 to 31 March 2028 and must be claimed in full by 31 March 2028 otherwise any unclaimed part of the funding will cease to be available to you.
The funding made available in the approved FBC is **£0.298m capital**.

A summary breakdown of funding is shown below:

Capital Budget: £0.298m consisting of:

	£m
Clinical / Subject matter expert	0.054
Business Case Development	0.071
Developing the Design	0.101
Legal and Commercial arrangements	0.072

5.2 In-year FINANCIAL POSITION 2026-27 – PET CT

5.2.1 The in-year financial position for **July 2026** is reporting a breakeven position.

- **CAPITAL** in-year spend to date of **£0.028m**, against a budget of **c£0.256m.** The outturn displays a breakeven position.

  The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2026-27

CAPITAL	Year to Date			Financial Year		
	Budget Jul-26	Spend Jul-26	Variance Jul-26	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PET-CT						
PET-CT Pay	0	0	0	54,277	54,277	0
Business Case	18,080	18,080	0	61,066	61,066	0
Design Development	10,074	10,074	0	72,868	72,868	0
Legal & Commercial	0	0	0	67,500	67,500	0
PET-CT Capital Total	**28,154**	**28,154**	**0**	**255,711**	**255,711**	**0**
CAPITAL TOTAL	**28,154**	**28,154**	**0**	**255,711**	**255,711**	**0**

6. Considerations for Board

6.1 An extract of this report is reported in the Trust Boards Finance Report.

7. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies, please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The financial implications are outlined in the report.

6. RECOMMENDATION

6.1. The nVCC Project Board are asked to **NOTE** the contents of this report.

Trust Board		
Trust Risk Register Report		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Mel Findlay, Risk and Assurance Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	Non Gwilym, Interim Director of Corporate Governance	
SCRUTINY ROUTE TO DATE		
	Data shared	Welsh Blood Service Leadership Team
	Data Shared	Velindre Cancer Centre Leadership Team
	24/08/2026	Executive Management Board
	17/09/2026	Audit, Risk and Assurance Committee
ONWARD SCRUTINY ROUTE	Trust Board	
PURPOSE OF THE REPORT	Assurance / for noting and scrutiny	
EXECUTIVE SUMMARY	This paper presents the current public Trust Risk Register for assurance and scrutiny following EMB review on 24 August 2026 and ARAC review on 17 September 2026. It reports Quality and Safety risks scoring 12 or above and all other risks scoring 15 or above.	
ACTION / DECISION	The Trust Board is asked to: • **NOTE** the September 2026 Trust Risk Register position. • **NOTE** the EMB discussion on new risks, consolidated Treatment Helpline risks, sub-threshold risks, overdue reviews, and the need to strengthen the quality and discipline of risk review arrangements. • **TAKE ASSURANCE** that actions arising from EMB have been identified for follow-up.	
ADDITIONAL RESOURCES	Nil return.	
RELEVANT TRUST STRATEGIC GOALS • Outstanding for quality, safety, and experience		

RELEVANT TRUST WELLBEING GOALS
• A Resilient Wales • A Healthier Wales • A More Equal Wales
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
• Safe • Timely • Efficient • Effective • Patient Centred
QUALITY IMPACT ASSESSMENT (QIA) Not required. This is an assurance report and does not seek a new strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specifc equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	Appendix title
APPENDICES	Appendix 1	Public Trust Risk Register

1. SITUATION

This report presents the 2026 public Trust Risk Register for assurance, following review by EMB on 24 August 2026 and Audit and Risk Assurance Committee on 17 September 2026. Based on Datix and service-level reviews, it includes Quality and Safety risks scoring 12 or above and all other risks scoring 15 or above. The Board is asked to note the current position and actions to improve the quality, accuracy and discipline of risk review.

2. BACKGROUND

The Trust Risk Register provides a consolidated view of operational risks that meet the Trust Board-approved reporting thresholds: risks in the Quality/Safety domains scoring 12 and above, and risks in all other domains scoring 15 and above.

Operational risks are aligned to the appropriate Board Assurance Framework risk and support committees to conduct focused scrutiny of controls, assurances, gaps and required actions.

3. MATTERS FOR CONSIDERATION

3.1 The Trust Risk Register is available as Appendix 1. Two new Welsh Blood Service risks related to end- of-life FoxPro and DOS-based systems supporting Welsh Bone Marrow Donor Registry services have been raised. Two Velindre Cancer Service Treatment Helpline risks have closed following consolidation into Risk 3969, which covers access, clinical triage, escalation and timely decision- making. The wider profile remains concentrated on patient safety, treatment access, capacity and demand, digital dependency, laboratory information systems, governance and organisational resilience, with several risks dependent on national or partner-led programmes, including LIMS, FEDIS, WLIMS, WHAIS and wider DHCW integration activity. The appendix provides risk descriptions and current actions to support scrutiny of ownership, scoring, target ratings, actions and escalation. Two risks are due to reach their target dates within the next two weeks.

The main themes are patient safety, service capacity, treatment access, digital dependency, laboratory information systems and organisational resilience. The highest current score is 20 for the Corporate WLIMS 2.0 delay risk. Other risks rated 15 or 16 include WBS digital and laboratory systems, VCS treatment access and escalation, organisational leadership capacity, hosted services assurance and Pharmacy Technical Services quality assurance capacity. Several mitigations depend on workforce capacity, business cases, procurement, national programmes or external partners and therefore require continued executive oversight and timely escalation.

The public Trust Risk Register currently contains 14 reportable risks: seven Quality and Safety risks scoring 12 or above, comprising three VCS and four WBS risks; and seven risks scoring 15 or above in other domains, comprising four WBS and three Corporate risks.

3.2 Sub-threshold risk review

The six-monthly Datix review assessed whether sub-threshold risks remain appropriately owned, reviewed and controlled. It covered Quality and Safety risks below 12, other risks below 15 excluding risks already overseen through established divisional quality and safety arrangements and Welsh Blood Service venue-related tolerated risks. Most risks remained appropriately managed at operational or divisional level, with many at or near their target rating. Fourteen reviews were overdue, an improvement since March 2026 but still requiring follow-up. The Risk and Assurance Manager will continue to follow-up on ownership, review schedules and escalation through routine governance reporting.

3.3 Executive Management Board discussion: 24 August 2026

EMB noted the August position, including the two new Welsh Blood Service legacy-system risks, consolidation of the Treatment Helpline risks into Risk 3969 and the six-month review of sub-threshold risks. The Board noted that most sub-threshold risks remained appropriately managed or tolerated at operational or divisional level and requested a follow-up of overdue reviews, correction of scoring anomalies, clearer distinction between risks and issues, and

stronger descriptions of the actions and conditions required to move risks towards target ratings. The wider framework refresh, including the establishment of an Executive Risk Management Group, is expected to improve alignment between operational risks, the Board Assurance Framework and the revised committee structure.

3.4 Audit and Risk Assurance committee discussion: 17 September 2026

The Audit and Risk Assurance committee (ARAC) scrutinised the register on 17 September 2026, requesting clearer explanations for long-standing static risks, greater understanding of risk mitigations in support of risk tolerance and their effectiveness. ARAC also noted progress on the Risk Management Policy, the risk management replacement system decision expected by mid-October 2026 and welcomed the proposed Executive Risk Management Group as the mechanism for stronger executive oversight and assurance.

3.5 Datix System Replacement and Risk Management System Development

The Trust remains on Datix V14 and is testing the Datix Cymru Risk Module. The assessment follows national direction to test the existing procured platform first and builds on compliant pre-market engagement supported by NWSSP Procurement. Experienced and level 1 users are assessing usability, workflow, risk review, escalation, action tracking, reporting, audit trail, assurance-framework functionality, data migration and integration, informed by benchmarking with Betsi Cadwaladr University Health Board. Testing is due to conclude by the end of September 2026 with the gap analysis and options appraisal informing a decision expected in early October 2026.

3.6 Risk Management Policy and Framework Refresh

The Trust is refreshing its Risk Management Policy, Framework and supporting procedures with Lineofsight and a dedicated working group. The update will align risk identification, scoring, review, escalation and reporting with the new committee structure; set minimum Datix documentation standards; and clarify how programme and project risks connect to Trust-wide governance. A draft policy is expected by the end of September 2026 and will be supported by a Board development session to inform a new risk appetite statement, a new risk strategy and updated procedures.

3.7 FINANCIAL IMPLICATIONS

No additional funding is sought through this report. The potential cost of a new risk management system has been considered as part of in-year financial planning.

3.8 LEGAL IMPLICATIONS

No specific legal implications arise directly from this assurance report.

3.8 PEOPLE IMPLICATIONS

No direct staffing implications arise from this report. Any implications relating to the risk are outlined in the relevant BAF risks.

3.9 WELSH LANGUAGE IMPLICATIONS

No direct Welsh language implications arise from this assurance report.

3.10 RISKS / REPUTATIONAL IMPLICATIONS

Relevant Strategic Risk - Board Assurance Framework (BAF)

08 - Governance

Operational Risks

Nil return.

Risk Number	Risk title	Risk lead	Current score

4. RECOMMENDATIONS FOR ACTION / DECISION

- **NOTE** the August 2026 public Trust Risk Register position, following EMB review on 24 August 2026, including risks in the Quality/Safety domains scoring 12 and above and risks in all other domains scoring 15 and above.
- **NOTE** the EMB discussion on new risks, consolidated Treatment Helpline risks, sub-threshold risks, overdue reviews, and the need to strengthen the quality and discipline of risk review arrangements.
- **TAKE ASSURANCE** that actions arising from EMB have been identified for follow-up, including reduction of overdue reviews, correction of scoring anomalies, clarification of risks versus issues, and strengthening of controls, actions, target dates and progress updates before onward reporting.

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	RISK TITLE & DESCRIPTION	INHERENT RATING	CURRENT RATING	TARGET RATING & EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS	CONTROLS IN PLACE & PROGRESS SINCE LAST REPORTING PERIOD
	Velindre Cancer Service										
	12+ Risks in the Quality and Safety domains										
1	3747 01.08. 25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment.	**20** 4x5	**12** 3x4	**6** 3x2 Target date: 1.10.26	→	1. Business case to be updated to include growth and resource requirements for next 3 year period. 2. Business case held by SACT improvement group, reporting into the SACT Steering Group 3. 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.	**PROGRESS NOTES:** Risk review held with divisional Tri on 11/08/26- advised that the scalp cooling SBAR is to be presented at QSE Committee September 2026.
2	3714 24.06. 25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches	**16** 4x4	**15** 3x5	**6** 2x3 Target date: 30.09.26	→	1. SACT Escalation - Create policy/procedure/protocol/process/guideline. 2. RAG rated escalation document to be written with associated actions based on Chair Capacity / Pharmacy Capacity / 3. 3. Numbers on pending list and so on. Ongoing work - link to whole site sit rep and daily meetings	**PROGRESS NOTES:** Team at establishment, however x1 LTS. Recognised that the team are under resourced against demand with no increase in establishment over recent years. This is quantified within the SACT Business case which has been submitted to the Division and is being discussed during August 26, with a proposal to increase the workforce. Link to SACT capacity risk number 3747.

TRUST RISK REGISTER – SEPTEMBER 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).

3	3969	VCS	Safety	Head of Nursing	There is a risk that patients may not be escalated appropriately to senior decision maker due to unclear escalation pathways, staff uncertainty, scope of practice or availability of on call team due to other workload pressures, resulting in delayed decision making, inappropriate management and increased risk of harm.	**20** 5x4	**12** 4x3	**8** 4x2 Target date: 18.12.26	↓	1. Clarify and map escalation pathways and produce quick reference guides for staff within resource folder 2. Define role and responsibilities 3. Clarify when escalation to senior decision maker is mandatory 4. Review of on call workload patterns and use of AOS consultant/ consultant on call 5. Review of helpline data to determine wider workforce planning is required 4. Undertake monthly audit of calls on AMaT to assess compliance with escalation . 5. Benchmark with other providers to assess their protocols for escalation 6. Workforce – consider additional member of staff covering helpline – ACP or Medical (Clinical fellow level)	**Progress Notes** Following Monthly audits undertaken on AMaT demonstrate where appropriate triage compliance processes 100% Attend anywhere treatment Helpline clinic set up to enhance assessment processes by enabling virtual assessments to be undertaken where appropriate - staff working in the helpline have been granted access by digital team and this has been used with a small number of patients with positive feedback - will continue to work with digital team for further roll out and use of this platform. The Head of nursing for AIPC shadowed helpline team. Whilst triage and escalation processes are improving the risk score remains the same due to the risk of delay in call answering times ongoing work to minimise inappropriate calls, call redirection from other departments and maximise efficiencies within the helpline. Review of the Treatment Helpline risk profile, this risk now incorporated into Risk 3967 and 3968, which provides a comprehensive description of risks associated with access, clinical triage, escalation and timely decision-making within the Treatment Helpline service. To avoid duplication and improve oversight, therefore the title and description has been altered to reflect all three.

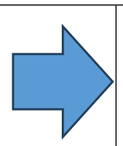
TRUST RISK REGISTER – SEPTEMBER 2026

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).

	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
4	3418 03.07. 25	WBS	Quality/ Safety	Director of Welsh Blood Service	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 30.11.26	⇨	1. Implementation of LIMS 2 in Transfusion Laboratories, ensuring all relevant workflows are transitioned and staff are trained, to reduce the likelihood of reporting errors, as evidenced by a measurable reduction in incident reports or data discrepancies related to reporting errors within 6 months post-implementation.	**PROGRESS NOTES:** By 30 November 2026, implement the NHS Wales LIMS 2 Programme within Transfusion Services, ensuring all relevant workflows are transitioned and staff are trained, to reduce the likelihood of reporting errors, as evidenced by a measurable reduction in incident reports or data discrepancies related to reporting errors within 6 months post-implementation. Target date has increased to 30 November due to delays in project timelines The risk has been reassessed in light of the HistoTrac LIMS implementation in Transplantation. Although manual transcription has been partially reduced, repeated incidents of incorrect reporting continue within Transfusion, with associated SABRE reporting to the MHRA. As a result, the likelihood cannot be reduced at this time. Mitigating actions include the planned implementation of LIMS 2 in Transfusion, scheduled for 30 November 2026. A revised risk assessment has been attached under documents.
5	3716 24.06. 25	WBS	Quality	Director of Welsh Blood Service	There is a risk to patient safety as a result of reusing sample numbers leading to incorrect patient results reported.	**12** 4x3	**12** 4x3	**8** 4x2 Target date 30.09.27	⇨	1. Ensure that Immulink information sent manually contains only current sample results. Update LAB-066, Printing and Reporting of Results from NEO Iris; the SOP is in draft and awaiting review. 2. Update the middleware so that it no longer supports the reuse of sample numbers; this will be completed through the change management process.	**PROGRESS NOTES:** No change to risk- managing manually and no further incidents. Action remains outstanding to implement the new LIMS system. The TCLE National Project has an estimated completion date of September 2027. Action will be measurable by the implementation of TCLE system. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of the TCLE LIMS system will directly address this risk; the estimated completion date is September 2027.

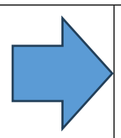
TRUST RISK REGISTER – SEPTEMBER 2026

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).

6	3388 07/05/ 24	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	**16** 4x4	**16** 4x4	**2** 2x1 Target date 31.12.26		1. Development, testing, and validation of the FEDIS, eMPI and WRRS interfaces (project PR000553 under Transplantation workstream of WBS Futures). 2. Update the intermittent message transmission issue within the DHCW	**PROGRESS NOTES:** Stable/No movement – The risk continues to be dependent on DHCW resolution of issues affecting the FEDIS demographic and reporting integrations. The intermittent messaging issue within the DHCW SIT environment remains unresolved despite ongoing technical investigations and escalation. DHCW have indicated that WBS may proceed with SIT sign-off on a risk-managed basis by undertaking multiple message transmission tests to provide sufficient assurance while investigations continue. Although this provides a potential route to progress, formal SIT testing remains dependent on DHCW resource availability. DHCW have advised that testing support is unlikely to be available before September 2026 due to competing priorities and resource constraints associated with Welsh Government-mandated programmes. As a result, progression through SIT and UAT remains delayed, with no confirmed scheduled dates. A meeting has been arranged with DHCW for 14/08/2026 to agree the remaining delivery approach, including SIT, UAT and go-live activities, and to obtain a clearer end-to-end implementation plan. The issue continues to be actively managed through PR000553 and remains escalated via WBS Futures and senior Digital leadership. The approved project extension currently supports a planned go-live by the end of October 2026 and project closure by the end of November 2026. However, continued delays may result in resource conflicts with other priority digital programmes and may require consideration of alternative delivery or resourcing arrangements. The clinical impact remains unchanged, with continued limited visibility of fetal RhD results across Welsh Health Boards due to the absence of the planned system integration.

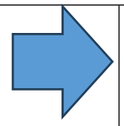
TRUST RISK REGISTER – SEPTEMBER 2026

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).

7	3643 11/04/2025	WBS	Quality/Safety	Director of Welsh Blood Service	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 Target date 30.11.26		1. Implementation of WLIMS2.0 in WBS as priority 2. 2. Re-prioritise WBS Future projects in RCI to create testing capacity for WLIMS2.0 and provide support to local HB to ensure National Delivery 3. Re-direct staff resources to increase the pace of User Acceptance Testing and Validation activities for WLIMS2.0. 4. Understand inter-dependencies with national progress and feasibility of go live by September 2026. 5. Collaborate with Transfusion colleagues across Wales to progress the national deliverables for the 'core' functionality which is a pre-requisite for WBS implementation. 6. Review of scope, complexity, and risk of a series of prioritised improvements to legacy system (SERIF).Action outstanding to implement new LIMS system. TCLE National Project has a estimated completion of September 2027. 7. Action will be measurable by the implementation of TCLE system	**PROGRESS NOTES:** Overall risk has not changed. Updated additional mitigations for increasing risk section to align with implementation date for LIMS. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of TCLE LIMS system will directly address this risk- implementation date delayed to 30/11/2026.
	15+ Risks in other domains										

TRUST RISK REGISTER – SEPTEMBER 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).

8	3801 14.10.25	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	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: 30.11.26		1. Management of FEDIS Phase 2 Delays and DHCW Dependency 2. Continue to escalate FEDIS Phase 2 delivery delays and risks to the WBS Futures Delivery Board to obtain indicative timelines from DHCW. 3. Maintain active monitoring of project progress through weekly touchpoint meetings with DHCW and updated project plan. Identify and implementing feasible efficiencies to reduce the duration of UAT and validation where possible.	**PROGRESS NOTES:** The intermittent message transmission issue within the DHCW SIT environment remains unresolved despite ongoing technical investigations, weekly engagement and escalation. DHCW have advised that WBS can progress towards SIT sign-off on a risk-managed basis by undertaking multiple message transmission tests to provide assurance while investigations continue. However, progression remains dependent on DHCW resource availability. DHCW have indicated that formal SIT testing support is unlikely to be available before September 2026 due to competing priorities and resource constraints associated with Welsh Government-mandated programmes. As a result, completion of SIT, progression to UAT and implementation timelines continue to be delayed, with no confirmed dates. The project team remains concerned regarding the absence of an agreed end-to-end implementation plan covering completion of SIT, UAT, go-live and support arrangements. A meeting has been arranged with DHCW for 14/08/2026 to agree the remaining delivery approach and obtain greater clarity regarding timescales and responsibilities. An Exception Report has been approved extending project resources to support a planned go-live by the end of October 2026 and project closure by the end of November 2026. However, continued delays increase the likelihood of further extension, resulting in resource conflicts with other priority digital programmes which may impact the ability of WBS to maintain dedicated Digital, Validation and operational support for the project beyond this period. The issue remains escalated through WBS Futures and senior Digital leadership. The patient and service impacts remain unchanged, with ongoing limited accessibility of fetal RhD results through national clinical systems and continued reliance on alternative reporting arrangements. Risk score remains unchanged at present but will require review should further slippage occur beyond the currently approved project timelines.

TRUST RISK REGISTER – SEPTEMBER 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	4003 *new risk Risk accepted July 26	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	There is a risk to reputation, performance and service sustainability as a result of the ongoing use of end of life FoxPro and DOS based systems in respect of interfacing requirements with laboratory systems and databases, leading to IT system failures and inability to provide one or more WBMDR services.	**15** (5x3)	**15** (5x3)	**5** (5x1) Target Date: 31.12.27	New risk	1. Recruit and onboard WBMDR project resources 2. Review, update and obtain approval for the User Requirements Specification (URS) 3. Confirm procurement strategy and prepare procurement documentation 4. Establish governance arrangements for project delivery 5. Confirm project board membership and reporting arrangements	Reporting to Digital Modernisation Board and project board monthly DPIF funding has been secured for the procurement phase until March 2027. This project also includes the development and implementation phases. Action will be updated in Q3.
10	4004 *New risk Accepted July 26	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk to reputation, performance and service sustainability as a result of the ongoing use of end of life FoxPro and DOS based systems in respect of the global communication with external registries, leading to IT system failures and inability to provide one or more WBMDR services.	**16** (4x4)	**16** (4x4)	**4** (4x1) Target Date: 31.12.27	New risk	1. Recruit and onboard WBMDR project resources 2. Review, update and obtain approval for the User Requirements Specification (URS) 3. Confirm procurement strategy and prepare procurement documentation 4. Establish governance arrangements for project delivery 5. Confirm project board membership and reporting arrangements 6. By 30 September 2026, the following will be completed: • Full multi-disciplinary project team recruited and onboarded. • User Requirements Specification reviewed, updated and formally approved. • Procurement strategy agreed with NWSSP Procurement. • Procurement documentation completed and approved. • Project governance framework established and operational. • Project Board membership confirmed with agreed Terms of Reference and reporting arrangements. • Dependencies • Availability and engagement of WBMDR subject matter experts. • Timely support from NWSSP Procurement and relevant procurement governance groups. • Stakeholder agreement on system requirements and project scope. • Availability of organisational recruitment support and approval processes. • Engagement of Project Board members and senior stakeholders. • Project Board meetings scheduled and reporting arrangements implemented.	DPIF funding has been secured for the procurement phase until March 2027. This project also includes the development and implementation phases. Action will be updated in Q3. Cost below is only for procurement phase.

TRUST RISK REGISTER – SEPTEMBER 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).

11	3306 15/01/25	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	**20** 5x4	**15** 5x3	**5** 5x1 Target date: 01.12.26	⇨	1. Incoming electrical supply to be upgraded to dual supplies, this will be actioned with TGI planned works. 01/12/2026	**PROGRESS NOTES:** No change to risk, continue to manage the PPM programmes in place across site.
Corporate											
15+ Risks in other domains											
12	3646 15.04. 2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline, affecting the realisation of project outcomes and creating additional demand for further development of existing legacy systems.	**20** 4x5	**20** 4x5	**4** 2x2 Target date: 30.11.26	⇨	1. CEO of DHCW took a paper to DDAT Board regarding congestion in digital planning quarter 4. 2. Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. 3. Agree the new launch date with WBS Futures Programme. 4. Mitigation plan in place with existing SERIF system.	**PROGRESS NOTES:** Internal work for WLIMS is largely complete and low risk. the national programme continues to be challenged. September is still the official go live Tranche five, however it is expected to shift to October 2026. WLIMS has been escalated to the CEO management team. There is no change to the current risk rating.
13	3656 24.04. 25	Corporate	Multiple Risk Domains	Director of Corporate	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: 30.11.26	⇨	1. Assurance mapping to be reviewed and completed by September 2026 2. Implementation of NWSSP Review Recommendations to be completed by end of September 2026.	**PROGRESS NOTES:** Ongoing progress on assurance maps. On track for completion by end of September. WG implementation group considering all relevant issues and on track for completion of majority by end of September. Target date amended to end of November 2026, with amendments to Standing Orders as evidence of conclusion.
14	3633 15.04. 25		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 Trust's 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: 30.10.26	⇨	1. Agree with DHCW a prioritised integration plan for IRS, WHAIS and FEDIS, including named leads, dependencies and delivery milestones. 2. Maintain regular programme-level engagement with DHCW to monitor SIT, UAT, assurance and go-live readiness, escalating unresolved constraints through the agreed governance routes. 3. Develop and maintain risk-managed contingency arrangements for delayed national integration, with progress reported through Trust and DHCW digital governance.	**PROGRESS NOTES:** FEDIS is progressing, due for go live in October and monitoring until November 2026. WHAIS is proceeding to plan. Risk review, rating unchanged.

TRUST RISK REGISTER – SEPTEMBER 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
3967	Velindre Cancer Centre	Safety	Head of Nursing	There is a risk of incorrect clinical triage of patients who contact the Velindre treatment helpline due to variable staff experience, inconsistent application of the triage tool or incomplete triage assessment resulting in delayed access to safe and timely assessment and intervention, delayed escalation, unmanaged symptoms.	**15**	**12**	**10**	→	Following review of the Treatment Helpline risk profile, this risk has been incorporated into Risk 3969, which provides a comprehensive description of risks associated with access, clinical triage, escalation and timely decision-making within the Treatment Helpline service. To avoid duplication and improve oversight, this risk will be managed through Risk 3969 and is therefore closed.
3968	Velindre Cancer Centre	Safety	Head of Nursing	There is a risk that patients may be unable to access timely clinical advice during peak demand or out of hours due to their call being unanswered at switchboard, insufficient staffing in the helpline, rising call volumes and complexity, or inappropriate calls being redirected to the helpline, resulting in delayed escalation, unmanaged symptoms, increased emergency admissions, reduced patient confidence in the service and increased levels of reported patient concerns.	**15**	**12**	**5**	→	Following review of the Treatment Helpline risk profile, this risk has been incorporated into Risk 3969, which provides a comprehensive description of risks associated with access, clinical triage, escalation and timely decision-making within the Treatment Helpline service. To avoid duplication and improve oversight, this risk will be managed through Risk 3969 and is therefore closed.
3881	Corporate	Performance and Service Sustainability	Chief Pharmacist	There is a risk to performance and service sustainability and clinical safety as a result of Pharmacy Technical Services having insufficient Quality Assurance resource & expertise, which will lead to non-compliance of the Pharmaceutical Quality Assurance requirements of the service and ultimately reduced aseptic unit capacity because of either internally imposed or externally-enforced restrictions	**12** 3x4	**12** 3x4	**6** 3x2	↓	PROGRESS NOTES: 0.4 WTE QA Pharmacist appointed to 21 Aug; likely to onboard Nov. Business case approved for maternity leave backfill, about to go to advert. Development of proposal to secure Consultant QA Pharmaceutical Lead services initiated.

Trust Board		
Board Assurance Framework Report		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	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 • 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	
REPORT SPONSOR	Non Gwilym, Interim Director of Corporate Governance	
SCRUTINY ROUTE TO DATE		
	24/08/2026	Executive Management Board
	08/09/2026	People, Culture and Engagement Committee BAF 06
	10/09/2026	Performance and Finance Committee BAF04 and BAF05
	15/09/2026	Quality, Safety and Experience Committee BAF01, BAF02 and BAF07
	17/09/2026	Audit and Risk Assurance Committee BAF01-BAF08
ONWARD SCRUTINY ROUTE	n/a	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 2 - RED (Some measurable impact evident from actions initially taken)	
EXECUTIVE SUMMARY	This paper provides the Trust Board with an overview of the development of the Board Assurance Framework (BAF), the current position of public strategic risks BAF 01–BAF 08, and the arrangements being strengthened to support effective Board oversight. The BAF is maturing under the revised committee structure, with clearer Executive ownership and more detailed	

	scrutiny of strategic risks. Some improvements are evident in the articulation of controls, assurance gaps, mitigating actions and links to operational risks outlined in the appendices. However, further work is required to evidence control effectiveness consistently, explain static risk scores, strengthen traceability across the risk hierarchy, and consolidate committee assurance into a clear Trust-wide view. The Board is therefore asked to note the current position and the priorities for further improvement
ACTION / DECISION	The Trust Board is asked to: • **NOTE** the current BAF and strategic risk position, the positive but qualified assurance on the developing arrangements, and the priorities identified to strengthen strategic risk oversight.
ADDITIONAL RESOURCES	n/a

RELEVANT TRUST STRATEGIC GOALS

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

RELEVANT TRUST WELLBEING GOALS

• A Prosperous Wales
• A Healthier Wales
• A globally responsible Wales

QUALITY AND SAFETY IMPLICATIONS

This report impacts one or more of the following Six Domains of Quality:

- Safe
- Timely
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)

Not required. This is an assurance report and does not seek a new strategic decision.

Status: QIA not required - not a strategic decision

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Not required - There are no specifc equality, diversity or inclusion impacts related to the activity in this report

APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	BAF 01
	Appendix 2	BAF 02
	Appendix 3	BAF 03
	Appendix 4	BAF 04
	Appendix 5	BAF 05
	Appendix 6	BAF 06
	Appendix 7	BAF 07
	Appendix 8	BAF 08

KEY CONSIDERATIONS

1. SITUATION

1.1 This paper provides Trust Board with an overview of the current development of the BAF, the position of public strategic risks BAF 01–BAF 08 and the arrangements being strengthened to support effective Board oversight. It highlights progress, the principal areas requiring further development and the actions planned to improve the quality and coherence of strategic risk assurance.

2. BACKGROUND

2.1 Strategic risks are allocated to the relevant Board committees for detailed scrutiny of controls, assurances, gaps and mitigating actions. Corporate Governance consolidates this intelligence to support a coherent Trust-wide view, while the Audit, Risk and Assurance Committee oversees the effectiveness of the underlying risk-management and assurance processes.

2.2 The developing Executive Risk Forum and integrated committee reporting model are intended to strengthen Executive challenge, improve consistency and provide clearer consolidated assurance to the Board. Planned committee deep dives and better alignment of reporting cycles will support timely escalation and provide further evidence of whether controls and actions are reducing exposure.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 The quality of the BAF is improving through clearer Executive ownership, stronger descriptions of controls and assurance, more specific mitigating actions and better linkage to the Trust Risk Register and operational risks.

3.1.2 Strategic risks that remain at the same score over an extended period require a clear explanation of why exposure has not changed, whether residual risk is being tolerated, the

impact of mitigating actions and whether further action is required. Executive risk owners remain accountable for maintaining accurate and complete strategic risks and demonstrating that controls and assurances are effective.

3.2 Committee consideration: August-September

3.2.1 The new committee structure provides the principal route for detailed scrutiny of individual BAF risks, with each strategic risk allocated to a lead committee and associated operational risks aligned for review. Committee-level scrutiny will inform the continuing development of the BAF and support escalation to the Board where changes in risk exposure, assurance gaps or material delivery concerns are identified.

3.2.2 Executive Management Board noted that the framework is developing positively and becoming easier to read and more accessible. EMB also recognised that further work is required to improve consistency, strengthen the assurance narratives and ensure the BAF operates as a clear Board-level tool for monitoring strategic risk exposure, controls, assurances, gaps and delivery of mitigating actions.

3.2.3 The People, Culture and Engagement Committee noted that BAF06 remains a work in progress with the Executive Director explaining that it is currently under review and scheduled for further development and scrutiny. Concurrently, work is underway to review the operational risks underpinning BAF 06. The Committee agreed to conduct a deep dive at its November meeting.

3.2.4 The Performance and Finance Committee noted the way strategic risks will be scrutinised within the new governance structure, with detailed consideration of the Financial Sustainability and Sustainability strategic risks and agreement on future areas for deeper scrutiny. BAF 04 and 05 received detailed scrutiny.

3.2.5 The Committee considered BAF 04 (Financial Sustainability) and received assurance from the NHS Wales Grip and Control review that financial governance arrangements remain robust, with improvement actions identified but no significant issues requiring escalation. Members requested clearer target dates and future deep dives on key areas such as commissioning and Long-Term Agreements (LTAs).

3.2.6 The Committee also reviewed BAF 05 (Sustainability), noting progress in climate action, environmental sustainability and staff engagement initiatives. Discussion focused on ensuring sustainability is embedded within service planning, clinical decision-making and future infrastructure developments, with further work required to better reflect this activity within future risk reports.

3.2.7 The Quality, Safety and Experience committee acknowledged the updates to BAF 02 which it believed had been significantly strengthened. Clear executive ownership had been established and gaps in controls and assurances had been reviewed and updated. Deep dives on each of the three strategic risks aligned to the committee would be taken at future meetings.

3.2.8 The Audit and Risk Assurance Committee (ARAC) considered the BAF on 17 September. The Committee broadly agreed that:

- risk management arrangements are improving;
- Executive ownership of some strategic risks is strengthening;
- the new committee structure should provide better assurance to Board;
- the successful embedding of the ARAC's remit and role in coordinating assurance from the Board's committees and the establishment of the new Executive Risk Forum were deemed critical to future success.

The committee also identified a number of priorities for future reporting:

- Stronger narrative explaining rationale for static risks.
- Stronger alignment between operational risks and strategic BAF risks.
- Clear evidence that all relevant operational risks feed into strategic risks.
- Improved written reporting of committee discussions to ARAC.

As BAF 08 is the strategic risk allocated to ARAC, the Committee considered Strategic Risk 8: Organisational and Clinical Governance in further detail. It noted that the risk score remains static but is expected to reduce once the NWSSP Governance and Accountability Review implementation work is concluded and the revised Risk Management Policy has been approved and embedded.

Overall, the discussion was largely positive and constructive. Members recognised significant progress in risk governance but acknowledged that the new arrangements remain in early implementation. The emphasis was on improving executive ownership, and ensuring clear line of sight from operational risks through to strategic Board risks and Board assurance.

3.2 FINANCIAL IMPLICATIONS

No additional funding is sought through this report. The financial implications are indirect and relate to ensuring that governance, risk management and assurance arrangements provide appropriate oversight of financial stewardship, internal control, audit recommendations and escalation of risks that may affect delivery of the Trust’s objectives. Any financial decisions arising from specific mitigating actions will be taken through the appropriate governance and approval route.

3.3 LEGAL IMPLICATIONS

No specific legal implications arise directly from this assurance report. The report supports scrutiny of strategic risks, controls, assurances, gaps and actions through the Trust’s established governance arrangements. Any legal implications arising from specific mitigating actions or future decisions will be considered through the relevant approval route.

3.4 PEOPLE IMPLICATIONS

No direct staffing implications arise from this report.

3.5 WELSH LANGUAGE IMPLICATIONS

No direct Welsh language implications arise from this assurance report. Any specific Welsh language considerations arising from future mitigating actions or service changes linked to the Board Assurance Framework risks will be considered through the relevant planning, consultation and governance routes.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Public strategic risks BAF 01 – BAF 08 in the Board Assurance Framework

Operational Risks

3.6.2 Associated operational risks are included in appendices for reference.

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

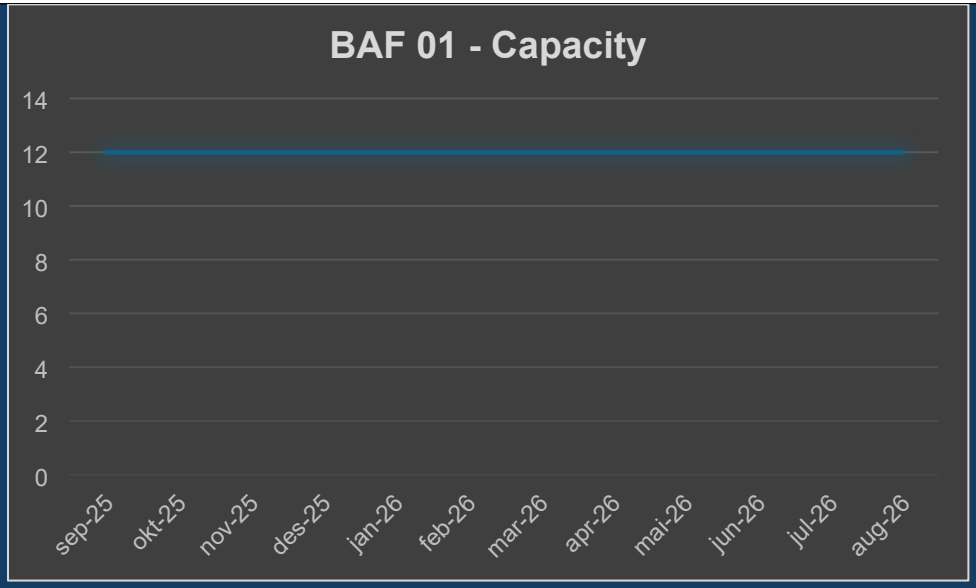
- **NOTE** the current BAF and strategic risk position, the positive but qualified assurance on the developing arrangements, and the priorities identified to strengthen strategic risk oversight.

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	
		August 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			January 2026			March 2026			May 2026			July 2026			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	Insufficient capacity within the SACT day case service leading to delays in patients receiving SACT treatment.	12
	3714	Increased demand on the SACT booking team leading to delay in scheduling SACT treatments and potential breaches.	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.	Work is progressing at a UK and Welsh level to support delivery of the Infected Blood Inquiry recommendations, with strengthened leadership, governance and delivery arrangements in place. Key areas of focus include digital connectivity and transfusion laboratory workforce, both identified as priorities to support implementation across NHS Wales. WBS is progressing work to map workforce	WBS Director	December 2026

			requirements for transfusion laboratory services, in partnership with Health Education and Improvement Wales, and is developing an Outline Business Case to define the digital requirements needed to support delivery of recommendations, including the ability to better understand and report patient outcomes. Delivery remains dependent on securing appropriate resource and system support across NHS Wales.		
	01.03	Develop and progress capacity and demand business cases across key operational areas within WBS, and engage with commissioners (JCC) to secure agreement and funding to support sustainable service delivery. 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	Initial capacity and demand business cases across WBS operational areas were not approved; however, work is ongoing to engage with JCC. **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	WBS Director	March 2027

		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.	development to provide assurance on supply chain alignment. First draft due Q1/2 2026/27; development of supporting dashboard starts in Q3 2026/27.		
	01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing capacity within the outpatient facility and providing care closer to home for the patient	Revised Modelling being undertaken by the Data & Insights Team using the GE 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.	VCS Director	August 2026
	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	VCS Director	February 2026

			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.		
	01.06	Strengthen WBS service resilience and infrastructure assurance.	Existing business continuity and supply resilience arrangements are in place, with ongoing monitoring through operational and escalation routes. The Business Justification Case and Outline Business Case for the Talbot Green Infrastructure Programme have been submitted to Welsh Government to support infrastructure upgrades, service sustainability and future capacity requirements. Work is ongoing to develop to Full Business case stage.		December 2026
	01.07	Strengthen oversight of digital dependencies affecting WBS capacity and sustainability.	Programme governance arrangements are in place, with risks escalated through relevant WBS, Trust and national routes. Further work is required to	Chief Digital Officer / WBS Director	December 2026

			provide a consolidated view of digital dependency risks, delivery confidence and impact on WBS capacity and sustainability.		

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) Blood Supply Chain Planning Group and developing Operational Assurance Framework to strengthen oversight of demand forecasting, collection activity, component production, supply chain resilience and capacity planning. Digital dependency management for WBS critical systems and programmes, including escalation of national and supplier-related risks through appropriate WBS, Trust and national governance routes. Commissioning and investment planning controls, including development and resubmission	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). Limited organisational control over national and supplier-led digital programme timelines, including WLIMS2.0, FEDIS and BECS dependencies, which creates uncertainty for WBS capacity and sustainability planning. Delivery of infrastructure improvements remains dependent on approval and funding of the TGI	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. Blood Supply Chain Planning Group reporting and development of the Operational Assurance Framework, including oversight of demand forecasting, collection	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 Limited assurance on delivery confidence for national and supplier-led digital programmes that affect WBS capacity and sustainability, including WLIMS2.0 and FEDIS. Limited assurance that capacity and demand business cases will secure the investment required to mitigate known demand and sustainability pressures.

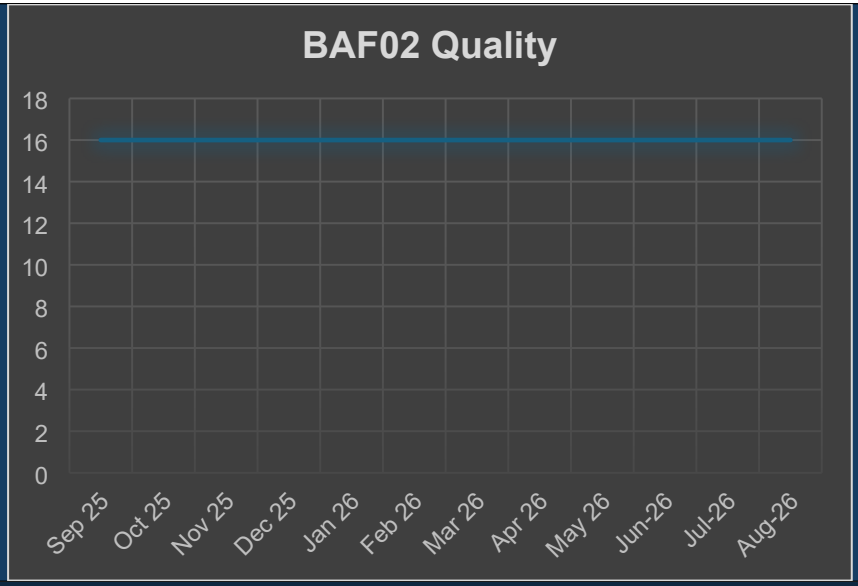
of capacity and demand business cases to support sustainable service delivery. Infrastructure resilience and capacity planning are managed through the Talbot Green Infrastructure (TGI) Programme, including development and submission of the Business Justification Case (BJC) and Outline Business Case (OBC) to support infrastructure upgrades, service sustainability and future capacity requirements.	Business Case, limiting current organisational control over timing and implementation of required upgrades. Capacity and demand business cases have been developed and submitted to JCC , but delivery of some mitigations remains dependent on commissioner support and investment decisions.	activity, component production and supply chain resilience. Programme reporting through WBS Futures and relevant digital governance routes, including monitoring of delivery risks, national dependencies and supplier-related risks affecting WBS sustainability. Commissioner engagement and JCC review of WBS capacity and demand business cases to support scrutiny of service sustainability requirements.	

Risk 02	There is a strategic risk that the quality, safety and experience outcomes the Trust seeks to achieve for patients, donors and populations may be adversely impacted if the organisation is unable to effectively deliver, embed and sustain the improvements, transformation, leadership and governance arrangements required to meet increasing service complexity and future expectations.	**Date of Risk** 1 April 2026 **Last Review Date** August 2026	**Current Risk Score** 16

Executive Summary	The Trust continues to pursue ambitious improvements in quality, safety and experience whilst managing increasing service complexity, workforce pressures and significant organisational transformation. Progress is being made across quality improvement, patient and donor experience, organisational learning and service redesign programmes. However, variation in outcomes, experience, workforce capacity, data gaps and the pace of change across services means there remains a risk that the Trust does not fully achieve its ambition to provide harm-free care, excellent outcomes and experience, and be recognised as an outstanding organisation. Continued focus is required on strengthening quality governance, organisational learning, compassionate leadership, workforce capability and delivery of improvement priorities.

Associated Strategic Objectives	Outstanding for quality, safety and experience • Deliver consistently safe, effective and person-centred care that achieves the best possible outcomes and experience for patients, donors and populations **in line with national and organisational policies and strategies.**. • Embed a culture of continuous learning and improvement, informed by patient, donor and staff feedback, quality intelligence and outcomes. • Demonstrate compassionate, inclusive and visible leadership at every level of the organisation. • Maintain exemplary standards of quality, safety and governance that meet or exceed organisational**,** regulatory, professional and accreditation requirements. • Be recognised nationally and internationally as a leading organisation for quality, safety, experience and clinical outcomes.	**Exec Lead**	Director of Nursing, AHPs & Healthcare Science, Executive Medical Director & Chief Operating Officer
		Assurance Level	3
		Risk Appetite	Cautious

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			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
	3747	Insufficient SACT day case capacity leading to delays in patients receiving SACT treatment.	12
	3714	Increased demand on the booking team causing delays in scheduling SACT treatments and potential breaches.	15
	3969	Treatment Helpline escalation and timely decision-making risk, incorporating access, triage and escalation arrangements.	15
	3418	Pre- and post-examination process risk for tests yielding patient results, with potential adverse impact on patient care.	12
	3388	FEDIS interface limitations affecting accessibility of reports and potentially impacting antenatal care.	16
	3643	Aged Laboratory Information System risk affecting RCI and Automated Testing ability to operate a safe service.	16
	3801	FEDIS Phase 2 schedule slippage and DHCW dependency affecting fetal DNA screening sustainability and go-live certainty.	16
	3870	Trust response to Infected Blood Inquiry recommendations and potential impact on service provision to the population in Wales.	15
	3534	Capacity to deliver the Vulnerable Persons workplan, impacting statutory responsibilities and equality of care for patients and donors with additional needs.	12
	3633	DHCW capacity to integrate VUNHST digital systems into national architecture, affecting delivery of digital systems supporting strategic objectives.	12
	3656	Quality of clinical and corporate governance assurance and reporting arrangements for hosted services.	15

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	02.01	Implement the digitisation of a robust set of service level to Board quality, safety	Some enhancements made to PMF further work	Director of Strategy, Planning & Performance	Dec 2026

		outcome and experience metrics including mortality, aligned with the Performance Management Framework.	required in respect of mortality metrics, PROMs and increasing patient experience feedback at VCS. WBS has established routine reporting of quality, safety and donor experience metrics through the PMF, with improved visibility of laboratory indicators and donor feedback. Further work is required to strengthen Board-level alignment, enhance outcome measures and support integration with developing digital systems. A Integrated Performance Framework Task and Finish Group was established in July 2026. This group is responsible for revising and refreshing the performance management process, which will include bringing together the quality and activity performance metrics into an integrated performance framework. This work also includes consideration of the mechanism used to produce the performance information and will take into account Welsh Government expectations around standardisation and use of digital platforms to produce the reports. This work aims to		

			produce a final draft product by December 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. WBS continues to roll out investigation training with improving uptake. Review of recent incidents has identified recurring themes, highlighting the need to further embed training and strengthen the quality and consistency of investigations to support learning and improvement. The Corporate Quality and Safety Team have developed a comprehensive investigation training package. The investigation incorporates, human factors, system thinking and takes a treat me fairly approach to professional curious investigation training. The sessions are available to book to all relevant staff and support is provided to trained staff to undertake an investigation. The training has been well evaluated by all staff who have attended, and the Trust has increased its pool of trained investigators.	Director of Nursing, AHP and Health Science	Sept 2026

			A recent Welsh Risk Pool assessment commended the quality of Trust part 5 investigation reports during the assessment fieldwork.		
	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. Will be going live in VAP to improve clinical efficiency in Q3. Plan in place to roll out across VCS over the next 2-3 years. Work ongoing to import the data to facilitate meaningful analysis and ease of access for clinicians for direct patient care. Data flow approved for integration with NDR (for WCP) and NHS App. Integration with WCP due December 2026.	Executive Director Finance	March 2028
	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 General Meds is about to go into UAT with Nov target for go-live	Chief Digital Officer	Nov 2026
	02.05	Fully implement all Trust required IBI recommendations.	WBS is contributing to the Trust response to IBI recommendations through established governance and national engagement, with ongoing work in transfusion laboratory education and national digital programmes to strengthen training, data connectivity and reporting.	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. Implemented across VelinTrust. Awaiting nation	Director of Nursing, AHP and Health Science	Sept 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 published by WHC April 2026. Self-assessment completed , to re assess as part of Trust review around Experience, coproduction and engagement.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	October 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, Executive medical director and Executive Director of Nursing, AHP and Health Science	August 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	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	Sept 2026

			level to accountable Director. Benchmarking and Peer Review being incorporated into service redesign and performance, where possible. Trust wide learning framework review 10 Sept 26. Fully engaged with national learning networks and aligning as systems under review.		
	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	Sept 2026
	02.11	Implement a Quality Dashboard and balanced score card	Site visit held – project / implementation plan required - timescales for delivery unclear. Digital resource currently focused on PMF then on Quality dashboard.	Chief Digital Officer	Oct 2026
	02.12	Strengthen WBS portfolio prioritisation and sequencing	WBS has strengthened portfolio prioritisation through the WBS Futures governance framework, with improved alignment to strategic priorities and clearer management of programme interdependencies. Further work is underway to enhance oversight and align prioritisation to capacity and demand.	Chief Operating Officer / WBS Director	October 2026
	02.13	Implement capacity and demand planning for transformation delivery at WBS	WBS is reviewing change control processes and developing a workforce	Chief Operating Officer / WBS Director	December 2026

			planning approach to support capacity and demand planning for transformation delivery.		
	02.14	Strengthen governance and assurance of WBS transformation delivery	WBS has strengthened governance of transformation delivery through WBS Futures, improving visibility and escalation of programme risks and dependencies. Further work is underway to align programme reporting with portfolio oversight and Board assurance.	Chief Operating Officer / WBS Director	October 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
• Quality, safety and experience oversight through the Trust Performance Management Framework (PMF), Annual Management Action Tracker (AMaT), Executive Management Board (EMB), Quality, Safety and Experience Committee (QSPc) and divisional governance arrangements. • Trust Patient Safety Framework, Putting Things Right arrangements, organisational learning framework, duty of candour processes and investigation management systems.	• PROMs, outcome measures and mortality metrics are not yet fully embedded within routine performance reporting, limiting comprehensive oversight of quality outcomes. • Service-level balanced scorecards and a Trust-wide quality dashboard are not yet implemented, reducing visibility of quality, safety, experience and	• Regular review through EMB, QSPc, Trust Board and relevant sub-committees. • Performance Management Framework reporting, quality and safety reporting, experience reporting and corporate performance reviews. • Internal Audit reviews and follow-up of management actions.	• Limited Board assurance regarding patient-reported outcome measures (PROMs) because routine reporting and analysis are not yet fully established. • Incomplete assurance regarding mortality, outcomes and quality impact due to gaps in metric development and reporting. • Limited assurance that patient and donor feedback is consistently informing operational, strategic and Board decision-making. • Absence of a comprehensive quality dashboard and service-level balanced scorecards limits the Board's ability to triangulate quality, safety, experience, workforce and outcome intelligence. • Limited assurance regarding the effectiveness and sustainability of organisational learning and whether actions consistently result in measurable improvement. • Limited assurance regarding the maturity of governance and reporting arrangements for hosted services and some transformation programmes. • Reliance on external organisations, national programmes and digital delivery partners creates assurance gaps regarding delivery timescales and achievement of strategic benefits.

• Structured mortality review processes, Medical Examiner Service, clinical audit programme and regulatory compliance monitoring. • Established patient and donor experience feedback mechanisms, co-production arrangements and routine reporting of experience measures. • Workforce development, leadership and capability programmes, including the Velindre Oncology Academy, investigation training and professional development frameworks. • Quality improvement, benchmarking and peer review activity to support service redesign, organisational learning and performance improvement. • Integrated programme and risk management arrangements supporting major transformation programmes, including WBS Futures, digital transformation, nVCC readiness and service redesign programmes. • Portfolio governance, prioritisation and escalation	outcome performance. • Patient and donor voice is not yet systematically embedded through all governance and decision-making structures from service to Board level. • Organisational learning is not consistently translated into demonstrable and sustained improvement, with recurring themes identified through incidents, complaints and investigations. • Variation remains in the maturity and consistency of quality governance, assurance and reporting arrangements across services, including hosted services. • Capacity and demand planning, workforce	• External regulatory and accreditation scrutiny including Healthcare Inspectorate Wales (HIW), Wales Audit Office, Welsh Risk Pool and relevant professional or regulatory bodies. • Compliance monitoring against national standards, accreditation requirements and statutory obligations. • Mortality review reporting, Medical Examiner Service reports, clinical audit reports and quality improvement outcomes. • Organisational learning reports, incident investigations, complaints, claims and Putting Things Right reporting. • Patient and donor experience reporting,	• Limited assurance regarding future workforce capacity, transformation capability and organisational readiness to sustain the scale of change required to deliver Destination 2033 and the Trust's quality ambitions.

arrangements for major change programmes, including management of national dependencies with DHCW, Welsh Government and suppliers.	modelling and transformation delivery arrangements remain at varying levels of maturity across programmes and services. • Continued reliance on legacy digital systems and delivery dependencies outside Trust control creates vulnerability in the delivery of strategic improvement programmes. • Leadership, culture and quality improvement capability metrics are not consistently used to demonstrate the impact of compassionate and inclusive leadership on quality and safety outcomes.	engagement activity and feedback analysis. • Benchmarking, peer review activity and participation in national learning and improvement networks. • Programme reporting through transformation boards, WBS Futures governance structures and digital programme governance arrangements.	
30 Aug 2026: the current score of 16 remains appropriate. Whilst we have a significant number of controls in place and there has been good progress against many of the actions, there are still some important gaps in our quality intelligence, governance and assurance arrangements.			

We know there is variation across services, we are managing increasing complexity, workforce pressures and large-scale transformation programmes, and some of the key enablers we need, such as the quality dashboard, full PROMs reporting, mortality metrics and more systematic use of patient and donor voice, are not yet fully embedded.

The Board can therefore take assurance that the risk is being actively managed but there remains a realistic likelihood that we may not consistently achieve all of our quality, safety and experience ambitions if we do not continue to drive these improvements forward.

For that reason, I believe a residual score of 16 (Major x Likely) remains proportionate at this stage. The ambition is to reduce the score to 9 once the key actions have been delivered, the assurance gaps have been addressed and we can demonstrate that the improvements have become embedded and sustainable across the organisation.

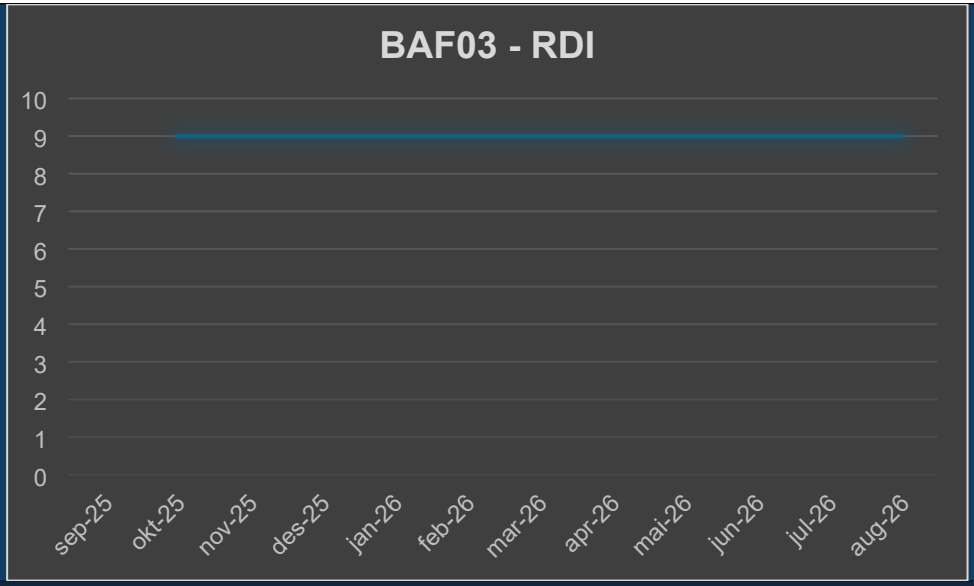
Gill Knight

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 August 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			January 2026			March 2026			May 2026			July 2026			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	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 recommendations to inform a phased programme of improvement and	• Associate Medical Director for RD&I • Cancer R&D Strategy Lead • Head of R&D • Research Delivery Manager	Dec 2026

			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 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.	• Head of R&D • Research Delivery Manager	Mar 2027

			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.	To be advised	Apr 2027

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	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 &	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,	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).

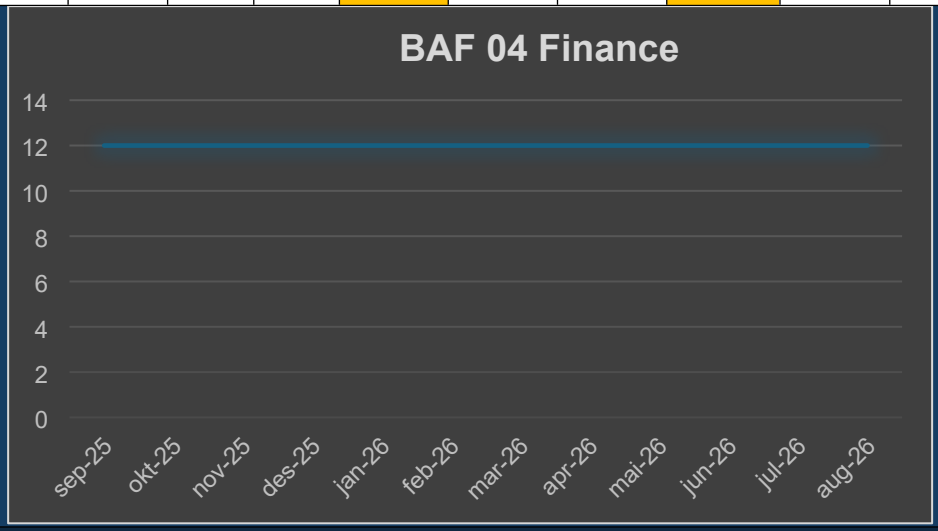
Benchmarking research activity (via OECI accreditation membership and UK peer cancer centre comparisons) Engagement with UK / National bodies Cardiff Cancer Research Partnership (CCRP) Welsh Blood Service research governance	Performance Committee (and Charitable Funds Committee / CCRP Project Board where 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.	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.	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.

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	
		August 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			January 2026			March 2026			May 2026			July 2026			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				
Action to Address Gaps	**Action ID**	**Action Detail**	**Progress Notes**	**Action Lead**	**Target Date**
	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 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.	EDoF / EDoSTP&D / DDoF / DDoP	Ongoing
	09.04	Development of Investment Appraisal process and prioritisation framework	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 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.	EDof / EDirector of Planning / COO / VCS Director	2026/27

			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.		
	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.	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). VCS is currently reported a LTA activity over performance for 2025-26 which was used to mitigate the risk on the RSU activity underperformance.	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. This resulted in a £0.825m loss in income recurrently from Hywel Dda UHB on NICE & HCD. 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		2027/28

			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 2027-28.		
	09.08	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	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. This has been shfited to qtr 2 due to capacity gaps in the team.	DDof/ Head of VBHC / Divisional Directors	October 2026 (revised from July 26)
	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 The draft 2025/26 Annual Accounts, Financial Returns & Remuneration Report were submitted to Welsh Government & Audit Wales by the required deadlines (1 May & 8 May 2026 respectively). Accounts were endorsed by the Audit Committee on the 24th of June and approved by Trust Board on 25th June, with final submission to WG due by 30 June 2026. The Trust's response to Audit Wales letter seeking information & assurances on fraud & governance matters was submitted on 8 May 2026. lessons learnt from last year's audit will be embedded into the timetable	Head of Financial Accounting	Ongoing

			and working paper approach. Early & ongoing engagement with Audit Wales and Welsh Government is supporting consideration of key accounting judgements & disclosures.		
	29.06.2026	Procurement contract register	The need to create a robust contract management process, with a live maintained contract register held locally and aligned to all Wales registers.	Deputy Director of Finance / Head of Contracts	October 2026

Key Controls Established	Assurance	Key Gaps in Controls	Key Gaps in Assurance
FSLTV1 – Divisional Financial Outturn (Detective) FSLTV2 – Quarterly Finance Reviews (Detective) FSLTV3 – Divisional Performance Review (Detective) FSLTV4 – Executive and Trust Board Reporting (Detective)	Budget holders (reports and training), Touch Point Meetings Directorate Level Budget holders, reports and training, Touch point meetings Directorate Level Budget holders, reports and training, Touch point meetings Executive budget holders / Programme SROs	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, particularly relating to Radiotherapy IRS implementation, which is being addressed with Service and Business Intelligence.	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.

FSLTV5 – Statutory and Mandatory Financial Reporting (incl. Annual Accounts) (Detective)	Executive budget holders / Programme SROs		
FSLTV6 – Monthly Finance and Performance Meetings (Mitigating)	Executive budget holders / Programme SROs		
FSLTV7 – Collective Commissioners Review (Preventative)	Directorate Level Budget holders, reports and training, Collective Commissioners Group, LTA Reporting		
FSLTV8 – Investment Appraisal (Preventative)	Executive budget holders / Programme SROs, Capital Planning Group		
FSLTV9 – Financial Strategy / Medium Term Financial Plan / Budget Setting (Preventative)	Executive budget holders / Programme SROs		
FSLTV10 – Scheme of Delegation and Delegated Financial Authority (Preventative)	Oracle financial system controls, budget holders, Delegated Financial Limits		
	Value Based Healthcare project leads; VBH programme SROs, VBHC Steering Group		

FSLTV11 – Value Based Healthcare programme (Detective) FSLTV12 – Procure to Pay monitoring (Detective) 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)	Requisitioners / budget holders, PSPP Group. (P2P), Private Patients lead (debtors), etc. Debtors Reporting Budget Holders / Capital leads, Capital Planning and Delivery Group, Fixed Asset Register Programme SROs, Scheme of delegation, governance framework CP&D Group Budget Holders, training Counter Fraud Reports Budget Holders, requisitioners, buyers, FA team, VAT Working Group, EY, HMRC		

FSLTV18 – Procurement (Preventative) FDLTV18 – Procurement - Contract Management	Budget Holders, reporting, training, Procurement compliance reporting *Additional assurance is provided by* Divisional Finance Reports, 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. Internal Audit External Audit External oversight/advisory bodies incl NHS Exec (P&I) / WG / LHB Commissioners / HMRC		

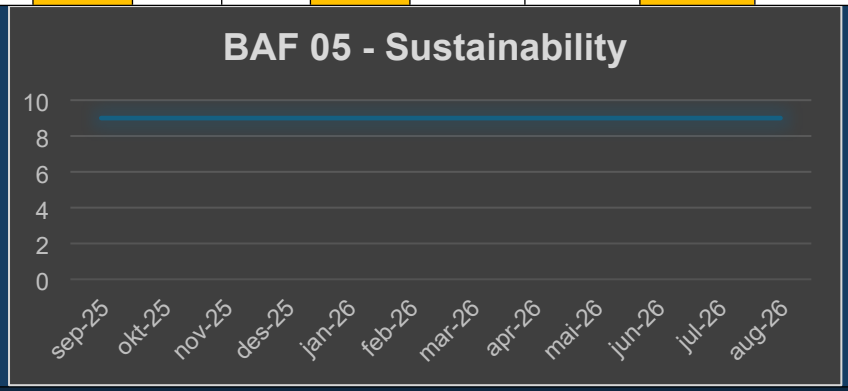
Risk 05	There is a strategic risk that the Trust fails to effectively embed its role as a sustainable organisation - outside of main infrastructure and specific centrally led activity - resulting in a failure to improve the health of the population we serve and non-compliance with the Well-being of Future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

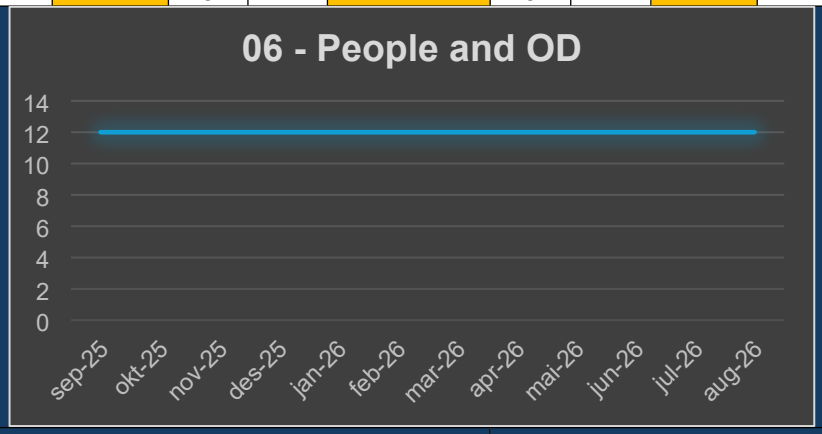
Risk 06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive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

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 There is a risk of a negative impact to staff wellbeing due to the psychological and physical impact of the sustained pressure of work, continued transformation of services and the challenge in reconciling continued high levels of clinical and non-clinical demand with available resources. This could lead to high levels of sickness absence, reduced organisational and individual effectiveness, higher staff turnover and staff burnout. This is exacerbated at times of industrial action which remains a risk in 2025/26. 1. Staff wellbeing & organisation performance 2. Leadership & Management 3. Culture, Values & behaviours

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)	Exec Lead	Director of People and OD
		Assurance Level	3 moderate
		Risk Appetite	Open

- Safe, high-quality care enabled by the workforce (because workforce culture/capacity directly affects patient and donor care)

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			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	12	3	4	12	2	4	8



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.	12

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	6.1	Culture, Values & behaviour Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	New reporting process to Welsh Government in place, with three categories scored out of 5. VUNHST reported 2 (Early Progress) for Workforce and Access and Experience and 3 (Results) for Overall. This report provides foundation for the 2026-27 SEP Action Plan. The received the WES report and Welsh Government	OD Specialist	March 2027

			feedback on the SEP maturity matrix giving scores of 1 for Workforce and Access and Experience and 2 for Overall. The feedback from both reports will be taken forward in the SEP actions for the remainder of 2026-27		
	6.2	Staff wellbeing & organisation performance Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	The Staff Wellbeing service met increased demand in Q4 and provided support and sessions across all levels of the stepped care model. The business case for the Staff Psychology and Wellbeing Service is due to be taken through committees in August 2026 with a request for 12 months further funding.	OD Specialist	December.2026
	6.3	Culture, Values & behaviours Embed positive values and behaviours across the Trust to create positive culture. Cultural Baseline Review	This work is being progressed through the existing priorities of 1. Our Governance and Leadership work with Line of Sight 2. Executive team recruitment 3. Supporting Velindre Cancer Service to move 4. Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES) 5. Wider leadership development. Capability and capacity required to complete the work.	Interim Director of People and OD	December 26

			A programme of work for supporting nVCC and for embedding positive behaviours has been outlined with an external provider. The resources to enable this work to take place are being sought.		
	6.4	Staff wellbeing & organisation performance Gaps in recording and reporting of return-to-work interviews	IT solution being explored	Director of OD and Workforce	30.09.26
	6.5	Staff wellbeing & organisation performance Gaps in reporting on staff who have met the triggers/who are on formal stages of the policy	Reporting solution being explored	Director of OD and Workforce	30.09.26
	6.6	Leadership & Management		Asst Director of Workforce Planning	31.12.26

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 brand activity supported by recruitment metrics.	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 reporting) Internal Audit reports Internal and External Audit	Dedicated governance related to People and Culture. Internal governance progress in review.

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.		Welsh Government reporting via JET and IMTP	
Strategy progress reports monitored through Management Group	Strategy progress reports assured through Workforce & OD Committee		
Plan developed through Staff Health & Wellbeing Group	Plan approved through Management Board	Plan assured through Workforce & OD Committee	
Adherence to policy monitored through monthly performance meetings	Adherence to policy assured through Management Group	Adherence to policy assured through Workforce & OD Committee	
Trend data included in Integrated Performance Report for review by Management Group	Trend data included in Integrated Performance Report assured through Workforce & OD Committee	Integrated Performance Report assured through Board	

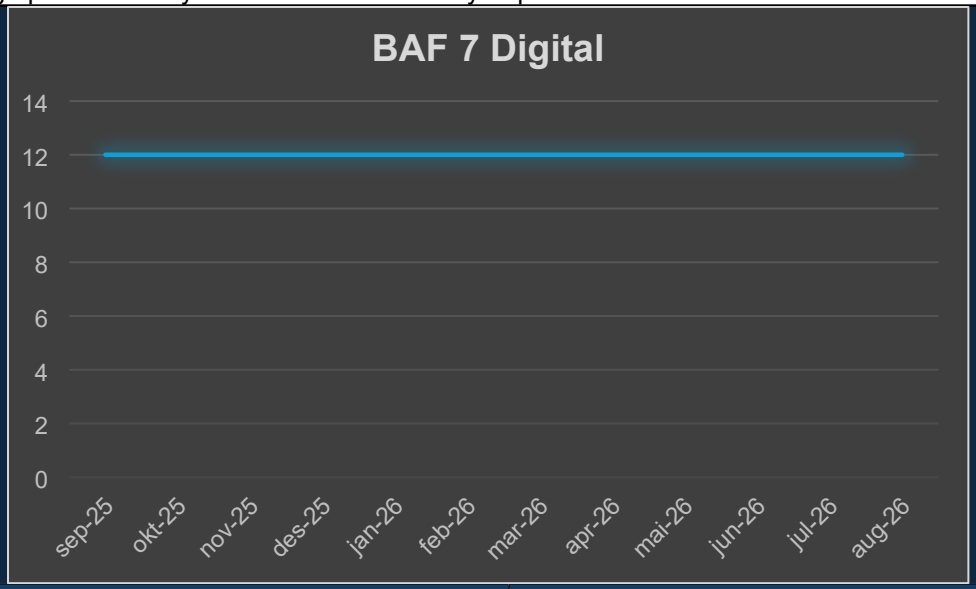
Risk 07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical 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** August 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 and that system wide Cyber threat level remains high for Healthcare. The aggregate risk for National Programmes for RISP/EPMA/LIMS has been reduced as RISP is now live (April 26) and has now reached stable operations, EPMA is on track for Nov go-live in VCS. There continues to be high-risk with the go-live date for WLIMS Tranche 5 (Blood Transfusion) nationally, although the Trust continues to be well placed with its internal preparations for LIMS and is providing additional support to the National Programme. The latest proposed go-live is scheduled for 23/11/2026, although pre-cursor are running late. Work on agreeing overall digital plans has made progress, with the Digital plan for nVCC Readiness now approved by the Executive. Additional capacity is required for this and additional funding has been made available, good progress has been made with the recruitment. Digital plan is now integrated into the overall nVCC Readiness plan. The delivery of National Programmes through DHCW continues in escalation Level 4: Targeted Intervention (was previously 3) in April 26. The Level 4 escalation now also includes aspects of systems leadership. Welsh Government have engaged Tara Donnelly to write a new Digital and Data Strategy for NHS Wales for Nov 26, as part of the 100 day plan activities. The Trust Digital Excellence Strategy will need to be reviewed when this is available. 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			January 2026			March 2026			May 2026			July 2026			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
	2745	Cyber security breach or other equivalent malicious activity, leading to a data protection / IT security incident and/or disruption to critical operational or clinical services.	15
	3646	WLIMS 2.0 go-live date delayed due to national programme timeline delays, impacting delivery of project outcomes and increasing demand on existing legacy systems.	20
	3633	Limited capacity within Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis, affecting IRS, WHAIS and FEDIS delivery.	12
	4003 / 4004	Ongoing use of end-of-life FoxPro and DOS-based WBMDR systems, creating risks to reputation, performance and service sustainability through potential IT system failure and inability to provide one or more WBMDR services.	15 / 16



Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	07.01	Complete the Digital Reference Architecture impact assessment, confirming alignment between the NHS Wales National Target Architecture / Digital Blueprint and the Trust's local digital architecture, including implications for WLIMS, BECS, FEDIS, WHAIS, EPMA, IRS, cyber resilience and nVCC readiness.	National Target Architecture and the Digital Blueprint have progressed and are now sufficiently developed to enable local impact assessment. The Trust is well placed on several national programmes, with RISP live and stable, EPMA on track for November 2026, and internal	Chief Digital Officer	October 2026

			WLIMS preparations largely complete; however, WLIMS Tranche 5 remains high risk nationally, with the proposed go-live now November 2026 and precursor activities running late. FEDIS and WHAIS continue to progress, with FEDIS planned for October go-live and monitoring to November 2026. This action should now focus on documenting local implications, dependencies and any residual gaps arising from the national architecture.		
	07.02	Establish and implement a Trust-wide prioritisation framework for Data, Insight and Digital service requests, ensuring clear escalation, decision-making and alignment with digital capacity, national programme dependencies, nVCC readiness and operational risk priorities.	Limited digital capacity remains a recurring theme across the Trust risk profile, with pressures linked to national programme delivery, digital integration dependencies, WBS Futures, nVCC readiness and cyber resilience. Current prioritisation continues to be managed locally within teams rather than through a consistent Trust-wide framework. The action remains overdue and should be reset with a defined implementation route, including Portfolio Team input, reporting arrangements and criteria for prioritising high-risk digital work.	Director of Place, Portfolio and Partnership	30 September 2026
	07.03	Confirm the Trust's representation and escalation route within the revised NHS Wales digital governance arrangements, including Digital Blueprint implementation, Digital Advisory Group engagement, DDAT escalation arrangements and senior routes for national programme risks.	The previous action to participate in Digital Data and Technology Leadership arrangements is complete. However, the risk remains because national digital governance has changed, with DHCW delivery in Level 4 targeted intervention and the Digital Blueprint / Digital Advisory Group becoming increasingly important. The Trust does not currently have a declared IM for Digital, which creates a gap in representation at key national groups, including the Digital IM Peer Group and national strategy development. This action has therefore been reframed to ensure representation, escalation and influence are formally confirmed.	Chief Digital Officer	30 September 2026
	07.04	Complete the digital diagnostic and develop the investment case for future digital service capacity, explicitly addressing resilience, cyber security, national programme support, legacy system reduction, data and insight prioritisation, and nVCC readiness requirements.	The initial diagnostic has been completed and reported through Digital Programme Board and EMB. Work has been delayed while the digital workstream for nVCC readiness was established; this workstream is now approved by the Executive, integrated into the wider nVCC readiness plan and supported by additional funding, with recruitment progressing. The updated investment case should now	Chief Digital Officer and Director of Finance	October 2026

			incorporate the current TRR themes: cyber security actions, WLIMS / LIMS national programme risk, BECS transition and testing dependencies, FEDIS / WHAIS integration, and the continuing gap against the 4% digital investment benchmark.		

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). A new Digital Capabilities Framework is available from HEIW. 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. Prioritisation and change framework for managing service requests. Reduce/monitor unsupported applications and legacy systems. Trust digital governance.	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 blueprint and how it aligns with local Velindre architecture. As the National Target Architecture has now been agreed this work can commence.	Digital governance and delivery forums (e.g., Digital Programme Board; WBS/Velindre Futures, nVCC Readiness Board), 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., 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).	The Trust does not have a declared IM for Digital which means we are not represented at key groups – such as the Digital IM Peer Group – or National Digital Strategy Development.

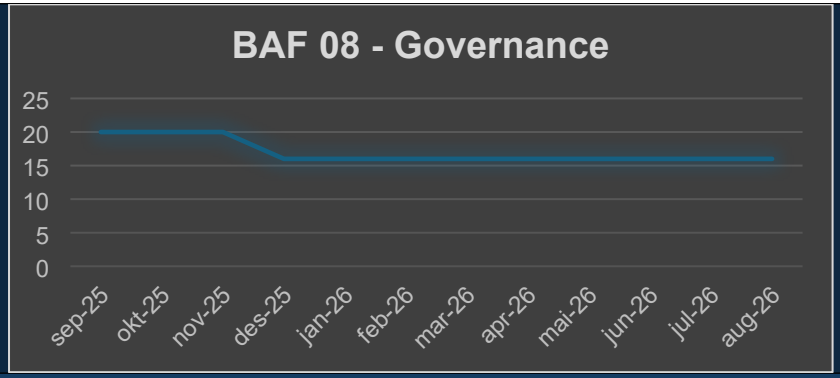
Lead/lag indicator reporting integrated into the wider performance framework. Cyber assurance controls in place. Digital transformation guided by an agreed digital architecture (Design Authority being established). AI strategy, policies and guidance for implementation and maintenance. Trust Information Governance arrangements.			

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	
		September 2026	

Executive Summary	The Trust continues to work with Welsh Government and NWSSP to implement the recommendations of the review of NWSSP Accountability and Governance Arrangements. The new Board Committee structure is operational with the first cycle of meetings taking place in September 2026. This includes the development of new Cycles of Business (capturing routine business) aligned to the Terms of Reference. A forward look to capture *ad-hoc* agenda items is in development. The Board approved its development and governance improvement programme in July 2026 to be completed by March 2027. The new Risk Policy will be considered by EMB in September 2026. ARAC will receive a draft at its December meeting, prior to Trust Board. Risk score trend: The overall risk score has remained static since the last period. The successful implementation of the committee restructure, approval of the Risk policy and implementation of the NWSSP review will inform reviews of the risk over the coming months. I expect to see a reduction in the overall score from January 2027.

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			January 2026			March 2026			May 2026			July 2026			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	12	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
	08.03	Review Trust Risk Policy	New policy, appetite statement and supporting procedures drafted and under review in partnership with external partner. Due for EMB consideration in September/October 2026 as part of Governance Improvement Plan and prior to Trust Board consideration.	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 Plan 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. In development *–first draft due to completion by 18 September.* • New Board Committee structure including new Terms of Reference, Cycles of Business, ways of working. *Completed – implementation from September 2026.*	Director of Corporate Governance	March 2027

			• New assurance framework outlining the Trust's governance framework – *in draft, for completion by end of November 2026.* • Work to review the current Trust hosting arrangements underway to include consideration of Welsh Government NWSSP review.		
	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. Aiming for completion by end of October 2026.	Director of Corporate Governance	Nov.26
	08.09	New Board Development Programme delivered	12 month Board development programme approved by Trust Board in July 2026.	Director of Corporate Governance	March 2027
	08.10	New Governance Improvement Plan delivered	Newly adopted Governance Improvement plan for completion by March 2027.	Director of Corporate Governance	March 2027
Closed Actions					
	08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work.	Benchmarking integral to the development of the Board Development and Governance Improvement Plan. New Risk Management Framework and System Development informed by NHS Wales benchmarking. Supplier demonstration days held over May-June period to inform system replacement.	Director of Corporate Governance	April 2026
	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	December 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 and to be considered as part of Governance Improvement Plan. Key briefing documents shared with Trust Board members and available for staff.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	Nov-25

	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 WSP Committee twice a year.	Director of Corporate Governance	Nov-25

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 and Governance Improvement Programme approved by Trust Board July 2026 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 September 2026 Governance improvement Plan for Trust Board approval July 2026 - *completed* Implementation of NWSSP Accountability and Governance review implemented by September 2026. Refreshed Trust Clinical Governance Framework	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 and audit (internal and external) when required Revised assurance mapping on core and hosted governance via new committee structure and reviewed arrangements for hosting Approval of 2026-27 IMTP Development of new Clinical Governance Framework aligned to soon to be published Welsh Government policy	Approval by Audit Committee and Board regarding the new Framework Third line of defence in respect of C4 – Board Development Programme underway Structured Assessment and Annual Audit Plan for 2026/27 underway Establishment of new Executive Risk Forum

TRUST BOARD		
Cardiff Health Partners (CHP) and Cardiff Cancer Research (CCRP) Partnership Agreements Approval		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Gavin Bryce, Associate Director of Portfolio	
PRESENTED BY	Jacinta Abraham, Executive Medical Director/ Deputy Chief Executive and Lauren Fear, Director of Place, Portfolio and Partnerships and	
REPORT SPONSOR	Jacinta Abraham, Executive Medical Director/ Deputy Chief Executive and Lauren Fear, Director of Place, Portfolio and Partnerships	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	24/08/2026	Executive Management Board
	08/09/2026	Research, Development & Innovation Committee
	The two Partnership Agreements were endorsed for Board approval by Executive Management Board and Research, Development and Innovation Committee.	
ONWARD SCRUTINY ROUTE	n/a	
PURPOSE OF THE REPORT	FOR APPROVAL	
	This report sets out two partnership agreements relating to Cardiff Health Partners and Cardiff Cancer Research Partnership. It outlines the purpose and intent of these agreements as well as the benefits and risks.	
EXECUTIVE SUMMARY	The Trust has been engaging on both the Cardiff Cancer Research Partnership (CCRP) and Cardiff Health Partnership (CHP) for some time now. Both are considered high value partnerships that have buy in at the most senior levels of respective organisations, those being: (i) Velindre University NHS Trust (ii) Cardiff & Vale University Health Board (iii) Cardiff University Although both CCRP and CHP have been ongoing for some time, it is an important step in the maturity of the arrangements for each respective organisation to consider approving a tri-party partnership agreement. This report will set of the following for both CCRP and CHP:	

	(i) Aims and scope of each strategic partnership (ii) Features of each agreement (iii) Material Benefits and Risks
ACTION / DECISION	The Board is asked to: **APPROVE** the two partnership agreements
APPENDED DOCUMENTS	Appendices listed below

RELEVANT TRUST STRATEGIC GOALS
This report addresses the following goal(s) within the Trust's strategic plan:

- 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

RELEVANT TRUST WELLBEING GOALS
This report addresses the following wellbeing goal(s):

- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Globally Responsible Wales

QUALITY AND SAFETY IMPLICATIONS
This report impacts one or more of the following Six Domains of Quality:

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)
A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA completed - document provided as an appendix to this report – **Appendix 5**

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: EQIA completed – document provided as an appendix to this report – **Appendix 6**

APPENDICES	**Appendix no.**	**Appendix title**
	1	Context and summary slides
	2	Features of CCRP Agreement

	3	CCRP Agreement
	4	CHP Agreement
	5	QIA
	6	EQIA

1. SITUATION

1.1 The Trust has been engaging on both the Cardiff Cancer Research Partnership (CCRP) and Cardiff Health Partnership (CHP) for some time now. Both are considered high value partnerships that have buy in at the most senior levels of the respective organisations, those being:

(i) Velindre University NHS Trust
(ii) Cardiff & Vale University Health Board
(iii) Cardiff University

1.2 Although both CCRP and CHP have been ongoing for some time, it is an important step in the maturity of the arrangements for each respective organisation to consider approving a tri-party partnership agreement.

1.3 This report will set of the following for both CCRP and CHP:

(i) Aims and scope of each strategic partnership
(ii) Features of each agreement
(iii) Material Benefits and Risks

Cardiff Cancer Research Partnership (CCRP)

1.4 The CCRP provides a single front door to expertise and facilities spanning haematological and solid tumour cancers, from early discovery phase through to complex and late phase clinical trials.

1.5 The CCRP provides a team of expert clinicians and researchers at the forefront of advancing cancer research and transforming patient outcomes. With strong partnerships across the cancer research community in Wales, CCRP is ideally placed to develop the next generation of cancer treatments and have a number of live clinical trials already underway as developing and trialling new drugs and therapies into the NHS is key to delivering better health outcomes for patients in the future.

1.6 The Goals of CCRP are as follows:

(i) Increase Welsh patients' access to cancer research by bringing new trials to Wales
(ii) Academics and clinicians working in partnership to increase multi-organisation research studies and industry funded clinical trials
(iii) Translate research into new cancer treatments by doing more translational research to take discoveries from the lab to clinical trials
(iv) Build capacity to carry out complex clinical trials by increasing the number of staff and amount of infrastructure available

(v) Grow a future-focused research workforce by increasing the number of clinical academics and making research easier across NHS & academia

Current Arrangements

1.7 The CCRP's current arrangements are:

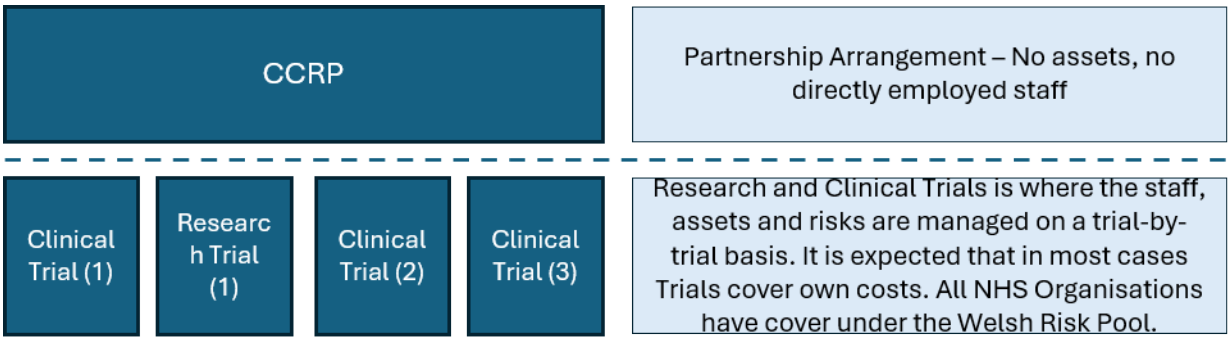
- CCRP is currently operating under an initial Heads of Terms' signed in 2024.
- The HoT's have been further developed into a fuller Partnership Agreement.
- CCRP is making cross organisational working more seamless.
- The Trust has taken responsibility as the Programme Management Office and also the banker for CCRP.
- The Partnership Agreement is linked to Strategic and Operational Plan, and planning cycle over seen by the CCRP Board.

Features of the CCRP Partnership Agreement:

1.8 The CCRP Partnership agreement has been developed in partnership between all three organisations. NWSSP Legal Services have led on the drafting and providing advice and support to VUNHST and CAVUHB. CU have had their own legal advice also.

1.9 The CCRP is as it states, a partnership agreement that binds all three organisations together. It is not a limited company, it has no assets, it doesn't employ staff directly and liabilities are at least for the NHS organisations covered with normal business arrangements.

1.10 However, it is recognised that the commercial arrangements and funding are important for clinical and research trials and it is for that reason that a decision was taken that research trial agreements take individual primacy and set out commercial, contractual and financing arrangements as they currently do now. Given there are many varying features of these arrangements, it was agreed that it would not be effective to "hard bake" overarching arrangements into the main partnership agreement. This allows for flexibility and gives all organisations the ability to look at the benefits and risks associated with trials and research on an individual basis, as set out in the diagram below:



1.11 The Benefits of the CCRP Partnership agreement are:

(i) Greater clarity on Partnership working arrangements
(ii) Contractually confirms subscription to fund the Project Management Office on a part-time basis

(iii) Gives clarity on IP, Branding and need for financial transparency
(iv) Any party can choose to leave the partnership
(v) Arguably more risk in not having a partnership agreement than having one

1.12 The CCRP Partnership agreement and summary of main terms / clauses can be found at Appendix 2.

1.13 Another important factor is the progression of the partnership agreement from the starting point of the Heads of Terms from 2024 which were considered to be high level and non-binding – the AI analysis of this supported by a human review reflects that there has been substantial progression in clarifying the partnership arrangements across a number of important areas, please see table below:

Area	CCRP Partnership Agreement (2026)	Heads of Terms (2024)	Key Difference
Legal status	A **binding contract**: "*This Agreement… constitutes a contract within the ordinary meaning under the law of England and Wales*"	Non-binding: "This document… is not intended to be legally binding"	Agreement formalises and legally commits the parties; Heads of Terms only expresses intent.
Purpose / scope	Establishes the Cardiff Cancer Research Partnership (CCRP) as the formal vehicle for cancer research collaboration.	Establishes intention to create the Cardiff Cancer Research Hub at UHW.	No Hub was achieved as planned due to CAV BMT business case not gaining approval and also drove the name change away from a "hub" more into the partnership space
Governance	Detailed governance: CCRP Board, CHP oversight, reporting structures, escalation routes.	High-level governance intentions: Partnership Board, JRO involvement.	Agreement provides full governance architecture; Heads of Terms only outlines principles.
Workforce model	Defines Core Team, employment rules, HR responsibilities, redundancy processes, TUPE considerations. "The posts funded jointly… are referred to as the CCRP's Core Team"	States intention to uplift workforce and appoint senior managers; no binding workforce structure.	Agreement creates a formal workforce structure; Heads of Terms only signals future workforce needs.
Finance	Full financial framework: contributions, invoicing, deficits, business	States intention to develop an investment strategy	Agreement operationalises finance; Heads of Terms expresses principles only.

	planning, accounting, surplus reinvestment.	and share risk/reward.	
Research governance	Detailed, binding governance pathway, quality indicators, SOP alignment, sponsor oversight.	High-level commitment to JRO-led governance and consistent processes.	Agreement specifies processes; Heads of Terms outlines aspirations.
Intellectual property	Detailed IP clauses, licensing, academic rights, infringement processes.	rinciple: fair and transparent sharing of IP benefits.	Agreement defines IP rights and restrictions; Heads of Terms sets principles only.
Data protection	Full GDPR-compliant controller-to-controller data sharing framework.	General commitment to negotiate data sharing arrangements.	Agreement operationalises data governance; Heads of Terms expresses intent.
Confidentiality & FOI	Detailed confidentiality obligations, FOI processes, retention rules.	High-level confidentiality commitment and FOI consultation.	Agreement is prescriptive; Heads of Terms is indicative.
Termination	Detailed termination triggers, managed wind-down, patient safety obligations, third-party obligations.	High-level principle: termination must consider patient safety and collaborator commitments.	Agreement formalises termination pathways; Heads of Terms outlines principles.
Physical resources	Physical resources referenced only as part of Workplan and Schedule 3.	Extensive detail on UHW facilities, research beds, critical care footprint, shared spaces.	Heads of Terms contains detailed physical resource commitments; Agreement does not. This reflects the BMT business case non approval and ongoing issues regarding footprint and staffing.
Branding	Formal CCRP branding rules and logo usage.	No branding provisions.	Branding is introduced only in the Agreement.
Insurance & liability	Detailed liability caps, indemnities, insurance requirements.	General principle that parties will consider liability arrangements.	Agreement formalises risk allocation; Heads of Terms does not.
Schedules	Includes Schedule 1 (Board ToR) and Schedule 2 (Finance).	Includes Appendix A (Physical Resources).	Agreement focuses on governance & finance; Heads of Terms focuses on facilities.

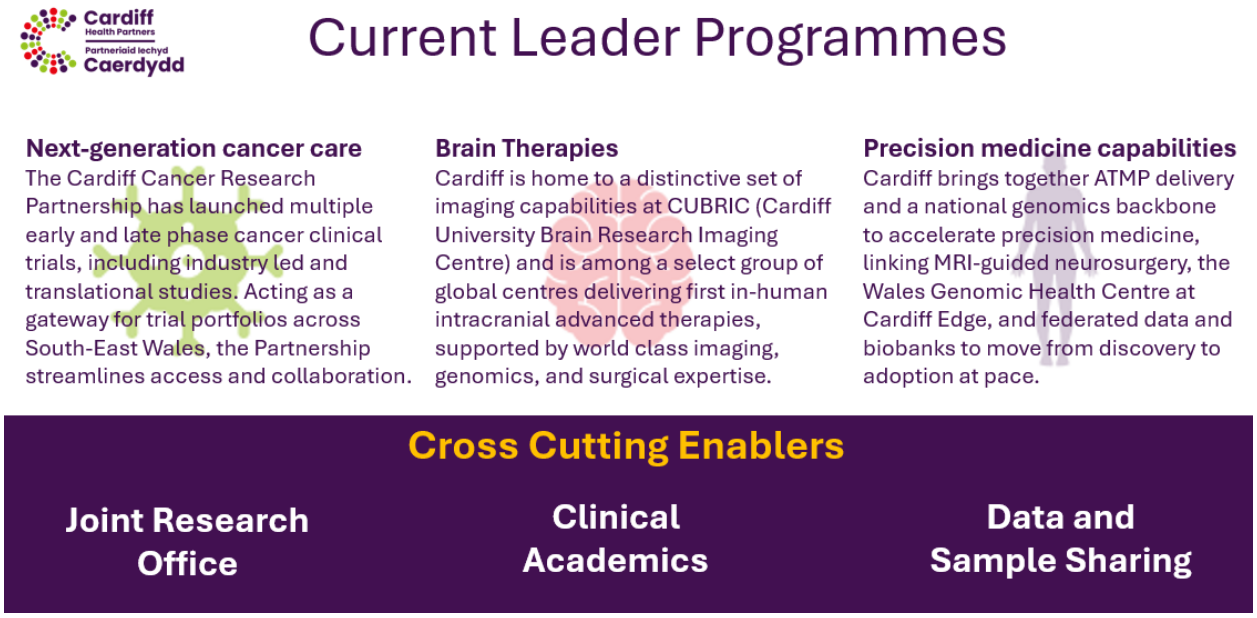
Cardiff Health Partnership (CHP)

1.14 The tri-partite working started with Cardiff Cancer Research Partnership and, in 2025, developed into a wider strategic partnership between the three organisations.

1.15 CHP was developed as the vehicle for health innovation, anchored in Cardiff and connected for global impact. We are a strategic partnership between Cardiff University, Cardiff and Vale University Health Board, and Velindre University NHS Trust that aligns discovery science, clinical care, education, and industry partnerships to accelerate innovation into practice, improve health equity, and drive inclusive economic growth and regeneration.

1.16 CHP aligns discovery science, healthcare, education, and industry partnerships to accelerate innovation into practice, improve health and equity, and drive inclusive economic growth and regeneration. By connecting world-class research with frontline delivery and a strong regional life sciences base, it acts as the engine of a place-based strategy that reduces fragmentation, speeds translation, and makes Wales a partner of choice for research, innovation, investment, and talent. The outcome is a gateway for collaboration, faster routes from researcher to patient, and a workforce trained across academic, clinical, and industry settings.

1.17 The current Leader Programmes:



1.18 An AI and Human compare of the CCRP and CHP agreements showed the following:

	CHP Agreement	CCRP Agreement
Overall Purpose	**Broad strategic partnership** across Neuroscience, Mental Health, Cancer, Precision Medicine. *"designed to accelerate health innovation… improve*	**Cancer-specific partnership** delivering the cancer focus of CHP. *"principal vehicle for addressing the Cancer focus… Cardiff Cancer Research Partnership (CCRP)"*

	health outcomes… drive inclusive economic growth"	
Relationship Between Agreements	Umbrella partnership.	Operates within CHP. "CHP… within which CCRP sits."
Governance Body	CHP Management & Development Group (MDG).	CCRP Board (Schedule 1).
Project Structure	Uses Project Schedules for each project. "must" enter into separate and more Project specific agreements"	Uses an annual Workplan of Projects delivered by the Core Team. "Workplan… annual programme of Projects"
Scope of Activities	Any project within CHP's broad focus areas.	Only cancer research activities: clinical trials, ATMPs, translational research, data-rich studies.
Workforce Model	Programmes Team jointly funded by all Parties. "posts funded jointly… Programmes Team"	Core Team, ordinarily employed by VUNHST.
Workforce Governance	Changes approved by CHP MDG.	Changes approved by CCRP Board within budget.
Financial Model	Investment strategy for CHP; funding sources include grants, Welsh Government, industry.	Detailed cancer-specific finance including trial income, commercial trial overheads, and a CCRP Business Plan.
Branding	CHP Branding Guidelines; includes Non-Project IPR jointly owned.	CCRP Branding Guidelines; no joint ownership of branding.
IPR	Includes Non-Project IPR (e.g., CHP logos).	No Non-Project IPR concept; IPR rules focus on research studies and Workplan projects.
Academic Publication	Detailed publication controls, including notice periods and confidentiality protections.	Similar protections but tailored to cancer research outputs and Hosted Studies.
Dispute Resolution	NHS-to-NHS disputes resolved by Welsh Ministers. University disputes via mediation.	Same structure, but with stronger patient-safety obligations. "No Party shall take any action… contrary to the safety or best interests of such patients."
Termination	Project Schedules can be terminated independently.	CCRP termination does not affect individual research study agreements.
Focus Definition	Broad, multi-theme.	Detailed cancer-specific focus including ATMPs, early-phase trials, data science, translational research.

1.19 As the comparison shows, there is a great deal of commonality between the two Agreements. Variation is expected related to scope and governance hierarchy and the difference between regional working and cancer trials and research studies.

1.20 For CHP there is an expectation with this being a strategic endeavour that funding to continue the partnership will be required on an ongoing basis.

2 MATTERS FOR CONSIDERATION

2.4 FINANCIAL IMPLICATIONS

Financial considerations outlined in paper – no further financial ask associated with the approval of the Agreements.

2.5 LEGAL IMPLICATIONS

None

2.6 PEOPLE IMPLICATIONS

Workforce considerations outlined in paper – no further workforce risks associated with the approval of the Agreements.

2.7 WELSH LANGUAGE IMPLICATIONS

None Identified

2.8 RISKS / REPUTATIONAL IMPLICATIONS

Relevant Strategic Risk - Board Assurance Framework (BAF)

03 - Research Development & Innovation (RD&I)

Operational Risks

None currently above 12

3 RECOMMENDATIONS FOR ACTION / DECISION

3.1 The **TRUST BOARD** are asked to **APPROVE** the two partnership agreements and delegate the signing of which to the Executive Medical Director/ Deputy Chief Executive Officer.

Appendix 2 – Feature of CCRP Agreement

Clause	Title	This section sets out…	Key Points
-	Background	The parties and the nature of the agreement	
1	Interpretation	The definitions and rules of interpretation	
2	Commencement and Duration	The start date of the agreement and how it will continue or be extended	Aiming for signature within the next 4-6 weeks
3	Collaboration and Cooperation	How the parties will work together	3.4 uses wording from the Heads of Terms to set out what the CCRP will essentially do. 3.6 sets out the principles of partnership working.
4	Existing Arrangements	The fact that this agreement doesn't stop the parties from carrying on with their other activities as usual	
5	Proposals and Projects	How CCRP will approach possible projects	It notes that the detail will be in the project documentation itself.
6	Workforce	Arrangements for operation and funding of the CCRP's "Core Team" (i.e. the PMO)	Individual staff can be employed by any partner. Core Team currently in post employed by VUNHST.
7	Finance	How the Core Team is funded	VUNST is financial lead. Core Team jointly funded as part of an annually agreed operating budget.
8	Research Grant & Clinical Trial Finance	Makes clear that each research study or clinical trial will have its own contracting arrangements. Sets out CCRP business planning & financial reporting arrangements.	Any surplus income can be utilised to cover wider CCRP cost or support its growth. Annual Business Plan and quarterly accounts required.
9	Information and Project Management	How the parties will communicate with each other so that everyone is suitably informed about ongoing projects.	

10	Charges	How costs will be covered to a degree.	The starting point is that this agreement or the specific project agreement should set out what each party contributes or is responsible for underwriting
11	Invoicing and Payment	How the above works	Velindre will act as the invoicing partner for CCRP generally should it be required. Each project will be determined on a case-by-case basis.
12	Set off	Al amounts due under the Agreement are to be paid in full	
13	Confidentiality	The parties won't share confidential information outside of the partnership without permission.	Accepting that there may be legal reasons it has to be shared.
14	Announcements	How public announcements will be managed.	
15	Data Protection	How the partnership will comply with legislation.	There shouldn't be much personal data at this level – it will mostly sit within the projects themselves.
16	Intellectual Property	Ownership and transfer of IP.	Background IP will remain the property of the originating partner. Each partner will have free access to all IP for the purposes of pursuing any project and for resulting academic research. The project agreements will be more specific as to how IP will work within that project. Where necessary, the parties will create a strategy to deal with IP exploitation.
17	Academic Publication and Impact	Predominantly CU's need to make use of CCRP and then some detail around restrictions to publication and use of IP.	
18	Branding and Logos	Each party accepts their branding may be used within the confines of the partnership but not beyond it.	Branding guidelines to follow.
19	FOI	How each party will comply with it.	
20	Anti-bribery	How each party will comply with it.	
21	Warranties	Each party can carry out the activities in the agreement and that it doesn't create additional constraints.	

22	Indemnity	How each party indemnifies the others from claims brought against it by third parties.	Unless the indemnified party has acted negligently or engages in wilful misconduct.
23	Insurance	How each party is insured.	CVUHB and VUNT both fall under the Welsh Risk Pool arrangement (which has confirmed it would cover the activity of CCRP), and CU commits to having suitable cover in place.
24	Limits and Exclusion of Liability	How the insurance point above applies only to CCRP activity.	While recognising that some things cannot limit liability – death through negligence for example.
25	Intention to Terminate	How the parties will signal intent to terminate projects or CCRP	
26	Termination of Projects	How the parties can terminate projects	
27	Termination of agreement	How the parties can terminate the agreement	
28	Survival	If the agreement does terminated, some of the clauses will continue to bind the parties.	Such as confidentiality, for example.
29	Consequences of Termination	How the parties will deal with documentation, equipment, licenses, permissions, information etc if the agreement is terminated.	
30	Force Majeure	How some events will not place the party in breach of the agreement.	
31	Assignment and Other Dealings	Parties can't amend the agreement without consent from the others.	
32	Entire Agreement	This is the agreement.	So you can't rely on the heads of terms to bring a case against another party, for example.
33	Conflict	If there is a difference between this agreement and a specific project agreement, then the project agreement has priority.	Because the project-level agreement will have more detail in it.
34	Variation	If this agreement is to be changed it needs to be agreed by all 3 parties.	And will apply from that point on.
35	Notices	How the parties will communicate with the others if there is something to be raised regarding the contract.	Ie. so that the clock starts ticking on a legal action, for example
36	Severance	If part of the agreement becomes invalid or illegal it won't render the rest of the agreement void.	

37	No Partnership or Agency	This agreement doesn't provide a wider power to enter into other commitments on behalf of another partner.	
38	Rights and Remedies	Normal rights in law apply plus what this agreement sets out.	
39	Waiver	Waivers of the above need to be in writing.	And doesn't create a wider exemption.
40	Counterparts	How the agreement can be presented.	
41	Third Party Rights	No one else gets to use this agreement against the parties.	
42	Further Assurance	Each party will try and manage third parties so that this agreement is complied with.	
43	Costs	Each party pays its own costs for this agreement.	
44	Mediation	If there's a dispute, the parties will escalate the matter through their lines of management and then pursue alternative dispute resolution and not just go to Court.	Recognition here that CVUHB and VUNHST cannot take each other to Court, they would escalate to WG.
45	Governing Law	Is England and Wales	

Appendix 3 – CCRP Agreement

DATED XX/XX/2026

Collaboration Agreement
relating to
The Cardiff Cancer Research Partnership

BETWEEN

(1) Velindre University NHS Trust
and
(2) Cardiff and Vale University Health Board
and
(3) Cardiff University

CONTENTS

CLAUSE

1. INTERPRETATION..... 4
2. COMMENCEMENT AND DURATION..... 100
3.COLLABORATION AND CO-OPERATION..... 101
4.EXISTING ARRANGEMENTS..... 12
5. WORKFORCE..... 13
6.FINANCE..... 16
7. RESEARCH GRANT AND CLINICAL TRIAL FINANCE..... 17
8. INFORMATION FLOW AND PROJECT MANAGEMENT..... 19
9. INVOICING..... 20
10. SET OFF..... 200

11. CONFIDENTIALITY 210
12. ANNOUNCMENTS 232
13. DATA PROTECTION 222
14.INTELLECTUAL PROPERTY 245
15.CCRP BRANDING……..
.....26
16. FREEDOM OF INFORMATION……
.....27
17. ANTI-BRIBERY…
.....27
18. WARRANTIES…
.....28
19. INDEMNITY…
.....28
20. INSURANCE 30
21. LIMITATION AND EXCLUSION OF LIABILITY 31
22.INTENTION TO TERMINATE 31
23.TERMINATION OF AGREEMENT 32
24. SURVIVAL 34
25. CONSEQUENCES OF TERMINATION 34
26. FORCE MAJEURE… 35
27. ASSIGNMENT…
.....35
28. ENTIRE AGREEMENT…
.....36
29. CONFLICT……
.....36
30. VARIATION 36
31.NOTICES 36
32. SEVERANCE 37
33. NO PARTNERSHIP OR AGENCY 37
34. RIGHTS AND REMEDIES……
37
35. WAIVER 37

36. COUNTERPARTS.....38
37. THIRD PARTY RIGHTS.....38
38. FURTHER ASSURANCE.....38
39. COSTS.....38
40. MEDIATION..... 38
41. GOVERNING LAW.....39
42. JURISDICTION.....39

SCHEDULES

Schedule 1 - CCRP Management Board Terms of Reference 37
Schedule 2 – Fiance 42
Signatures.....44

PARTIES

Velindre University NHS Trust whose principal address is Unit 2 Charnwood Court Heol Billingsley, Cardiff CF15 7QZ *(* "**VUNHST**");

Cardiff and Vale University Local Health Board of Heath Park, Cardiff, CF14 4XW ("**CVUHB**");

Cardiff University of Main Building, Cathays Park, Cardiff, CF10 3AT (Charity Registered No: 1136855) (the "**University**").

(together the "Parties," references to "Party" shall be construed accordingly).

BACKGROUND

Cardiff Health Partners (CHP) is a strategic partnership between the parties to this Agreement, designed to accelerate health innovation, improve health outcomes and equity, and drive inclusive economic growth in Wales. The partnership will align discovery science, clinical care, education,

and industry partnerships, speeding translation of research into practice, reducing fragmentation in health innovation pathways, and positioning Wales as a partner of choice for trials, innovation, investment, and talent.

CHP is a novel and evolving entity and the Parties have agreed to work together to initially focus on Neuroscience and Mental Health, Cancer, and Precision Medicine.

This Agreement aims to establish the principal vehicle for addressing the Cancer focus set out above. This will be the Cardiff Cancer Research Partnership (CCRP).

VUNHST, CVUHB and the University wish to enter into this partnership to: offer patients requiring complex systemic treatments and high-risk trial interventions the opportunity to access these treatments in Wales; enable closer working between solid cancer and haemato-oncology services; bring NHS and academic colleagues together to build a translational cancer research portfolio and train future cancer researchers in Cardiff; and increase the region's capacity and capability to undertake cancer research. This will be enabled by the establishment of a research partnership and cross-site, regional research network. The University, VUNHST and CVUHB are the three partner organisations who constitute the CCRP.

Each Party has signed a Heads of Terms, signalling their intention to collaborate to form this partnership (for the avoidance of doubt, the Heads of Terms document has now been superseded by this Agreement). The CCRP's Partnership Arrangements Workstream, which includes representatives from all three Parties, has developed a framework for how the three Parties will work together in practice as the CCRP.

The CCRP's focus will be on the three Parties working in partnership to attract clinical trials and research awards to South-East Wales. CCRP's ambition is to:

- build a joint reputation for cancer research to benefit cancer patients in South Wales and beyond;
- develop a broad, well-balanced portfolio of both high and intermediate risk, early phase and ATMP trials in both solid cancers and haemato-oncology. This will include complex phase 3 trials and/or all trials that need access to specialist services and staff on University Hospital of Wales site;
- increase commercial trials in Cardiff optimising research, income, enabling growth and sustainability;
- significantly increase opportunities for patients to be recruited in South Wales to cancer clinical trials over the next 10 years;
- significantly increase the number of data-rich translational research studies;
- accelerate innovation through linking discovery science with clinical studies (bench to beside) and bring together a critical mass of cancer researchers in Cardiff to attract grant and infrastructure funding;
- develop an integrated model for solid cancer and haemato- oncology, managed by an operation research delivery team; and
- grow and nurture future cancer research leaders.

This Agreement governs the overall relationship of the Parties in relation to the CCRP. The Parties will enter into separate agreements to govern specific research studies which arise from the CCRP.

The Parties to this Agreement wish to establish a framework to govern their respective rights and obligations in relation to particular Projects, in respect of which they wish to co-operate where such Projects fall within the Focus of this Agreement. Each Party shall carry out its respective roles and responsibilities as set out in this Agreement.

Research Governance:

The Parties will develop an effective, risk-adapted, efficient, and expeditious governance pathway to ensure patient safety, research governance and sponsor oversight is consistent, whether the research conducted through the CCRP is led by CVUHB, the University or VUNHST.

A process and criteria for agreeing which Party leads research studies enabled through the CCRP, whether sponsored by one or more of the Parties or a commercial or academic third party, will be developed by the Parties in collaboration.

The Parties will collaborate to monitor and assess performance against relevant quality performance indicators to include but not limited to National Standards for Infection Control, Improving Service Users and Carers Experience and Reducing Inequalities, organisational operational performance metrics for Improving Productivity and Access to Treatment and their Equality and Diversity policies for Reducing Barriers to Access.

The Parties will collaborate to develop for the CCRP an interface that represents and interfaces with each organisation's quality management system, comprising standard operating procedures and other quality management tools to support delivery of regulatory compliant and safe research.

The Parties will collaborate to maximise the quality, originality and rigour of research outputs arising from research conducted through the CCRP, recognising the Parties' policies, codes of practice and strategic priorities, commitments on research outputs and the principles set out in any Publication Scheme.

This Agreement between VUNHUST and CVUHB is regarded as an 'NHS Contract' within the meaning of section 7 of the National Health Service (Wales) Act 2006, meaning any disputes arising between VUNHUST and CVUHB cannot be heard within the Courts of England and Wales and instead resolved by the Welsh Ministers in accordance with clause 40.2 of this Agreement. Notwithstanding, VUNHST and CVUHB agree to act in good faith and in accordance with the provisions stated in this Agreement.

Notwithstanding paragraph (J)0 for the purposes of the nature of the Agreement between the NHS bodies, namely VUNHUST and CVUHB, and the University, this Agreement constitutes a contract within the ordinary meaning under the law of England and Wales.

This Agreement sets out the terms and conditions upon which the Parties have agreed that such Projects may take place.

1 DEFINITIONS

1.1. The following definitions and rules of interpretation apply in this Agreement.

Agreement: means this Partnership Agreement.

Academic Publication: means the publication of an abstract, article or paper in a journal or electronic repository, its presentation at a conference or seminar; Publish and Publication are to be construed as meaning such publication or presentation**.**

Background IPR: means any information, data, techniques, Know-how, inventions, software, discoveries and materials (regardless of the form or medium in which they are disclosed or stored) which are provided by one Party (whether belonging to that Party or to a third party) to another Party for use in the Project, and whether before or after the date of this Agreement), except any Project IPR.

Branding Guidelines: means the guidelines produced by a Party or a third party setting out the manner in which their name or logo may be used, which is made available upon request to a Party and as may be amended from time to time.

Business Day: a day other than a Saturday, Sunday or public holiday in England and Wales, when banks in Cardiff and London are open for business.

Business Plan: has the meaning given in clause 6.6.

CCRP Board: the Board of the CCRP as constituted in accordance with Schedule 3. The reporting structure, membership and remit of this Board may be amended from time to time by agreement between the Parties.

CCRP Branding Guidelines: means any guidelines produced by the Parties setting out the manner in which the CCRP Partnership name or logo may be used and which may be amended from time to time.

CCRP: means the Cardiff Cancer Research Partnership consisting of the Parties to this Agreement.

Charges: the charges payable by a Party to the other in relation to a Project (if any).

CHP: Cardiff Health Partners. The strategic partnership between the Parties within which CCRP sits.

Commencement Date: has the meaning given in clause 2 (Commencement and Duration).

Commercially Sensitive Information: information identified by any Party as being of a commercially sensitive nature relating to VUNHST, CVUHB or the University, their intellectual property rights or their businesses or which VUNHST, CVUHB or the University has indicated to the others that, if disclosed by the others, would cause VUNHST, CVUHB or the University significant commercial disadvantage or material financial loss.

Confidential Information: means all confidential information (however recorded or preserved) disclosed by a Party or its Representatives to the other Parties and that Party's Representatives in connection with this Agreement.

Control: has the meaning given in section 1124 of the Corporation Tax Act 2010 and **controls**, **controlled** and the expression **change of control** shall be construed accordingly.

Core Team: has the meaning given in Clause 5.2.

Data Protection Legislation: all applicable data protection and privacy legislation in force from time to time in the UK including the UK GDPR; the Data Protection Act 2018 ("DPA 2018") (and regulations made thereunder) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended, and the guidance and codes of practice issued by the Information Commissioner or other relevant regulatory authority and applicable to a Party.

Data Subject: as defined in the Data Protection Legislation.

Employing Party: as defined in clause 5.7.

Environmental Information Regulations: the Environmental Information Regulations 2004 together with any guidance and / or codes of practice issued by the Information Commissioner or relevant Government department in relation to such regulations.

Financial Year shall mean the period commencing on 1 April 2026 and ending on 31 March of the following calendar year, and each successive 12 month period thereafter.

Focus: is as defined under clause 3.4.

FOIA: the Freedom of Information Act 2000, and any subordinate legislation made under the Act from time to time, together with any guidance and/or codes of practice issued by the Information Commissioner or relevant government department in relation to such legislation.

Input: in relation to a Party, the services, resources, workforce or other tangibles or intangibles that such Party provides in accordance with this Agreement in relation to a Project, as set out in a Workplan.

Intellectual Property Rights (IPR): means patents, utility models, rights to inventions, copyright and neighbouring and related rights, trademarks and service marks, business names and domain names, rights in get-up and trade dress, goodwill and the right to sue for passing off or unfair competition, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information (including know-how and trade secrets), and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.

Information: has the meaning given under section 84 of FOIA.

Know-how: means unpatented technical information (including information relating to inventions, discoveries, concepts, methodologies, models, research, development and testing procedures, the results of experiments, tests and trials, manufacturing processes, techniques and specifications, quality control data, analyses, reports and submissions) which is not in the public domain.

Month: a calendar month.

Permitted Recipient: means the Parties to this Agreement, the employees of each Party and any third parties engaged to perform obligations in connection with this Agreement.

Personal Data: as defined in the Data Protection Legislation.

Physical Resources: the resources provided by the Parties as set out in **Error! Reference source not found.**.

Project: a project that is agreed by the Parties as part of the annual Workplan in order to enable the delivery of the ambition of the partnership and which the Parties will collaborate on in accordance with this Agreement. It does not include activities relating to individual research studies or trials which will be covered by their own agreements.

Project IPR: means all Intellectual Property Rights developed or created by a Party pursuant to a Project and is owned by that Party.

Project Period: subject to earlier termination in accordance with this Agreement, the period from the start date to the end date for a Project, as set out in a Project Schedule.

Project Schedule: a document specifying particulars in relation to a particular Project, agreed by the Parties.

Redundancy Costs means any contractual or statutory redundancy payments, any enhanced contractual pension costs or other benefits which arise directly out of a Redundancy Situation, or the costs arising from giving contractual notice of termination by reason of redundancy.

Redundancy Situation means when an employee is dismissed in the circumstances set out in section 139 of the Employment Rights Act 1996.

Representatives: means, in relation to a Party, its employees, officers, contractors, subcontractors, representatives and advisors.

Request for Information: a request for information or an apparent request under the FOIA or the Environmental Information Regulations.

Shared Personal Data: means the personal data to be shared between the Parties under or in connection with this Agreement in accordance with clause 13.

UK GDPR: has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.

Workplan: an annual programme of Projects to be delivered by the Core Team and agreed in advance by the CCRP Board. The Workplan may be varied in-year by unanimous agreement of the CCRP Board. If the CCRP Board agrees to variation of the Workplan, such variations will be undertaken within existing budgetary and resource constraints. The Parties will determine whether variations to the Workplan can be accommodated within the agreed budget. Mitigations might include, but shall not be limited to, scaling-back or deferral of other planned activities to accommodate the variations.

1.2. Clause, Schedule, and paragraph headings shall not affect the interpretation of this Agreement.

1.3. The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement. Any reference to this Agreement includes the Schedules.

1.4. References to clauses and Schedules are to the clauses and Schedules of this Agreement and references to paragraphs are to paragraphs of the Schedules.

1.5. A person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality) and that person's personal representatives, successors and permitted assigns.

1.6. Unless the context otherwise requires, words in the singular shall include the plural and, in the plural, shall include the singular.

1.7. Unless the context otherwise requires, a reference to one gender shall include a reference to the other genders.

1.8. This Agreement shall be binding on, and inure to the benefit of, the Parties to this Agreement and their respective personal representatives, successors and permitted assigns, and references to any Party shall include that Party's personal representatives, successors and permitted assigns.

1.9. Unless expressly provided otherwise in this Agreement, a reference to legislation or a legislative provision is a reference to it as amended, extended, or re-enacted from time to time.

1.10. Unless expressly provided otherwise in this Agreement, a reference to legislation or a legislative provision shall include all subordinate legislation made from time to time under that legislation or legislative provision.

1.11. A reference to writing or written includes email but not fax.

1.12. Any obligation on a Party not to do something includes an obligation not to allow that thing to be done.

1.13. References to a document in agreed form are to that document in the form agreed by the Parties and initialled by them or on their behalf for identification.

1.14. Any reference to an English and Welsh legal term for any action, remedy, method of judicial proceeding, legal document, legal status, court, official or any legal concept or thing shall, in respect of any jurisdiction other than England and Wales, be deemed to include a reference to that which most nearly approximates to the English and Welsh legal term in that jurisdiction.

1.15. A reference to this Agreement or to any other agreement or document referred to in this Agreement is a reference to this Agreement or such other agreement or document as varied or novated (in each case, other than in breach of the provisions of this Agreement) from time to time.

1.16. Where any statement is qualified by the expression so far as VUNHST, CVUHB or the University is aware or to VUNHST's, CVUHB's or the University's knowledge (or any similar expression), that statement shall be deemed to include an additional statement that it has been made after due and careful enquiry.

1.17. Any words following the terms including, include, in particular, for example or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase, or term preceding those terms.

1.18. Any reference to this Agreement terminating shall, where the context requires, include a reference to this Agreement terminating by expiry.

2. COMMENCEMENT AND DURATION

2.1. This Agreement shall commence on 01st April 2026.

2.2. This Agreement shall continue, unless terminated earlier in accordance with clause 233, (Termination of Agreement), until 31 March 2029.

2.3. This Agreement may be extended by mutual agreement between the Parties for a further period of up to 36 months. The Parties shall agree in writing any extension in good time prior to the expiry of the initial period referred to in clause 2.2 above.

3. COLLABORATION AND CO-OPERATION

3.1. The Parties shall attend and participate in scheduled CCRP meetings with each other.

3.2. The Parties shall co-operate within the Focus of this Agreement in relation to Projects.

3.3. The Parties shall collaborate in relation to any agreed Workplan.

3.4. The Parties will collaborate to deliver, the following ("Focus"):

3.4.1. A broad, well-balanced portfolio of complex early to late phase clinical trials in solid cancer and haemato-oncology across VUNHST's and CVUHB's operating locations;

3.4.2. studies sponsored by pharmaceutical companies or non-commercial third parties and investigator-led studies with chief investigators employed by one of the Parties or another

organisation located in Wales; and sponsored by the Parties either individually or as co-sponsors;

3.4.3. significantly increased opportunities for patients to be recruited to solid cancers and haemato-oncology trials in South Wales within ten years;

3.4.4. bench to bedside studies with molecules and therapies generated by the Parties;

3.4.5. an expanded portfolio of solid cancer novel Drug-Radiotherapy Combination studies;

3.4.6. expanded trials activity in advanced therapies for both haematological and solid tumour indications (multiple modalities including cell therapies, vaccine therapies, virotherapies, cell engaging antibody therapies and any other therapies using genetically modified agents);

3.4.7. an improved pre-clinical to clinical interface and a critical mass of cancer researchers in Cardiff, which can attract infrastructure funding from (for example) UKRI;

3.4.8. a better-connected cancer research community to promote collaboration, develop researchers, research leaders, and focus education and training; and

3.4.9. an approach to data sharing that enables co-production of research and capitalises on opportunities to apply data science and precision medicine approaches to research.

3.5. The Parties shall co-operate within the Focus of this Agreement in relation to the agreed Workplan.

3.6. The Parties agree to adopt the following principles when carrying out the Workplan (Principles):

3.6.1. collaborate and co-operate - establish and adhere to the governance structure set out in this Agreement to ensure that activities are delivered and actions taken as required;

3.6.2. be accountable - take on, manage and account to each other for performance of the respective roles and responsibilities set out in this Agreement;

3.6.3. be open - communicate openly about major concerns, issues or opportunities relating to Proposals and Projects;

3.6.4 behave in a positive, proactive manner;

3.6.4. adhere to statutory requirements and best practice - comply with applicable laws and standards including applicable procurement rules, data protection and freedom of information legislation;

3.6.5. act in a timely manner - recognise the time-critical nature of the Workplan and respond accordingly to requests for support; and

3.6.6. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this Agreement, act in good faith to support achievement of the key objectives and compliance with these Principles.

3.7. The Parties will establish appropriate governance, leadership, and management structures with representatives of each Party in numbers and breadth of expertise and experience sufficient to ensure:

3.7.1. efficient and effective governance, leadership, and management;

3.7.2. effective and prompt resolution of any disputes, including those arising from conflicting interests of the Parties; and

3.7.3. accountability to the executive management of each of the Parties.

3.8. The Parties will develop an investment strategy to develop, enable, and sustain the CCRP and deliver the activities set out in the Focus. The Parties agree to work together to secure the necessary funding from research grant funders, the Welsh Government, industry, and other sources as identified in the strategy and to provide in good faith the staffing, physical and other resources they agree to contribute. The Parties will work collaboratively to define a set of principles and develop a mechanism to share the risk / reward and any surplus / deficit generated by the activities described in the Focus.

4. EXISTING ARRANGEMENTS

4.1. Nothing in this Agreement shall restrict a Party's right to continue to conduct its business activities or arrangements that existed on the Commencement Date or that otherwise come into being outside the scope of this Agreement.

4.2. However, as the Parties will be working together in relation to Projects where each Party may have access to information or Intellectual Property Rights of the other, each Party acknowledges that the other Parties will need to protect such information and Intellectual Property Rights.

5. WORKFORCE

5.1. The Parties have agreed that it is necessary to secure individuals' time and expertise specifically for the purposes of fulfilling the objectives of the CCRP. These individuals, or an agreed proportion of their time, will be dedicated to the CCRP.

5.2. The posts funded jointly by the three Parties are referred to hereafter as the CCRP's Core Team ("Core Team"). The agreed staff time and funding for the Core Team for 2026/27 is set out in Schedule 2. This will be reviewed annually, or as required, by the CCRP Board, and may be amended from time to time in agreement between the Parties.

5.3 The performance of the Core Team, including any issues significantly impacting on its performance, shall be reported to the CCRP Board.

5.4 Ordinarily, the Core Team will comprise individuals employed by VUNHST. However, alternative arrangements may be implemented with the approval of the CCRP Board. This may include individuals employed by or seconded from any of the Parties.

5.5 Any changes to the Core Team shall be subject to the approval of the Parties at the CCRP Board within the budgetary framework. Such changes shall include, but not be limited to the following:

5.5.1 creating an additional post;

5.5.2 removing a post;

5.5.3 recruiting and appointing a replacement for any vacated post;

5.5.4 varying the terms and conditions of employment and/or secondment of any post holder (other than nationally mandated changes) to the extent that such change may result in new or increased financial or other liability for the CCRP or any individual Party;

5.6 Prior to approving any change to the Core Team, the CCRP Board shall consider all relevant matters including, to the extent that they are applicable to the relevant change, as set out below:

5.6.1 the financial implications including how any additional costs will be met or how any savings will be re-applied;

5.6.2 any potential redundancy liability and how that might be mitigated;

5.6.3 whether it may be preferable to consider alternative means of employment pursuant to Clause 6.4;

5.6.4 the terms on which a post holder will be employed or engaged.

5.7 In respect of each individual member of the Core Team ("postholder"), the Party that employs the postholder ("Employing Party") shall:

5.7.1 use reasonable endeavours to ensure that the postholder performs his or her duties to the CCRP diligently and with reasonable skill and care, and complies with the decisions and directions of the CCRP Board;

5.7.2 provide human resources support equivalent to that provided to its other employees;

5.7.3 ensure the postholder is (unless agreed otherwise) only engaged in the activities of or relating to CCRP and CHP. If it agreed that a Post Holder may undertake other activities then Clause 5.8 shall apply;

5.7.4 be responsible for the Employee Costs for each day that they are engaged as a postholder (including bank holidays, weekends, illness and holidays taken by the Post Holder) but, save where Clause 6.8 applies, shall receive any agreed contributions or reimbursement from the other Parties in a timely manner;

5.7.5 apply its recruitment processes, contracts, payroll and HR policies and procedures provided that any decisions in respect of recruitment, redundancies, restructuring or other changes relevant to the postholder (other than day-to-day management decisions) must be approved by the CCRP Board;

5.7.6 be responsible for all other issues concerning the terms and conditions of employment of the Post Holder including disciplinary and grievance matters.

5.8 For the purposes of Clause 5.7 where a Post Holder's duties are shared between the CCRP, or other activities the employee costs shall be apportioned between CCRP (and, in the event of shortfall, the other Parties) and the Employing Party. Such apportionment shall be calculated to correspond to the apportionment of the Post Holder's duties and activities as between the CCRP and the Employing Party. The breakdown of an employee's work activities and splits of duties may be requested by any Party. In the event an employing party becomes aware that a member of staff for whatever reason is not able to delivery fully the prescribed CCRP duties they have a duty to inform the other Parties in writing.

5.9 It is agreed that upon the occurrence of any event or circumstances that may result in the potential redundancy of any member of the Core Team ("At Risk Post Holder"), the following provisions shall apply:

5.9.1 the redundancy situation will be managed by the Employing Party but under the oversight of the CCRP Board;

5.9.2 the Parties will use all reasonable endeavours to minimise the impact of the redundancy situation on the At Risk Post Holder and the financial implications for CCRP and the Parties;

5.9.3 the Employing Party (with the support and cooperation of the other Parties) will follow a reasonable, legally compliant and efficient redundancy consultation procedure in respect

of the At Risk Post Holder and take into account, when agreeing this procedure, the need to mitigate any cost and liability;

5.9.4 the Employing Party will, subject to its relevant policies and procedures, use all reasonable endeavours to find suitable alternative employment for the At Risk Post Holder;

5.9.5 Where the costs of a postholder's post is shared between two or more Parties, the Redundancy Costs shall be apportioned between those Parties. Such apportionment shall be calculated to correspond to the apportionment of funding for those particular posts based on the prescribed contractual hours, and duration of service for CCRP only.

5.10 The Parties agree that, as at the date of this Agreement, the implementation of the arrangements set out in Schedule 2 does not constitute a "business transfer" or a "service provision change" as those terms are defined by TUPE.

5.11 Save where TUPE applies, upon the expiry or termination of this Agreement for any reason, the Parties shall re-assume direct management control and responsibility for any members of the Core Team that it employs immediately prior to the expiry or termination of this Agreement, as the case may be.

5.12 Any party which becomes aware of the occurrence or probable occurrence of an event that might result in the applicability of TUPE shall promptly inform the other Parties. The Parties shall in good faith take such steps and initiate such discussions as may be necessary to comply with the obligations under TUPE and the partners shall provide to each other all such information as may reasonably be required. In particular, the Parties will ensure that if the identity of the Employing Party changes, the new employer (provided they are a party to this Agreement) shall not incur liability over and above that which would have accrued to the original Employing Party under this Agreement.

6. FINANCE

6.1 The Parties have agreed that VUNHST will act as the lead for CCRP on behalf of the other Parties. This section sets out the financial arrangements associated with this agreed approach and the approach to funding of the Core Team which acts as a Project Management Office for CCRP.

6.2 To date, VUNHST has provided the part time Project Management Office as set out in clause 5.2, As at the date of this Agreement, these posts comprise the entirety of the Core Team.

6.3 To fund the current baseline, each Party shall make the financial contributions to VUNHST at the beginning of the financial year (April) for the provision of the Core Team the details of which are set out in Schedule 2. Such contributions shall be made to VUNHST without deduction or set off in accordance with the provisions of Schedule 2.

6.4 The method by which each organisation funds its subscription costs to the CCRP Core Team is a matter for each Party and may vary. It is possible that some funding to be derived from trials management overhead or commercial income.

6.5 Schedule 2 resourcing is considered the baseline position reflected in this Agreement. It is anticipated that the Core Team may be required to expand in the future as CCRP increases in size. Any change to the baseline set out in Schedule 2 of this Agreement must be agreed by the CHP.

6.6 Any recurring costs, actual and contingent liabilities for the Core Team should be appropriately reflected in the Business Plan.

6.7 All Parties agree to an initial three-year funding arrangement commencing in the Financial Year 2026 as set out in Schedule 2. VUNHST will invoice the Parties to this Agreement.

6.8 The CHP will approve each annual Budget in accordance with this Agreement and the Parties agree to review the Budget regularly in meetings of the CCRP Board and otherwise as appropriate.

6.9 VUNHST shall only use such monies for the business of the Core Team to meet the outgoings and expenses incurred by VUNHST and its affairs in accordance with and subject to the terms of this Agreement and within the agreed annual budget and Workplan.

6.10 VUNHST may enter into contracts for the receipt of goods and/or services without the express permission of the partners. VUNHST's Standing Financial Instructions must provide always that provision for the financial commitments in such contracts is contained in the Budget and the Workplan or such commitments have been unanimously approved by partners at the CCRP Board within the budgetary framework determined in accordance with clause 6.8. Approval for any amendment to the Budget must be by unanimous agreement of partners via the CHP.

6.11 In the event that in any Financial Year VUNHST reasonably believes that there will be a deficit compared to the Budget it will notify the CHP as soon as reasonably practicable. The potential deficit identified will be considered by the CHP and to the extent that it is ratified by the partners via the CHP by unanimous agreement, each Party will make additional contributions of equal value to meet the deficit. The CHP will promptly notify the Parties of the extent of the shortfall and each Party (including, for the avoidance of doubt, VUNHST) shall pay its equal share of any Budget deficit to VUNHST within 30 days of receipt of an invoice.

7. RESEARCH GRANT AND CLINICAL TRIAL FINANCE

7.1 Clause 6 addresses core funding from Parties to this Agreement. In addition, each Research Study or Clinical Trial proposed under this Partnership Agreement will have its own contracting arrangements agreed between the relevant Parties and be approved by the CCRP Board.

7.2 Each organisation will maintain its own records relative to its Research Studies and Trials and make summary information available to VUNHST's quarterly in an agreed format. VUNHST will aggregate all information from Research Studies and Trials so that an accurate picture of CCRP's enabling activity and sustainability can inform the CCRP Board.

7.3 Once all Parties have had their costs reimbursed the remainder or ongoing income generated will be declared surplus and may in the first instance be used to offset payments for all parties associated with the CCRP's Core Team. Over and above this any surplus income could be reinvested into supporting the growth of the CCRP Partnership. Decisions on how any surplus monies (over and above the funding of Core Services and Core Team) should invested back into CCRP shall be proposed by the CCRP Board to the CHP MDG for approval.

7.4 To achieve the above VUNHST shall:

7.4.1 upon receipt of accounting information from partner organisation maintain a separately identifiable accounting record in respect of all CCRP monies (both for the core and research and trials). This accounting record shall maintain accurate and complete accounting and other financial records in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom;

7.4.2 prepare at least quarterly management accounts and reports which shall be submitted to the CCRP Board;

7.4.3 procure the preparation of accounts for the CCRP Board promptly after the end of each Financial Year and supply the same promptly to the CCRP Board; and

7.4.4 procure that each Party and/or its authorised representatives shall be permitted access at all reasonable times to examine the leger and financial records and to discuss its affairs with the CCRP Board.

7.5 There will be an annual business planning cycle relating to CCRP activities. Business planning will commence on or around September for the following financial year. The draft Workplan will be co-produced by all parties and shared at regular interval. The draft Workplan will be produced by 28 February for each year for approval by the CCRP Board (upon which it becomes the "Workplan") before implementation which shall include the following:

7.5.1 an operating budget (including estimated capital expenditure requirements);

7.5.2 a review of projected business;

7.5.3 a summary of the CCRP business objectives.

7.5.4 may trigger the need for a business case to be developed

7.6 Such operating budget becomes the "Budget" upon approval by the CCRP Board and CHP MDG. Unless otherwise agreed by the CCRP Board from time to time, the Workplan shall be organised around the themes that support the CCRP's strategy / aims, and which it is anticipated will continue to share the CCRP's work.

8. INFORMATION FLOW AND PROJECT MANAGEMENT

8.1 To enable the Parties to maximise the benefits of their collaboration, each Party shall:

8.1.1 engage the others in planning discussions in relation to the Focus from time to time;

8.1.2 keep the other Parties informed about its own progress in relation to each Project;

8.1.3 facilitate regular discussions between appropriate members of its personnel and those of the other Parties in relation to each Project, including in relation to:

8.1.3.1 performance and issues of concern in relation to each Project;

8.1.3.2 new developments and resource requirements;

8.1.3.3 compliance with deadlines; and

8.1.3.4 such other matters as may be agreed between the Parties from time to time.

8.2 Each Party shall:

8.2.1 supply to the other Parties any information and assistance reasonably requested by it relating to an enabling Project as is necessary to enable the other Parties to perform their own obligations in relation to the Project; and

8.2.2 review documentation, including draft specifications or service descriptions or other technical documentation, for use when performing its obligations in relation to a Project (if any), as soon as reasonably practicable at the request of the other Parties, and

8.2.3 notify it of any errors or incorrect assumptions made in any such documents as far as it is aware.

8.3 The CCRP Board will provide information to CHP as determined by the CHP agreement or operating model.

9. INVOICING AND PAYMENT

9.1 A Party shall pay an invoice issued to it in accordance with this Agreement within 30 days of the date of receiving the invoice.

9.2 The Parties acknowledge and agree that VUNHST will be responsible for invoicing any Charges due from any external and/or third-party organisations if required (ie. not contained within a Project agreement).

10. SET-OFF

All amounts due under this Agreement shall be paid in full without any set-off, counterclaim, deduction or withholding (other than any deduction or withholding of tax as required by law).

11. CONFIDENTIALITY

11.1 The provisions of this clause shall not apply to any Confidential Information that:

11.1.1 is or becomes generally available to the public (other than as a result of its disclosure by the receiving Party or its Representatives in breach of this clause);

11.1.2 was available to the receiving Party on a non-confidential basis before disclosure by the disclosing Party;

11.1.3 was, is or becomes available to the receiving Party on a non-confidential basis from a person who, to the receiving party's knowledge, is not bound by

11.1.4 a confidentiality agreement with the disclosing Party or otherwise prohibited from disclosing the information to the receiving Party;

11.1.5 the Parties agree in writing is not confidential or may be disclosed;

11.1.6 is developed by or for the receiving Party independently of the information disclosed by the disclosing Party.

11.2 Each Party shall keep the other party’s Confidential Information confidential and shall not:

11.2.1 use such Confidential Information except for the purpose of exercising or performing its rights and obligations under or in connection with this Agreement in relation to the Focus and any Project (Permitted Purpose); or

11.2.2 disclose such Confidential Information in whole or in part to any third party, except as expressly permitted by this clause.

11.3 A Party may disclose the other Parties’ Confidential Information to those of its Representatives who need to know such Confidential Information for the Permitted Purpose, provided that:

11.3.1 it informs such Representatives of the confidential nature of the Confidential Information before disclosure; and

11.3.2 at all times, it is responsible for such Representatives' compliance with the confidentiality obligations set out in this clause.

11.4 A Party may disclose Confidential Information to the extent such Confidential Information is required to be disclosed by law, by any governmental or other regulatory authority or by a court or other authority of competent jurisdiction provided that, to the extent it is legally permitted to do so, it gives the other Party as much notice of such disclosure as possible and, where notice of disclosure is not prohibited and is given in accordance with this clause 11.4, it takes into account the reasonable requests of the other Party in relation to the content of such disclosure.

11.5 A Party may, provided that it has reasonable grounds to believe that the other Party is involved in activity that may constitute a criminal offence under the Bribery Act 2010, disclose Confidential Information to the Serious Fraud Office without first informing the other Party of such disclosure.

11.6 Each Party reserves all rights in its Confidential Information. No rights or obligations in respect of a Party's Confidential Information other than those expressly stated in this Agreement are granted to the other Parties, or to be implied from this Agreement.

11.7 On termination of this Agreement, unless such things are needed by it to perform its obligations under a Research Study Schedule (and only until the end of such time), each Party shall:

11.7.1 destroy or return to the other Party all documents, data and materials (and any copies) containing, reflecting, incorporating or based on the other Party's Confidential Information;

11.7.2 erase all the other Party's Confidential Information from computer and communications systems and devices used by it, including such systems and data storage services provided by third parties (to the extent technically and legally practicable); and

11.7.3 certify in writing to the other Party that it has complied with the requirements of this clause, provided that a recipient Party may retain documents and materials containing, reflecting, incorporating or based on the other Party's Confidential Information to the extent required by law or any applicable governmental or regulatory authority. The provisions of this clause shall continue to apply to any such documents and materials retained by a recipient Party.

11.8 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information.

11.9 The provisions of this clause 01 shall continue to apply after termination of this Agreement in accordance with clause 244 (Survival).

12 ANNOUNCEMENTS

12.1 Subject to clause 12.2, a Party shall not make, or permit any person to make, any public announcement, communication or circular (announcement) concerning the existence, subject

matter or terms of this Agreement, the wider transactions contemplated by it, or the relationship between the Parties, without the prior written consent of the other Parties (such consent not to be unreasonably withheld or delayed). The Parties shall consult together on the timing, contents, and manner of release of any announcement.

12.2 Where an announcement is required by law or any governmental or regulatory authority (including any relevant securities exchange), or by any court or other authority of competent jurisdiction, the Party required to make the announcement shall promptly notify the other Parties. The Party concerned shall make all reasonable attempts to agree the contents of the announcement before making it.

13 DATA PROTECTION

13.1 The Parties will comply with all applicable requirements of the Data Protection Legislation and all Applicable Laws. In this **Error! Bookmark not defined.Error! Reference source not found.**3, Applicable Laws means (for so long as and to the extent that they apply to the Parties) the law of the European Union, the law of any member state of the European Union and/or Domestic UK law which relates to the protection of Personal Data; and Domestic UK Law means the Data Protection Legislation and any other law that applies in the UK. This **Error! Bookmark not defined.**133 is in addition to, and does not relieve, remove, or replace, a Party's obligations or rights under the Data Protection Legislation.

13.2 This clause sets out the framework for the sharing of personal data between the Parties as Controllers. Each Party acknowledges that one Party (referred to in this clause as the Data Discloser) will regularly disclose to the other Party or Parties Shared Personal Data collected by the Data Discloser for the purposes set out in the background and the Focus as set out in clause 3.4 of this Agreement.

13.3 Each Party shall comply with all the obligations imposed on a Controller under the Data Protection Legislation, and any material breach of the Data Protection Legislation by one Party shall, if not remedied within thirty (30) days of written notice from another Party, give grounds for a Party to terminate this Agreement with immediate effect.

13.4 Each Party shall:

13.4.1 ensure that it has all necessary notices and consents and lawful bases in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;

13.4.2 give full information to any Data Subject whose personal data may be processed under this Agreement of the nature of such processing. This includes giving notice that, on the termination of this Agreement, personal data relating to them may be retained by or, as

the case may be, transferred to one or more of the Permitted Recipients, their successors, and assignees;

13.4.3 process the Shared Personal Data only for the Agreed Purposes;

13.4.4 not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;

13.4.5 ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Agreement;

13.4.6 ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other Parties, to protect against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data;

13.4.7 not transfer any personal data received from the Data Discloser outside the UK unless the transferor ensures that (i) the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection; or (ii) there are appropriate safeguards or binding corporate rules in place pursuant to the applicable Data Protection Legislation; or (iii) the transferor otherwise complies with its obligations under the applicable Data Protection Legislation by providing an adequate level of protection to any personal data that is transferred; or (iv) on of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

13.5 Each Party shall assist the others in complying with all applicable requirements of the Data Protection Legislation. In particular each Party shall:

13.5.1 consult with the other Parties about any notices given to Data subjects in relation to the Shared Personal Data;

13.5.2 promptly inform the other Parties about the receipt of any Data Subject rights request;

13.5.3 provide the other Parties with reasonable assistance in complying with any Data Subject rights request;

13.5.4 not disclose, release, amend, delete, or block any Shared Personal Data in response to a Data Subject rights request without first consulting the other Parties wherever possible;

13.5.5 assist any Party, at the cost of that Party, in responding to any request from a data subject and in ensuring compliance with its obligations under the Data Protection Legislation with

respect to security, personal data breach notifications, data protection impact assessments and consultations with the Information Commissioner or other regulators;

13.5.6 notify the other Parties without undue delay on becoming aware of any breach of the Data Protection Legislation;

13.5.7 at the written direction of the Data Discloser, delete or return Shared Personal Data and copies thereof to the Data Discloser on termination of this Agreement unless required by law to store the Shared Personal Data;

13.5.8 use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;

13.5.9 maintain complete and accurate records and information to demonstrate its compliance with this clause 133 and allow for audits by a Party to this Agreement or that Party's designated auditor; and

13.5.10 provide the other Parties with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in the event of a data security breach, and the regular review of the Parties' compliance with the Data Protection Legislation.

13.6 The Parties shall indemnify each other against any losses, damages, cost, or expenses incurred by any of the Parties arising from, or in connection with, any breach of the other Party's obligations under this clause 13. This will be capped to a maximum of £1M.

13.7 This clause **Error! Reference source not found.**3 shall remain in force without limit in time.

14 INTELLECTUAL PROPERTY

14.1 This Agreement does not affect the ownership or transfer any interest in Intellectual Property Rights in any Background IPR which is not or in any other technology, design, work, invention, software, data, technique, Know-how, or materials which is not Project IPR. The Intellectual Property Rights in any Background IPR will remain the property of the Party which contributed them to the Project(s) (or its licensors). No licence to use any Background IPR is granted or implied by this Agreement except the rights expressly set out in this Agreement.

14.2 Each Party grants to the other Parties a non-exclusive, personal, royalty-free licence during the applicable Project Period to use its Project IPR in relation to a Project to the extent necessary for the other Parties to carry out their obligations in relation to that Project.

14.3 Subject to clause 14.6 at the end of the applicable Project Period, a Party licensed to use Project IPR under clause 14.2 shall cease to use that Project IPR and shall return any physical

embodiment of the Project IPR (including any copies) in its possession or control to the owning party.

14.4 Each Party shall immediately give written notice to the other Parties of any actual, threatened, or suspected infringement of any Party's IPR (including Project IPR) used in connection with a Project of which it becomes aware.

14.5 The individual Projects may contain more Project specific clauses relating to IPR.

14.6 In addition to the rights granted in clauses 14.2 and notwithstanding clause 14.3 and subject to clause 14.7, VUNHST and CVUHB, acknowledge and agree that as an academic Party, the University and each of its employees and students will have the irrevocable, royalty-free right to use any of the Project IPR for academic and research purposes.

14.7 Notwithstanding clause 14.6, and in relation to any Hosted Studies, the Parties represent and warrant that they will not attempt to seek commercial advantage or infringe the IPR of the other Party or any third party, nor knowingly allow any third party to do so and any such exploitation of any IPRs is subject to the terms and conditions of any agreements governing any Hosted Studies.

14.8 Nothing in this Clause 14 shall be construed so as to prevent or hinder a Party from using its Know-How or Project IPR generated during the performance of a Project in the furtherance of its normal activities, to the extent that such use does not result in the disclosure or misuse of Confidential Information or the infringement of any IPRS, or Know-How of any third party, without the prior written consent of that third party, or would cause a Party to be in breach of any obligations that it is bound to under any Hosted Study agreement.

14.9 The Parties will agree a strategy for any proposed exploitation of any IPRs.

15 CCRP BRANDING AND LOGOS

15.1 Each Party acknowledges and agrees that by signing this Agreement, it shall permit the other Parties to use its name or the name of any of its key Personnel, or its logo, in any press release or advertising, or for any other promotional purpose related to this Agreement, or any Projects

(if permitted by any separate Project Agreements or funding agreements), or any other CCRP and CHP activities.

15.2 The Parties shall not use a Party's name or logo or the name of any of its key personnel for any press release or advertising, or for any other promotional purpose that is not related to this Agreement, a Project or any other CCRP activities.

15.3 Neither Party will use a third party's name or logo or any name of the key personnel belonging to a third party, in any press release or product advertising, or any other promotional purpose relating to the CCRP or otherwise, without first obtaining that third party's written consent.

15.4 The Parties acknowledge and agree that in relation to clauses 15.1 and 15.3, any Party's name and logo or that of any third party must be used only in accordance with that Party's or a third party's Branding Guidelines, made available upon request and as amended from time to time.

16 FREEDOM OF INFORMATION

16.1 The Parties acknowledges that each of them is subject to the requirements of the FOIA and the Environmental Information Regulations.

16.2 The Parties shall:

16.2.1 provide all necessary assistance and cooperation as reasonably requested by VUNHST, CVUHB or the University to enable VUNHST, CVUHB and the University to comply with their obligations under the FOIA and EIRs;

16.2.2 transfer to VUNHST, CVUHB or the University all Requests for Information relating to this Agreement that it receives as soon as practicable and in any event within 2 Working Days of receipt;

16.2.3 provide VUNHST, CVUHB or the University with a copy of all Information belonging to VUNHST, CVUHB or the University requested in the Request For Information which is in its possession or control in the form that VUNHST, CVUHB or the University requires within 5 Working Days (or such other period as VUNHST, CVUHB or the University may reasonably specify) of VUNHST, CVUHB or the University's request for such Information; and

16.2.4 not respond directly to a Request for Information unless authorised in writing to do so by VUHNST, CVUHB or the University.

16.3 Each Party acknowledges that it may be required under the FOIA and Environmental Information Regulations to disclose Information (including Commercially Sensitive Information) without consulting or obtaining consent from the others. The Parties shall take reasonable steps to notify each other of a Request for Information (in accordance with the Cabinet Office's Freedom of Information Code of Practice issued under section 45 of the FOIA) to the extent that it is permissible and reasonably practical for it to do so but (notwithstanding any other provision in this Agreement) the Parties shall be responsible for determining in their absolute discretion

whether any Commercially Sensitive Information and/or any other information is exempt from disclosure in accordance with the FOIA and/or the EIRs.

17 ANTI-BRIBERY

17.1 Each Party shall in relation to this Agreement and the Programme:

17.1.1 comply with all applicable laws, statutes, regulations, and codes relating to anti-bribery and anti-corruption including but not limited to the Bribery Act 2010 ("Relevant Requirements");

17.1.2 have and shall maintain in place throughout the term of this Agreement its own policies and procedures, including but not limited to adequate procedures under the Bribery Act 2010, to ensure compliance with the Relevant Requirements and will enforce them where appropriate; and

17.1.3 promptly report to the other Parties any request or demand for any undue financial or other advantage of any kind received by it in connection with the performance of this Agreement.

Breach of this clause 17 shall be deemed a material breach under clause 26.2

18 WARRANTIES

18.1 Each Party warrants that:

18.1.1 it has full power and authority to carry out the actions contemplated under this Agreement; and

18.1.2 its entry into and performance under the terms of this Agreement will not knowingly infringe the Intellectual Property Rights of any third party or cause it to be in breach of any obligations to a third party; and

18.1.3 so far as it is aware, all information, data and materials provided by it under this Agreement will be accurate and complete in all material respects, and it is entitled to provide the same to the other without recourse to any third party.

18.2 Except as expressly provided in this Agreement, there are no conditions, warranties, or other terms binding on the Parties with respect to the actions contemplated by this Agreement. Any condition, warranty or other term in this regard that might otherwise be implied or incorporated into this Agreement, whether by statute, common law or otherwise, is, to the extent that it is lawful to do so, excluded by this Agreement.

19 INDEMNITY

19.1 In this clause, a reference to an **indemnified party** shall include that Party's subsidiaries, and the provisions of this clause shall be for the benefit of that Party and each such subsidiary, and shall be enforceable by each such subsidiary, in addition to the Party.

19.2 Each Party (**indemnifying party**) shall indemnify the other Parties (**indemnified party**) against all liabilities capped to a maximum of £1M, this includes, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with:

19.2.1 Any claim made against the indemnified party for actual or alleged infringement of a third party's Intellectual Property Rights arising out of or in connection with:

19.2.1.1 the indemnified party's use in accordance with this Agreement of Intellectual Property Rights licensed to it by the indemnifying party under clause 04; or

19.2.1.2 the receipt or use by the indemnified party of Inputs or other items or services provided by the indemnifying party in relation to a Project;

19.3 This indemnity shall not cover the indemnified party to the extent that a claim under it results from the indemnified party's negligence or wilful misconduct.

19.4 Liability under this indemnity is conditional on the indemnified party discharging the following obligations. If any third party makes a claim, or notifies an intention to make a claim, against the indemnified party which may reasonably be considered likely to give rise to a liability under this indemnity (**Claim**), the indemnified party shall:

19.4.1 as soon as reasonably practicable, give written notice of the Claim to the indemnifying party, specifying the nature of the Claim in reasonable detail;

19.4.2 not make any admission of liability, agreement or compromise in relation to the Claim without the prior written consent of the indemnifying party (such consent not to be unreasonably conditioned, withheld or delayed), provided that the indemnified party may settle the Claim (after giving prior written notice of the terms of settlement (to the extent legally possible) to the indemnifying party, but without obtaining the indemnifying party's consent) if the indemnified party reasonably believes that failure to settle the Claim would be prejudicial to it in any material respect;

19.4.3 give the indemnifying party and its professional advisers access at reasonable times (on reasonable prior notice) to its premises and its officers, directors, employees, agents, representatives or advisers, and to any relevant assets, accounts, documents and records within the power or control of the indemnified party, so as to enable the indemnifying party and its professional advisers to examine them and to take copies (at the indemnifying party's expense) for the purpose of assessing the Claim; and

19.4.4 subject to the indemnifying party providing security to the indemnified party to the indemnified party's reasonable satisfaction against any claim, liability, costs, expenses,

damages, or losses which may be incurred, take such action as the indemnifying party may reasonably request to avoid, dispute, compromise or defend the Claim.

19.5 If a payment due from the indemnifying party under this clause is subject to tax (whether by way of direct assessment or withholding at its source), the indemnified party shall be entitled to receive from the indemnifying party such amounts as shall ensure that the net receipt, after tax, to the indemnified party in respect of the payment is the same as it would have been were the payment not subject to tax.

19.6 Nothing in this clause shall restrict or limit the indemnified party's general obligation at law to mitigate a loss it may suffer or incur as a result of an event that may give rise to a claim under this indemnity.

20 INSURANCE

20.1 The Parties acknowledge and agree that at all times during the term of this Agreement:

20.1.1 VUNHST will remain a member of the Welsh Risk Pooling Scheme or any subsequent Welsh Risk Pool arrangements and as such applies the NHS indemnity to its activities which are covered by this Agreement; and

20.1.2 CVUHB will remain a member of the Welsh Risk Pooling Scheme or any subsequent Welsh Risk Pool scheme and applies the NHS Indemnity to its activities which are covered by this Agreement.

20.2 The University undertakes that during the term of this Agreement and for a period of 2 years thereafter, it shall either self-insure or maintain in force, with a reputable insurance company, professional indemnity insurance in an amount that will reasonably cover claims arising from a single event or series of related events in a single calendar year, and shall, on the other Party's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium.

20.3 Each Party shall notify the other if any policy is (or will be) cancelled or its terms are (or will be) subject to any material change.

21 LIMITATION AND EXCLUSION OF LIABILITY

21.1 The limits and exclusions in this clause reflect the insurance cover the Parties have been able to arrange for themselves, respectively.

21.2 References to liability in this clause include every kind of liability arising under or in connection with this Agreement including but not limited to liability in contract, tort (including negligence), misrepresentation, restitution or otherwise.

21.3 A Party may not benefit from the limitations and exclusions set out in this clause in respect of any liability arising from its deliberate default.

21.4 Nothing in this Agreement shall limit any liability under clause 19 (Indemnity).

21.5 Nothing in this clause shall limit a Party's payment obligations to the others under this Agreement.

21.6 Nothing in this Agreement limits any liability that cannot legally be limited, including liability for:

21.6.1 death or personal injury caused by negligence;

21.6.2 fraud or fraudulent misrepresentation; and

21.6.3 breach of the terms implied by section 12 of the Sale of Goods Act 1979 or section 2 of the Supply of Goods and Services Act 1982 (title or quiet possession).

21.7 Subject to clause 21.31.3 (no limitations in respect of deliberate default), clause 21.41.4 (no limitation of payment obligations), clause 21.5 (liability under identified clauses) and clause 21.6 (liabilities which cannot legally be limited), a Party's total liability to the other Parties under or in connection with this Agreement shall not exceed £1m.

22 INTENTION TO TERMINATE

22.1 Subject to clause 02 , in the event that any Party (the "Initiating Party") contemplates the termination of this Agreement, the Initiating Party shall provide prompt written notification to the other Parties, detailing its intention to terminate. The Parties shall then engage in good faith discussions for a period of not less than thirty (30) days from the date of such notification, or such other period as mutually agreed, to explore the intention to terminate and to agree upon a managed wind-down of activities under this Agreement and its impact on any individual Research Study Agreements.

22.2 Notwithstanding any other provision in this Agreement, the Parties acknowledge and agree that their paramount duty of care is to patients participating in Projects supported by CCRP. Accordingly, each Party shall, at all times, act in accordance with the safety and efficacy of such research and in the best interests of the safety and well-being of all such patients. No Party shall take any action, including but not limited to the termination of this Agreement, if to do so would be contrary to the safety or best interests of such patients, or would compromise the integrity or continuity of ongoing Projects critical to patient safety. The Parties shall cooperate fully to ensure the continued safety and care of patients and the ethical conduct of Research Studies, even in circumstances contemplating termination.

22.3 The Parties further acknowledge their respective obligations to third parties, including but not limited to sponsors of Hosted Studies, other sponsors of Research Studies supported by CCRP, and funders (collectively, "Third-Party Stakeholders").

22.4 In considering any termination of this Agreement, or any action that may impact the continuation of individual Project Schedule activities, each Party shall be mindful of and take all reasonable steps to mitigate any adverse impact on its obligations to Third-Party Stakeholders. The Parties shall collaborate to inform relevant Third-Party Stakeholders of any potential termination or

significant changes to the Agreement in a timely and appropriate manner, and to agree upon a coordinated approach to minimise disruption to Projects and funding arrangements. This includes, where necessary and reasonably practicable, assisting with the orderly transfer of responsibilities or data to ensure compliance with existing agreements with Third-Party Stakeholders.

23 TERMINATION OF AGREEMENT

23.1 Subject to clause 22, (Intention to Terminate) without affecting any other right or remedy available to it, a Party may terminate this Agreement with immediate effect by giving written notice to the other Party if:

23.1.1 the other Party fails to pay any amount due under this Agreement on the due date for payment and remains in default not less than 90 days after being notified in writing to make such payment;

23.1.2 the other Party commits a material breach of this Agreement;

23.1.3 the other Party repeatedly breach**es** any of the terms of this Agreement in such a manner as to reasonably justify the opinion that its conduct is inconsistent with it having the intention or ability to give effect to the terms of this Agreement.

23.1.4 if any warranty given by the other Party in clause 18 of this Agreement is found to be untrue or misleading;

23.1.5 in accordance with clause 26 (Force Majeure).

23.2 For the purposes of **Error! Bookmark not defined.Error! Reference source not found.**, a material breach means:

23.1.1 a breach of any of the obligations set out in **Error! Bookmark not defined.**3; or

23.2.2 a breach that has a serious effect on the benefit which the terminating Party would otherwise derive from this Agreement.

24 SURVIVAL

24.1 On termination of this Agreement, the following clauses shall continue in force:

clause 1 (Interpretation);

clause 9 (Invoicing and Payment);

clause 10 (Set-Off);

clause 11 (Confidentiality);

clause 13 (Data Protection);

clause 14 (Intellectual Property);

clause 16 (Freedom of Information);

clause 18.1.2 and clause 18.2 (Warranties);

clause 19 (Indemnity);

clause 20 (Insurance);

clause 21 (Limitation and Exclusion of Liability);

clause (Survival);

clause 25 (Consequences of Termination);

clause 26 (Force Majeure);

clause 28 (Entire Agreement);

clause 31 (Notices);

clause 32 (Severance);

clause 33 (No Partnership or Agency);

clause 34 (Rights and Remedies);

clause 35 (Waiver);

clause 37 (Third Party Rights);

clause 40 (Mediation);

clause 41 (Governing Law); and

clause 42 (Jurisdiction).

24.2 Termination of this Agreement shall not affect any rights, remedies, obligations, or liabilities of the Parties that have accrued up to the date of termination, including the right to claim damages in respect of any breach of the Agreement which existed at or before the date of termination.

25 CONSEQUENCES OF TERMINATION

25.1 In the event of the termination of a Research Study agreement or of this Agreement for any reason whatsoever, each Party shall remain fully obligated to, and shall continue to, deliver its commercial obligation and other commitments in relation to all Research Study Schedules which commenced or were formally committed to prior to the effective date of such termination. For the avoidance of doubt, the termination of this Agreement shall not release any Party from its

obligations or liabilities arising from or in connection with any Research Study Agreement commenced or formally committed to prior to the effective date of such termination.

25.2 Upon the effective date of termination of this Agreement, the Parties shall cease to enter into any new Research Study Agreement pursuant to CCRP and/or this Agreement or the legacy partnership it represents. Any new Research Study Agreements initiated after the effective date of termination shall require a separate and distinct agreement between the relevant Parties, independent of this terminated Agreement.

25.3 On termination of this Agreement, unless such things are needed by it to perform its obligations under a Research Study Agreement (and only until the end of such time), each Party shall, and shall use all reasonable endeavours to procure that its Representatives shall, no later than 7 days after termination of this Agreement:

25.3.1 return or destroy (as directed in writing by the other Party) any documents, handbooks, or other information or data provided to it by the other Party for the purposes of this Agreement. If reasonably required by the other Party, it shall provide written evidence (in the form of a letter signed by it no later than 7 days after termination of this Agreement) that these have been destroyed and that it has not retained any copies of them;

25.3.2 return all of the other Party's equipment and materials, failing which, the other Party may enter the relevant premises and take possession of them. Until these are returned or repossessed, that Party shall be solely responsible for their safe keeping;

25.3.3 cease all licences and permissions granted under this Agreement;

25.3.4 promptly return to the other any Confidential Information of the other Party, including any copies thereof;

25.3.5 cease use of a Party’s name, name of any of their key personnel or logo or that of any third party; and

25.3.6 cease use of the name and logo of the CCRP.

26 FORCE MAJEURE

A Party shall not be in breach of this Agreement nor liable for delay in performing, or failure to perform, any of its obligations under this Agreement if such delay or failure results from events, circumstances or causes beyond its reasonable control. In such circumstances the affected Party shall be entitled to a reasonable extension of the time for performing such obligations. If the period of delay or non-performance continues for 2 months the Party not affected may terminate this Agreement by giving 14 days' written notice to the affected Party.

27 ASSIGNMENT AND OTHER DEALINGS

A Party shall not assign, transfer, mortgage, charge, subcontract, delegate, declare a trust over or deal in any other manner with any or all of its rights and obligations under this Agreement

without the prior written consent of the other Parties (such consent not to be unreasonably withheld or delayed).

28 ENTIRE AGREEMENT

28.1 This Partnership Agreement constitutes the entire agreement between the Parties and supersedes and extinguishes all previous Tri-Party agreements relating to the development of CCRP, including its promises, assurances, warranties, representations, and understandings between them, whether written or oral, relating to its subject matter.

28.2 Each Party agrees that it shall have no remedies in respect of any representation or warranty (whether made innocently or negligently) that is not set out in this Agreement. No Party shall have any claim for innocent or negligent misrepresentation based on any statement in this Agreement.

29 CONFLICT

Where there is a conflict between the provisions of this Agreement, and a separate Research Study Agreement, the Research Study Agreement shall prevail.

30 VARIATION

No variation of this Agreement shall be effective unless it is in writing and signed by the Parties (or their authorised representatives) via the CCRP Board.

31 NOTICES

31.1 A notice given to a Party under or in connection with this Agreement shall be in writing and sent to the Party at the address or email address given in this Agreement or as otherwise notified in writing to other Party.

31.2 This clause 31.2 sets out the delivery methods for sending a notice to a Party under this Agreement and, for each delivery method, the date and time when the notice is deemed to have been received (provided that all other requirements of this clause have been satisfied, and subject to the provisions of clause 31.2.4):

31.2.1 if delivered by hand, at the time the notice is left at the address;

31.2.2 if sent by pre-paid first-class post or other next working day delivery service providing proof of postage, at 9.00am on the second Business Day after posting;

31.2.3 if sent by email, at the time of transmission.

31.2.4 If deemed receipt under clause 31.2 would occur outside business hours in the place of receipt, it shall be deferred until business hours resume. In this clause, business hours

means 9.00 am to 5.00 pm Monday to Friday on a day that is not a public holiday in the place of receipt.

31.3 This clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

32 SEVERANCE

32.1 If any provision or part-provision of this Agreement is or becomes invalid, illegal, or unenforceable, it shall be deemed deleted, but that shall not affect the validity and enforceability of the rest of this Agreement.

32.2 If any provision or part-provision of this Agreement is deemed deleted under clause 0, the Parties shall negotiate in good faith to agree a replacement provision that, to the greatest extent possible, achieves the intended commercial result of the original provision.

33 NO PARTNERSHIP OR AGENCY

33.1 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Parties, constitute any Party the agent of another Party, or authorise any Party to make or enter into any commitments for or on behalf of any other Party.

33.2 Each Party confirms it is acting on its own behalf and not for the benefit of any other person.

34 RIGHTS AND REMEDIES

Except as expressly provided in this Agreement, rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

35 WAIVER

35.1 A waiver of any right or remedy under this Agreement or by law is only effective if given in writing and shall not be deemed a waiver of any subsequent breach or default.

35.2 A failure or delay by a Party to exercise any right or remedy provided under this Agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict any further exercise of that or any other right or remedy. No single or partial exercise of any right or remedy provided under this Agreement or by law shall prevent or restrict the further exercise of that or any other right or remedy.

36 COUNTERPARTS

36.1 This Agreement may be executed in any number of counterparts, each of which when executed shall constitute a duplicate original, but all the counterparts shall together constitute the one Agreement.

36.2 Transmission of an executed counterpart of this Agreement (but for the avoidance of doubt not just a signature page) by email (in PDF, JPEG, or other agreed format) shall take effect as the transmission of an executed "wet ink" counterpart of this Agreement. If this method of transmission is adopted, without prejudice to the validity of the Agreement thus made, each Party shall on request provide the other with the "wet ink" hard copy original of their counterpart.

36.3 No counterpart shall be effective until each Party has executed at least one counterpart.

37 THIRD PARTY RIGHTS

37.1 This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

37.2 The rights of the Parties to rescind or vary this Agreement are not subject to the consent of any other person.

38 FURTHER ASSURANCE

Each Party shall and shall use all reasonable endeavours to procure that any necessary third Party shall, promptly execute and deliver such documents and perform such acts as may reasonably be required for the purpose of giving full effect to this Agreement.

39 COSTS

Subject to clause 7, each Party shall pay its own costs incurred in connection with the negotiation, preparation, and execution of this Agreement and any documents referred to in it.

40 MEDIATION

40.1 If a dispute or difference arises between any or all of the Parties in relation to any aspect of this Agreement, the Parties shall consult in good faith via the CCRP's coordination groups and hierarchy in an attempt to come to an agreement in relation to the disputed matter. Where the dispute is not resolved, the matter will be referred to the CHP Executive for resolution.

40.2 Where there is a dispute between VUNHST and CVUHB and such dispute cannot be resolved in accordance with clause 0, VUNHST and CVUHB Representatives (or their representatives) shall be referred to the Welsh Ministers for resolution pursuant to section 7(6) of the Nation al Health Service (Wales) Act 2006.

40.3 If any dispute arises in connection with this Agreement between VUNHST and/or CVUHB and the University and cannot be resolved pursuant to clause 0, the Parties agree to enter into mediation in good faith to settle such a dispute and will do so in accordance with [the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the Parties within 14 working days of notice of the dispute, the mediator will be nominated by CEDR. To initiate the mediation a Party must give notice in writing (ADR notice) to the other Party, referring the dispute to mediation. A copy of the referral should be sent to CEDR.

40.4 If there is any point on the logistical arrangements of the mediation, other than nomination of the mediator, upon which the Parties cannot agree within 14 working days from the date of the ADR Notice, where appropriate, in conjunction with the mediator, CEDR will be requested to decide that point for the Parties having consulted with them.

40.5 Unless otherwise agreed, the mediation will start not later than 28 working days after the date of the ADR notice. The commencement of a mediation will not prevent the Parties commencing or continuing court proceedings.

41 GOVERNING LAW

This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales as it applies in Wales.

42 JURISDICTION

Each Party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

clause 0

Schedule 1 - CCRP Management Board Terms of Reference

CCRP Management Board		
Chair	Mererid Evans / Awen Gallimore / Matt Wise (to alternate)	
Cadence	Bi-monthly	
	Clinical Operations Lead(s)	Mererid Evans Katie Gilmour/Emma Barker
	Discovery & Translational Research Lead	Awen Gallimore
	Cardiff University corporate representative(s) (& CHP)	Kerry Hood TBA
	VUNHST corporate representative(s) (& CHP)	Lauren Fear Gavin Bryce
	CVUHB corporate representative(s) (& CHP)	Matt Wise David Fluck
	Comms & Engagement Lead	Non Gwilym/Sarah Tipping
	CCRP Clinical Academic	Philip Savage
	Haematology representative	Keith Wilson/Wendy Ingram
	R&D Governance, CAV	Sarah Martin
	R&D Governance, VUNHST	Sarah Townsend
	Non-executive board member for VUNHST (also Professor of Medicinal Chemistry at CU)	Andy Westwell
	Strategic Service Planning, CAV:	Katie Innes/Harriet Ryland
	CCRP Operations/Project Management Office (Secretariat)	Rhyd Owen Kate Cleary Anna Farmer
Quorum	The Chair (or their nominee) together with representation from each of the three partner organisations.	
Purpose	Responsible for oversight and management of the CCRP. The group is accountable for ensuring the CCRP delivers its agreed outcomes on time, within budget, and to agreed quality standards. operational management of the CCRP. The CCRP is responsible for setting and delivering the CCRP's objectives, within the wider context of the Cardiff Health Partners (CHP) framework. The CHP will set the strategic context within which the CCRP operates, and co-ordination of collective activity between CCRP and other CHP programmes on cross-cutting themes. The CHP also provides an escalation route for CCRP.	
Responsibilities	• Approving and overseeing delivery of the CCRP's Strategic Plan and supporting Annual Plan(s). • Management of the CCRP's annual budget iaw Clause 6 and Schedule 2. • Delegate financial and other resource management authority to individual groups or individuals within CCRP as required.	

	• Oversight of the CCRP's governance and its risk management function, including reporting to and escalating issues/risks to CHP and/or individual partner organisations as necessary • Ensure effective communication of all CCRP activities, both to CHP and within partner organisations, as well as to external media and stakeholders.
Reporting Arrangement	Reporting into the CCRP Management Board: • CCRP's Clinical Operations Group • CCRP's Discovery & Translational Research Group • CCRP Project Management Office • Other CCRP groups and workstreams as required The Management Board reports to the CHP, as per specific reporting arrangements agreed with CHP from time to time. This currently includes: • Regular updates on progress against delivery, and escalation of risks/issues, to CHP's Management and Development Group • CCRP representation on CHP's Executive Partnership Board.
Outputs *(e.g. specific documents to be produced)*	• CCRP Strategic Plan • CCRP Annual Plan • Supporting documents set out in the above plans (e.g. CCRP Data Strategy) • A regularly reviewed CCRP Risk Register • Regular update reports to CHP • Periodically reviewed programme management arrangements

Schedule 2 - Finance

1.1 VUNHST agrees to provide a part time Core Team function that co-ordinates and supports the delivery of the CCRP. This is conditional upon all Parties providing funding, for a minimum of three years commencing April 2026 and an annual review.

1.2 The funding requirement is set out in Table 1 below. The figures in Table 1 are exclusive of VAT (if applicable) and are forecasted costs; as such, they may be increased in light factors such as pay awards. Liability for any deficit in accordance with the terms of this Agreement shall be equal to that of the other Parties.

TABLE 1

Post	**FTE**	**Total Forecasted cost**			**Forecasted Annual contribution required from each partner organisation**		
		2026/27	**2027/28**	**2028/29**	**2026/27**	**2027/28**	**2028/29**
Operational Lead	0.5	£58,710	Base year plus increment and cost of living rises, or other employer contribution increases	2027/2028 plus increment and cost of living rises, or other employer contribution increases	£19,570	TBC	TBC
Project Manager	0.5	£36,050			£12,017	TBC	TBC
Project Support Officer	0.5	£19,570			£6,523	TBC	TBC
Communications Officer	0.2	£12,360			£4,120	TBC	TBC
Non-staff costs		£20,000			£6,667	TBC	TBC
Total	**1.7**	**£146,690**			**£48,897**		

1.3 For the avoidance of doubt, the Parties may agree to increase the annual funding commitment if agreed unanimously at the Cardiff Health Partners Management & Development Group. Any changes to the annual funding levels will be recorded in a schedule of annual funding levels.

1.4 The Parties contribution may reduce or cease altogether if it is agreed by the CCRP Board that surplus / funding, or income may be used to negate the Parties contribution to the Core Team.

1.5 Nothing in this Agreement shall prevent any Party from voluntarily increasing its funding provision to CCRP in respect of any Financial Year. Any Party doing so will notify the CCRP Board that it is so increasing its funding commitment.

2. Approvals

2.1 For the avoidance of doubt the Budget, the Business Plan and variations to the funding commitment of each of the Parties shall be agreed by the CCRP Board annually and approved by Parties via CHP.

3. Overspends and Underspends

3.1 The Parties shall use all reasonable endeavours to arrange for the discharge of the CCRP activities in accordance with the Budget available in each Financial Year.

3.2 In the event that there will be a deficit compared to the Budget as determined in accordance with clause 6.11 this will be payable in addition. This payment would be shared equally between all Parties. For the avoidance of doubt the decision to pay any deficit shall not be a Reserved Matter.

3.3 The CCRP Board shall make the Parties aware of any potential underspend prior to the end of the Financial Year. The CCRP Board shall highlight reasons for the underspend and identify any part of that underspend which is already contractually committed.

4. Payment of Funding Commitment

4,1 Each Party agrees to pay their respective funding commitment as set out in Schedule 2 for the relevant Financial Year in full without deduction or set off in two equal instalments paid 6-monthly in advance commencing by 1st April of the relevant Financial Year.

4,2 VUNHST will issue invoices to Parties in April of each year.

This Agreement has been entered into on the date stated at the beginning of it.

Signed for and on behalf of

Velindre University NHS Trust

……..

Authorised Signatory

Name: Jacinta Abraham

Position: Executive Medical Director

Signed for and on behalf of

Cardiff & Vale University Health Board

……..

Authorised Signatory

Name: David Fluck

Position: Executive Medical Director

Signed for and on behalf of

Cardiff University

……..

Authorised Signatory

Name: Stephen Riley

Position: Pro-Vice Chancellor, College of Biomedical and Life Sciences

Appendix 3 – CHP Agreement

DATED XX/XX/**2026**

Appendix 4 - Collaboration Agreement
relating to
Cardiff Health Partners

BETWEEN

(1) Velindre University NHS Trust
and
(2) Cardiff and Vale University Health Board
and
(3) Cardiff University

CONTENTS

CLAUSE

1. INTERPRETATION....4
2. COMMENCEMENT AND DURATION....101
3.COLLABORATION AND CO-OPERATION....101
4.EXISTING ARRANGEMENTS....12
5.PROPOSALS AND PROJECTS....104
6.WORKFORCE....13
7. FINANCE....177
8. ADDITIONAL PARTNERS....168
9.INFORMATION FLOW AND PROJECT MANAGEMENT....20
10.CHARGES....21
11. INVOICING..... 22

12. SET OFF 202
13. CONFIDENTIALITY 212
14. ANNOUNCMENTS 234
15. DATA PROTECTION 22
16.INTELLECTUAL PROPERTY 248
17. ACADEMIC PUBLICATION 29
18. CHP BRANDING 31
19. FREEDOM OF INFORMATION 31
20. ANTI - BRIBERY 32
21. WARRANTIES 33
22.INDEMNITY 33
23. INSURANCE 35
24. LIMITATION AND EXCLUSION OF LIABILITY 35
25.INTENTION TO TERMINATE 36
26. TERMINATION OF PROJECTS 37
27.TERMINATION OF AGREEMENT 38
28. SURVIVAL 38
29. CONSEQUENCES OF TERMINATION 41
30. FORCE MAJEURE 42
31. ASSIGNMENT 42
32. ENTIRE AGREEMENT 42
33. CONFLICT 43
34. VARIATION 43
35.NOTICES 43
36. SEVERANCE 44
37. NO PARTNERSHIP OR AGENCY 44
38. RIGHTS AND REMEDIES 44
39. WAIVER 44
40.COUNTERPARTS 44
41.THIRD PARTY RIGHTS 45
42. FURTHER ASSURANCE 45
43. COSTS 45
44. MEDIATION 45

45. GOVERNING LAW…… 46

46. JURISDICTION…… 46

This Agreement is dated the day of 20

PARTIES

Velindre University NHS Trust whose principal address is Unit 2 Charnwood Court Heol Billingsley, Cardiff CF15 7QZ *(* "**VUNHST**");

Cardiff and Vale University Local Health Board of Heath Park, Cardiff, CF14 4XW ("CVUHB");

Cardiff University of Main Building, Cathays Park, Cardiff, CF10 3AT (Charity Registered No: 1136855) (the "**University**").

(together the "Parties," references to "Party" shall be construed accordingly).

BACKGROUND

Cardiff Health Partners (CHP) is a strategic partnership between the parties to this Agreement, designed to accelerate health innovation, improve health outcomes and equity, and drive inclusive economic growth in Wales. The partnership will align discovery science, clinical care, education, and industry partnerships, speeding translation of research into practice, reducing fragmentation in health innovation pathways, and positioning Wales as a partner of choice for trials, innovation, investment, and talent.

CHP is a novel and evolving entity and the Parties have agreed to work together to initially focus on Neuroscience and Mental Health, Cancer, and Precision Medicine.

The Parties wish to enter into this partnership to enable closer working between NHS and academic colleagues together to build a translational research portfolio and increase the region's capacity and capability for translational research. This will be enabled by the establishment of a research partnership and cross-site, regional research network.

This Agreement sets out the terms and conditions upon which the Parties have agreed and incorporates the roles and obligations set out herein.

Additional parties may be added to this Agreement if they agree to comply with all regulatory and legal requirements hereunder

The Parties to this Agreement wish to establish a framework to govern their respective rights and obligations in relation to particular Projects, in respect of which they wish to co-operate where such Projects fall within the Focus of this Agreement. Each Party shall carry out its respective roles and responsibilities as set out in this Agreement

Research Governance:

The Parties will develop an effective, risk-adapted, efficient, and expeditious governance pathway to ensure patient safety, research governance and sponsor oversight is consistent.

A process and criteria for agreeing which Party leads Projects conducted through the CHP, whether sponsored by one or more of the Parties or a third party, will be developed by the Parties in collaboration.

The Parties will collaborate to monitor and assess performance against relevant quality performance indicators to include but not limited to National Standards for Infection Control, Improving Service Users and Carers Experience and Reducing Inequalities, organisational operational performance metrics for Improving Productivity and Access to Treatment and their Equality and Diversity policies for Reducing Barriers to Access.

This Agreement as between NHS partners is regarded as an 'NHS Contract' within the meaning of section 7 of the National Health Service (Wales) Act 2006, meaning any disputes arising between NHS partners cannot be heard within the Courts of England and Wales and instead resolved by the Welsh Ministers in accordance with clause 44.2 of this Agreement. Notwithstanding, NHS partners agree to act in good faith and in accordance with the provisions stated in this Agreement.

For the purposes of the nature of the Agreement between the NHS bodies and the University and any Additional partners this Agreement constitutes a contract within the ordinary meaning under the law of England and Wales.

This Agreement sets out the terms and conditions upon which the Parties have agreed that such Projects may take place.

1. INTERPRETATION

1.1. The following definitions and rules of interpretation apply in this Agreement.

Agreement: means this Collaboration Agreement.

Academic Publication: means the publication of an abstract, article or paper in a journal or electronic repository, its presentation at a conference or seminar; Publish and Publication are to be construed as meaning such publication or presentation**.**

Background IPR: means any information, data, techniques, Know-how, inventions, software, discoveries and materials (regardless of the form or medium in which they are disclosed or stored) which are provided by one Party (whether belonging to that Party or to a third party) to another Party for use in the Project, and whether before or after the date of this Agreement), except any Project IPR.

Branding Guidelines: means the guidelines produced by a Party or a third party setting out the manner in which their name or logo may be used, which is made available upon request to a Party and as may be amended from time to time.

Business Day: a day other than a Saturday, Sunday or public holiday in England and Wales, when banks in Cardiff and London are open for business.

CHP Branding Guidelines: means any guidelines produced by the Parties setting out the manner in which the CHP name or logo may be used and which may be amended from time to time.

CHP: means the Cardiff Health Partners consisting of the Parties to this Agreement.

CHP Management and Development Group (MDG): the Decision making group of the CHP as constituted in accordance with Schedule 4. The reporting structure, membership and remit of this Group may be amended from time to time by agreement between the Parties.

Charges: the charges payable by a Party to the other in relation to a Project (if any).

Commencement Date: has the meaning given in clause 2 (Commencement and duration).

Commercially Sensitive Information: information identified by any Party as being of a commercially sensitive nature relating to any of the partners, their intellectual property rights or their businesses or which any party has indicated to the others that, if disclosed by the others, would cause significant commercial disadvantage or material financial loss.

Confidential Information: means all confidential information (however recorded or preserved) disclosed by a Party or its Representatives to the other Parties and that Party's Representatives in connection with this Agreement, including but not limited to:

a) the existence and terms of this Agreement or any agreement entered into in connection with the Focus or a Project;

b) any information that would be regarded as confidential by a reasonable businessperson relating to: (i) the business, affairs, customers, suppliers or plans of the disclosing Party; and (ii) the operations, processes, product information, know-how, designs, trade secrets or software of the disclosing Party;

c) any information developed by the Parties in the course of carrying out this Agreement;

d) Personal Data; and/or

e) any Commercially Sensitive Information.

Control: has the meaning given in section 1124 of the Corporation Tax Act 2010 and **controls**, **controlled** and the expression **change of control** shall be construed accordingly.

Programmes Team: has the meaning given in Clause 6.2

Data Protection Legislation: all applicable data protection and privacy legislation in force from time to time in the UK including the UK GDPR; the Data Protection Act 2018 (“DPA 2018”) (and regulations made thereunder) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended, and the guidance and codes of practice issued by the Information Commissioner or other relevant regulatory authority and applicable to a Party.

Data Subject: as defined in the Data Protection Legislation.

Employing Party: as defined in clause 6.7

Environmental Information Regulations: the Environmental Information Regulations 2004 together with any guidance and / or codes of practice issued by the Information Commissioner or relevant Government department in relation to such regulations.

Financial Year shall mean the period commencing on [] and ending on [ ] of the following calendar year, and each successive twelve (12) month period thereafter.

FOIA: the Freedom of Information Act 2000, and any subordinate legislation made under the Act from time to time, together with any guidance and/or codes of practice issued by the Information Commissioner or relevant government department in relation to such legislation.

Input: in relation to a Party, the services, resources, workforce or other tangibles or intangibles that such Party provides in accordance with this Agreement in relation to a Project, as set out in a Project Schedule.

Intellectual Property Rights (IPR): means patents, utility models, rights to inventions, copyright and neighbouring and related rights, trademarks and service marks, business names and domain names, rights in get-up and trade dress, goodwill and the right to sue for passing off or unfair competition, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information (including know-how and trade secrets), and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.

Information: has the meaning given under section 84 of FOIA.

Know-how: means unpatented technical information (including information relating to inventions, discoveries, concepts, methodologies, models, research, development and testing procedures, the results of experiments, tests and trials, manufacturing processes, techniques and specifications, quality control data, analyses, reports and submissions) which is not in the public domain;

Month: a calendar month.

Non-Project IPRs: means all Intellectual Property Rights which are not developed or created pursuant to a Project but are created for the purposes of the CHP and are owned jointly by the Parties [and in equal shares] (including but not limited to the CHP logos).

Permitted Recipient: means the Parties to this Agreement, the employees of each Party and any third parties engaged to perform obligations in connection with this Agreement.

Personal Data: as defined in the Data Protection Legislation.

Project: a project agreed by the Parties in accordance with clause 5 (Proposals and Projects) in relation to which the Parties will collaborate in accordance with this Agreement, as further described in a particular Project Schedule.

Project IPR: means all Intellectual Property Rights developed or created by a Party pursuant to a Project and is owned by that Party.

Project Period: subject to earlier termination in accordance with this Agreement, the period from the start date to the end date for a Project, as set out in a Project Schedule.

Project Schedule: a document specifying particulars in relation to a particular Project, agreed by the Parties in accordance with clause 5 (Proposals and Projects).

Redundancy Costs means any contractual or statutory redundancy payments, any enhanced contractual pension costs or other benefits which arise directly out of a Redundancy Situation, or the costs arising from giving contractual notice of termination by reason of redundancy;

Redundancy Situation means when an employee is dismissed in the circumstances set out in section 139 of the Employment Rights Act 1996;

Representatives: means, in relation to a Party, its employees, officers, contractors, subcontractors, representatives and advisors.

Request for Information: a request for information or an apparent request under the FOIA or the Environmental Information Regulations.

Shared Personal Data: means the personal data to be shared between the Parties under or in connection with this Agreement in accordance with clause 135.

Subsidiary: has the meaning given in clause 1.6.

UK GDPR: has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.

1.2 Clause, Schedule, and paragraph headings shall not affect the interpretation of this Agreement.

1.3 The Schedules form part of this Agreement and shall have effect as if set out in full in the body of this Agreement. Any reference to this Agreement includes the Schedules.

1.4 References to clauses and Schedules are to the clauses and Schedules of this Agreement and references to paragraphs are to paragraphs of the Schedule.

1.5 A person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality) and that person's personal representatives, successors and permitted assigns.

1.6 A reference to a company shall include any company, corporation, or other body corporate, wherever and however incorporated or established.

1.7 A reference to a holding company or a subsidiary means a holding company or a subsidiary (as the case may be) as defined in section 1159 of the Companies Act 2006 and a company shall be treated, for the purposes only of the membership requirement contained in sections 1159(1)(b) and (c), as a member of another company even if its shares in that other company are registered in the name of:

1.7.1 another person (or its nominee) by way of security or in connection with the taking of security; or

1.7.2 its nominee.

1.8 Unless the context otherwise requires, words in the singular shall include the plural and, in the plural, shall include the singular.

1.9 Unless the context otherwise requires, a reference to one gender shall include a reference to the other genders.

1.10 This Agreement shall be binding on, and inure to the benefit of, the Parties to this Agreement and their respective personal representatives, successors and permitted assigns, and references to any Party shall include that Party's personal representatives, successors and permitted assigns.

1.11 Unless expressly provided otherwise in this Agreement, a reference to legislation or a legislative provision is a reference to it as amended, extended, or re-enacted from time to time.

1.12 Unless expressly provided otherwise in this Agreement, a reference to legislation or a legislative provision shall include all subordinate legislation made from time to time under that legislation or legislative provision.

1.13 A reference to writing or written includes email but not fax.

1.14 Any obligation on a Party not to do something includes an obligation not to allow that thing to be done.

1.15 References to a document in agreed form are to that document in the form agreed by the Parties and initialled by them or on their behalf for identification.

1.16 Any reference to an English and Welsh legal term for any action, remedy, method of judicial proceeding, legal document, legal status, court, official or any legal concept or thing shall, in respect of any jurisdiction other than England and Wales, be deemed to include a reference to that which most nearly approximates to the English and Welsh legal term in that jurisdiction.

1.17 A reference to this Agreement or to any other agreement or document referred to in this Agreement is a reference to this Agreement or such other agreement or document as varied or novated (in each case, other than in breach of the provisions of this Agreement) from time to time.

1.18 Where any statement is qualified by the expression so far as VUNHST, CVUHB or the University is aware or to VUNHST's, CVUHB's or the University's knowledge (or any similar expression), that statement shall be deemed to include an additional statement that it has been made after due and careful enquiry.

1.19 Any words following the terms including, include, in particular, for example or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase, or term preceding those terms.

1.20 Any reference to this Agreement terminating shall, where the context requires, include a reference to this Agreement terminating by expiry.

2 COMMENCEMENT AND DURATION

2.2 This Agreement shall commence on [DATE].

2.3 This Agreement shall continue, unless terminated earlier in accordance with clause 237, (Termination of Agreement), until [DATE].

2.4 This Agreement may be extended by mutual agreement between the Parties

3 COLLABORATION AND CO-OPERATION

3.2 The Parties shall attend and participate in scheduled CHP meetings with each other.

3.3 The Parties shall co-operate within the Focus of this Agreement in relation to Projects.

3.4 The Parties shall collaborate in relation to Project Schedules agreed in accordance with clause 5 (Proposals and Projects).

3.5 The Parties agree to adopt the following principles when carrying out Proposals and Projects (Principles):

3.5.1 collaborate and co-operate - establish and adhere to the governance structure set out in this Agreement to ensure that activities are delivered and actions taken as required;

3.5.2 be accountable - take on, manage and account to each other for performance of the respective roles and responsibilities set out in this Agreement;

3.5.3 be open - communicate openly about major concerns, issues or opportunities relating to Proposals and Projects;

3.5.4 behave in a positive, proactive manner;

3.5.5 adhere to statutory requirements and best practice - comply with applicable laws and standards including applicable procurement rules, data protection and freedom of information legislation;

3.5.6 act in a timely manner - recognise the time-critical nature of the Proposals and Projects and respond accordingly to requests for support; and

3.5.7 deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this Agreement, act in good faith to support achievement of the key objectives and compliance with these Principles.

3.6 The Parties will establish appropriate governance, leadership, and management structures with representatives of each Party in numbers and breadth of expertise and experience sufficient to ensure:

3.6.1 efficient and effective governance, leadership, and management;

3.6.2 effective and prompt resolution of any disputes, including those arising from conflicting interests of the Parties; and

3.6.3 accountability to the executive management of each of the Parties.

3.7 The Parties will develop an investment strategy to develop, enable, and sustain the CHP and deliver the activities set out in the Focus. The Parties agree to work together to secure the necessary funding from research grant funders, the Welsh Government, industry, and other sources and to provide in good faith the staffing, physical and other resources they agree to

contribute. The Parties will work collaboratively to define a set of principles and develop a mechanism to share the risk / reward and any surplus / deficit generated by the activities described in the Focus.

4 EXISTING ARRANGEMENTS

4.2 Nothing in this Agreement shall restrict a Party's right to continue to conduct its business activities or arrangements that existed on the Commencement Date or that otherwise come into being outside the scope of this Agreement.

4.3 However, as the Parties will be working together in relation to Projects where each Party may have access to information or Intellectual Property Rights of the other, each Party acknowledges that the other Parties will need to protect such information and Intellectual Property Rights in accordance with clause 03 (Confidentiality) and clause 06 (Intellectual Property).

5 PROPOSALS AND PROJECTS

5.2 This clause 5 sets out the procedure to be followed where a Project falls within the scope of the Focus. The Parties agree that the terms of this Agreement shall apply when a Party (Proposing Party) wishes to propose to the other Parties (Receiving Parties) a Project falling within the scope of the Focus.

5.3 The Parties acknowledge and agree that this Agreement governs the overall relationship between the Parties in relation to the CHP and that they must enter into separate and more Project specific agreements for any Projects that may arise from this Agreement and/or the CHP. Notwithstanding clause 5.1, unless expressly stated in this Agreement or otherwise, nothing in this Agreement shall bind the Parties in relation to any Projects.

5.4 A Proposing Party may submit a proposal for a proposed Project falling within the scope of the Focus to the Receiving Parties at any time. The proposal shall contain high level details of the proposed Project, including an indication of the Parties' likely respective Inputs and any Charges the Proposing Party intends to make for its own Inputs (if applicable).

5.5 On receipt of a proposal, the Receiving Parties shall consider it, provide the Proposing Party with its comments and the Parties shall then discuss whether they wish to formalise the proposal so that it becomes a Project. A Party may, in its absolute discretion, decline to agree to formalise a proposal into a Project.

5.6 In order to formalise a proposal into a Project:

5.5.1 either Party may submit to the other Party a draft Project Schedule. Such document shall be based substantially on the relevant Project Schedule(s) to this Agreement, but it may include additional matters or exclude matters contained in the template that are not relevant to the particular Project;

5.5.2 each Party may sign the Project Schedule or decline to do so. A Project Schedule shall not have operative effect under this Agreement unless it is signed by both Parties. Once signed by both Parties, a Project Schedule becomes part of the Agreement.

5.7 A Project Schedule that has been signed by both Parties may be amended at any time in accordance with clause 34

5.8 Unless terminated earlier in accordance with this Agreement, each Project Schedule has contractual effect during the applicable Project Period.

5.9 Each Party shall in relation to the obligations allocated to it in respect of all and any Project agreed in accordance with this clause 5:

5.9.1 perform such obligations, including by providing the Project Services in accordance with timeframes or milestones (if any) specified in the Project Schedule;

5.9.2 use reasonable care and skill in performing such obligations;

5.9.3 comply with all laws applicable to it;

5.9.4 obtain and maintain consents, licences and permissions (statutory, regulatory, contractual or otherwise) that are necessary to enable it to comply with such obligations;

5.9.5 ensure that the Input it provides conforms with descriptions and specifications (if any) set out in the applicable Project Schedule;

5.9.6 and if on the other Party' premises, comply with that Party's health and safety and site regulations made known to it.

6 WORKFORCE

6.2 The Parties have agreed that it is necessary to secure individuals time and expertise specifically for the purposes of fulfilling the objectives of the CHP. These individuals, or an agreed proportion of their time will be dedicated to the CHP.

6.3 The posts funded jointly by the three Parties are referred to hereafter as the CHP's Programmes Team ("Programmes Team"). The agreed staff time and funding for the Programmes Team for 2026/27 is set out in Schedule 5. This will be reviewed annually, or as required, by the CHP MDG, and may be amended from time to time.

6.4 The performance of the Programmes Team, including any issues significantly impacting on its performance, shall be reported to the CHP MDG.

6.5 Any changes to the Programmes Team shall be subject to the approval of the CHP MDG. Such changes shall include, but not be limited to the following:

6.5.1 creating an additional post;

6.5.2 removing a post;

6.5.3 recruiting and appointing a replacement for any vacated post;

6.5.4 varying the terms and conditions of employment and/or secondment of any post holder (other than nationally mandated changes) to the extent that such change may result in new or increased financial or other liability for the CHP or any individual Party;

6.6 Prior to approving any change to the Programmes Team, the CHP MDG or its nominee shall consider all relevant matters including, to the extent that they are applicable to the relevant change, as set out below:

6.6.1 the financial implications including how any additional costs will be met or how any savings will be re-applied;

6.6.2 any potential redundancy liability and how that might be mitigated;

6.6.3 whether it may be preferable to consider alternative means of employment pursuant to Clause 6.4;

6.6.4 the terms on which a post holder will be employed or engaged.

6.7 In respect of each individual member of the Programmes Team ("postholder"), the Party that employs the postholder ("Employing Party") shall:

6.7.1 use reasonable endeavours to ensure that the postholder performs his or her duties to the CHP diligently and with reasonable skill and care, and complies with the decisions and directions of the CHP MDG;

6.7.2 provide human resources support equivalent to that provided to its other employees;

6.7.3 ensure the postholder is (unless agreed otherwise) only engaged in the activities of or relating to CHP. If it agreed that a Post Holder may undertake other activities then Clause 6.8 shall apply;

6.7.4 be responsible for the Employee Costs for each day that they are engaged as a postholder (including bank holidays, weekends, illness and holidays taken by the Post Holder) but, save where Clause 6.8 applies, shall receive any agreed contributions or reimbursement from the other Parties in a timely manner;

6.7.5 apply its recruitment processes, contracts, payroll and HR policies and procedures provided that any decisions in respect of recruitment, redundancies, restructuring or other changes relevant to the postholder (other than day to day management decisions) must be approved by the CHP Board;

6.7.6 be responsible for all other issues concerning the terms and conditions of employment of the Post Holder including disciplinary and grievance matters.

6.8 For the purposes of Clause 6.7 where a Post Holder's duties are shared between the CHP and its Employing Party, the employee costs shall be apportioned between CHP (and, in the event of shortfall, the other Parties) and the Employing Party. Such apportionment shall be calculated to correspond to the apportionment of the Post Holder's duties and activities as between the CHP and the Employing Party.

6.9 It is agreed that upon the occurrence of any event or circumstances that may result in the potential redundancy of any member of the Programmes Team ("At Risk Post Holder"), the following provisions shall apply:

6.9.1 the redundancy situation will be managed by the Employing Party but under the oversight of the CHP MDG or its nominee;

6.9.2 the Parties will use all reasonable endeavours to minimise the impact of the redundancy situation on the At Risk Post Holder and the financial implications for CHP and the Parties;

6.9.3 the Employing Party (with the support and cooperation of the other Parties) will follow a reasonable, legally compliant and efficient redundancy consultation procedure in respect of the At Risk Post Holder and take into account, when agreeing this procedure, the need to mitigate any cost and liability;

6.9.4 the Employing Party will, subject to its relevant policies and procedures, use all reasonable endeavours to find suitable alternative employment for the At Risk Post Holder;

6.9.5 Where the costs of a postholder's post is shared between two or more Parties, the Redundancy Costs shall be apportioned between those Parties. Such apportionment shall be calculated to correspond to the apportionment of funding for that particular post.

6.10 The Parties agree that, as at the date of this Agreement, the implementation of the arrangements set out in Schedule 5 does not constitute a "business transfer" or a "service provision change" as those terms are defined by TUPE.

6.11 Save where TUPE applies, upon the expiry or termination of this Agreement for any reason, the Parties shall re-assume direct management control and responsibility for any members of the Programmes Team that it employs immediately prior to the expiry or termination of this Agreement, as the case may be.

6.12 Any party which becomes aware of the occurrence or probable occurrence of an event that might result in the applicability of TUPE shall promptly inform the other Parties. The Parties shall in good faith take such steps and initiate such discussions as may be necessary to comply with the obligations under TUPE and the partners shall provide to each other all such information as may reasonably be required. In particular, the Parties will ensure that if the identity of the Employing Party changes, the new employer (provided they are a party to this Agreement) shall not incur liability over and above that which would have accrued to the original Employing Party under this Agreement.

7. FINANCE

7.1 The Host Organisation for administration and management of all monies on behalf of CHP shall be Cardiff University unless otherwise specified in the relevant Project Schedule

7.2 Each Party shall during the Term make the financial contributions to the CHP set out in Appendix 1. Such contributions shall be made to the Host Organisation without deduction or set off in accordance with the provisions of Appendix 1

7.3 The CHP MDG will approve each annual Budget in accordance with this Agreement and the Parties agree to review the Budget regularly in meetings of the MDG and otherwise as appropriate.

7.4 The Host Organisation shall hold the monies paid by each of the Parties in respect of CHP on trust for such Party. The Host Organisation shall only use such monies for the business of CHP to meet the outgoings and expenses incurred by the Host Organisation in relation to CHP and its affairs in accordance with and subject to the terms of this Agreement.

7.5 The Host Organisation shall be responsible for entering into contracts for the receipt of goods and/or services in accordance with the Host Organisation's Procurement processes provided always that provision for the financial commitments in such contracts is contained in the Budget, the Business Plan or such commitments have been unanimously approved by the CHP MDG . Approval for any overspend on Budget must be by agreement of the CHP MDG and unanimously approved by Exec Board members.

7.6 In the event that in any Financial Year the Host Organisation reasonably believes that there will be a deficit compared to the Budget it will notify the CHP Board as soon as reasonably practicable. The potential deficit identified will be considered by the CHP Board and to the extent that it is ratified by the CHP Board by unanimous agreement, each Party will make additional contributions of equal value to meet the deficit. The CHP Board will promptly notify the Parties of the extent of the shortfall and each Party (including, for the avoidance of doubt, the Host Organisation) shall pay its equal share of any Budget deficit to the Host Organisation within 30 days of receipt of an invoice.

7.7 The Host Organisation shall maintain a separately identifiable accounting record in respect of all CHP monies that it holds and shall maintain accurate and complete accounting and other financial records in accordance with the requirements of all Applicable Laws and generally accepted accounting practices applicable in the United Kingdom;

7.8 Procure the preparation of annual accounts for CHP promptly after the end of each Financial Year and supply the same promptly to the CHP Board; and

7.9 Procure that each Party and/or its authorised representatives shall be permitted access at all reasonable times to examine the books and records of the CHP and to discuss its affairs with the CHP MDG

7.10 The CHP Programmes Team shall prepare and propose an operating Budget annually for approval by the CHP MDG before implementation which shall include the following: an operating budget (including estimated capital expenditure requirements), a review of projected business and a summary of CHP business objectives. Such operating budget becomes the Budget upon approval by the CHP MDG.

ADDITIONAL PARTNERS

8.1 Additional Partners may join Cardiff Health Partners by agreeing to all the regulatory and legal requirements and responsibilities herein

8.2 Additional Partners must be proposed and agreed by the MDG and approved at CHP Board.

8.3 Once parties have signed the Agreement they shall be regarded as equal Partners of CHP and Parties to this Agreement in its entirety.

8.4 Additional Partners may include but are not limited to NHS Organisations, Higher Education Institutions, Local Authorities and Public Sector Bodies.

8.5 All Partners will have equal representation at CHP Board and CHP MDG and will nominate representatives at the appropriate level for these bodies

9. INFORMATION FLOW AND PROJECT MANAGEMENT

9.1. To enable the Parties to maximise the benefits of their collaboration, each Party shall:

9.1.1. engage the others in planning discussions in relation to the Focus from time to time;

9.1.2. keep the other Parties informed about its own progress in relation to each Project;

9.1.3. facilitate regular discussions between appropriate members of its personnel and those of the other Parties in relation to each Project it is engaged with, including in relation to:

9.1.3.1. performance and issues of concern in relation to each Project;

9.1.3.2. new developments and resource requirements;

9.1.3.3. compliance with deadlines; and

9.1.3.4. such other matters as may be agreed between the Parties from time to time.

9.2. Each Party shall:

9.2.1. supply to the other Parties any information and assistance reasonably requested by it relating to a Project as is necessary to enable the other Parties to perform their own obligations in relation to the Project; and

9.2.2. review documentation, including draft specifications or service descriptions or other technical documentation, for use when performing its obligations in relation to a Project (if any), as soon as reasonably practicable at the request of the other Parties, and

9.2.3. notify it of any errors or incorrect assumptions made in any such documents as far as it is aware.

10. CHARGES

10.1. Except as provided for in **Error! Bookmark not defined.**10.2, each Party shall:

10.1.1. not be entitled to charge the other Parties for the provision of anything (including Inputs) it provides in connection with each Project and this Agreement; and

10.1.2. be otherwise responsible for its own costs incurred in connection with each Project and this Agreement, including all Inputs it provides.

10.2. If a Project Schedule provides that a Party is responsible for paying the other Parties any Charges, such Charges shall be invoiced and paid for in GBP unless otherwise expressly provided for in the Project Schedule in accordance with clause 11 (Invoicing and payment).

11. INVOICING AND PAYMENT

11.1. If a Project Schedule provides that a Party will pay the other Parties any Charges in relation to a Project, the other Parties may issue invoices for such Charges:

11.1.1. in accordance with the invoicing procedure (if any) provided for in the Project Schedule; or

11.1.2. if no invoicing procedure is provided for in the Project Schedule, at the end of each month.

11.2. Unless otherwise provided in a Project Schedule, the Charges specified in a Project Schedule are exclusive of VAT, which shall be included in invoices and payable, if applicable, in addition to the Charges.

11.3. A Party shall pay an invoice issued to it in accordance with this Agreement within 30 days of the date of receiving the invoice.

11.4. The Parties acknowledge and agree that Cardiff University will be responsible for invoicing any Charges due from any external and/or third-party organisations.

12. SET-OFF

12.1. All amounts due under this Agreement shall be paid in full without any set-off, counterclaim, deduction or withholding (other than any deduction or withholding of tax as required by law).

13. CONFIDENTIALITY

13.1. The provisions of this clause shall not apply to any Confidential Information that:

13.1.1. is or becomes generally available to the public (other than as a result of its disclosure by the receiving Party or its Representatives in breach of this clause);

13.1.2. was available to the receiving Party on a non-confidential basis before disclosure by the disclosing Party;

13.1.3. was, is or becomes available to the receiving Party on a non-confidential basis from a person who, to the receiving party's knowledge, is not bound by a confidentiality agreement with the disclosing Party or otherwise prohibited from disclosing the information to the receiving Party;

13.1.4. the Parties agree in writing is not confidential or may be disclosed;

13.1.5. is developed by or for the receiving Party independently of the information disclosed by the disclosing Party.

13.2. Each Party shall keep the other party’s Confidential Information confidential and shall not:

13.2.1. use such Confidential Information except for the purpose of exercising or performing its rights and obligations under or in connection with this Agreement in relation to the Focus and any Project (Permitted Purpose); or

13.2.2. disclose such Confidential Information in whole or in part to any third party, except as expressly permitted by this clause.

13.3. A Party may disclose the other Parties Confidential Information to those of its Representatives who need to know such Confidential Information for the Permitted Purpose, provided that:

13.3.1. it informs such Representatives of the confidential nature of the Confidential Information before disclosure; and

13.3.2. at all times, it is responsible for such Representatives' compliance with the confidentiality obligations set out in this clause.

13.4. A Party may disclose Confidential Information to the extent such Confidential Information is required to be disclosed by law, by any governmental or other regulatory authority or by a court or other authority of competent jurisdiction provided that, to the extent it is legally permitted to do so, it gives the other Party as much notice of such disclosure as possible and, where notice

of disclosure is not prohibited and is given in accordance with this clause 11.4, it takes into account the reasonable requests of the other Party in relation to the content of such disclosure.

13.5. A Party may, provided that it has reasonable grounds to believe that the other Party is involved in activity that may constitute a criminal offence under the Bribery Act 2010, disclose Confidential Information to the Serious Fraud Office without first informing the other Party of such disclosure.

13.6. Each Party reserves all rights in its Confidential Information. No rights or obligations in respect of a Party's Confidential Information other than those expressly stated in this Agreement are granted to the other Parties, or to be implied from this Agreement.

13.7. On termination of this Agreement, unless such things are needed by it to perform its obligations under a Project Schedule (and only until the end of such time), each Party shall:

13.7.1. destroy or return to the other Party all documents, data and materials (and any copies) containing, reflecting, incorporating or based on the other Party's Confidential Information;

13.7.2. erase all the other Party's Confidential Information from computer and communications systems and devices used by it, including such systems and data storage services provided by third parties (to the extent technically and legally practicable); and

13.7.3. if requested to do so, certify in writing to the other Party that it has complied with the requirements of this clause, provided that a recipient Party may retain documents and materials containing, reflecting, incorporating or based on the other Party's Confidential Information to the extent required by law or any applicable governmental or regulatory authority. The provisions of this clause shall continue to apply to any such documents and materials retained by a recipient Party.

13.8. Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information.

13.9. The provisions of this clause 03 shall continue to apply after termination of this Agreement in accordance with clause 248 (Survival).

14. ANNOUNCEMENTS

14.1. The Parties will be free to communicate the collaborative arrangement in respect of this collaboration except that the terms of this Agreement shall remain confidential.

14.2. Subject to clause 14.1, a Party shall not make, or permit any person to make, any public announcement, communication or circular (announcement) concerning the existence, subject matter or terms of this Agreement, the wider transactions contemplated by it, or the relationship between the Parties, without the prior written consent of the other Parties (such consent not to be unreasonably withheld or delayed). The Parties shall consult together on the timing, contents, and manner of release of any announcement.

14.3. Where an announcement is required by law or any governmental or regulatory authority (including any relevant securities exchange), or by any court or other authority of competent jurisdiction, the Party required to make the announcement shall promptly notify the other Parties. The Party

concerned shall make all reasonable attempts to agree the contents of the announcement before making it.

15. DATA PROTECTION

15.1. The Parties will comply with all applicable requirements of the Data Protection Legislation and all Applicable Laws. In this **Error! Bookmark not defined.Error! Reference source not found.**5, Applicable Laws means (for so long as and to the extent that they apply to the Parties) the law of the European Union, the law of any member state of the European Union and/or Domestic UK law which relates to the protection of Personal Data; and Domestic UK Law means the Data Protection Legislation and any other law that applies in the UK. This **Error! Bookmark not defined.**13 is in addition to, and does not relieve, remove, or replace, a Party's obligations or rights under the Data Protection Legislation.

15.2. This clause sets out the framework for the sharing of personal data between the Parties as Controllers. Each Party acknowledges that one Party (referred to in this clause as the Data Discloser) will regularly disclose to the other Party or Parties Shared Personal Data collected by the Data Discloser for the purposes set out in the background and the Focus as set out in clause 3.4 of this Agreement.

15.3. Each Party shall comply with all the obligations imposed on a Controller under the Data Protection Legislation, and any material breach of the Data Protection Legislation by one Party shall, if not remedied within thirty (30) days of written notice from another Party, give grounds for a Party to terminate this Agreement with immediate effect.

15.4. Each Party shall:

15.4.1. ensure that it has all necessary notices and consents and lawful bases in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;

15.4.2. give full information to any Data Subject whose personal data may be processed under this Agreement of the nature of such processing. This includes giving notice that, on the termination of this Agreement, personal data relating to them may be retained by or, as the case may be, transferred to one or more of the Permitted Recipients, their successors, and assignees;

15.4.3. process the Shared Personal Data only for the Agreed Purposes;

15.4.4. not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;

15.4.5. ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Agreement;

15.4.6. ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other Parties, to protect against unauthorised or unlawful

processing of personal data and against accidental loss or destruction of, or damage to, personal data;

15.4.7. not transfer any personal data received from the Data Discloser outside the UK unless the transferor ensures that (i) the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection; or (ii) there are appropriate safeguards or binding corporate rules in place pursuant to the applicable Data Protection Legislation; or (iii) the transferor otherwise complies with its obligations under the applicable Data Protection Legislation by providing an adequate level of protection to any personal data that is transferred; or (iv) one of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

15.5. Each Party shall assist the others in complying with all applicable requirements of the Data Protection Legislation. In particular, each Party shall:

15.5.1. consult with the other Parties about any notices given to Data subjects in relation to the Shared Personal Data;

15.5.2. promptly inform the other Parties about the receipt of any Data Subject rights request;

15.5.3. provide the other Parties with reasonable assistance in complying with any Data Subject rights request;

15.5.4. not disclose, release, amend, delete, or block any Shared Personal Data in response to a Data Subject rights request without first consulting the other Parties wherever possible;

15.5.5. assist any Party, at the cost of that Party, in responding to any request from a data subject and in ensuring compliance with its obligations under the Data Protection Legislation with respect to security, personal data breach notifications, data protection impact assessments and consultations with the Information Commissioner or other regulators;

15.5.6. notify the other Parties without undue delay on becoming aware of any breach of the Data Protection Legislation;

15.5.7. at the written direction of the Data Discloser, delete or return Shared Personal Data and copies thereof to the Data Discloser on termination of this Agreement unless required by law to store the Shared Personal Data;

15.5.8. use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;

15.5.9. maintain complete and accurate records and information to demonstrate its compliance with this clause 13 and allow for audits by a Party to this Agreement or that Party's designated auditor; and

15.5.10. provide the other Parties with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in

the event of a data security breach, and the regular review of the Parties' compliance with the Data Protection Legislation.

15.6. The Parties shall indemnify each other against any losses, damages, cost, or expenses incurred by any of the Parties arising from, or in connection with, any breach of the other Party's obligations under this **Error! Bookmark not defined.Error! Reference source not found.**5. Any Party may, at any time on not less than 30 Working Days' prior written notice to the other Parties, revise this **Error! Bookmark not defined.Error! Reference source not found.**5 by replacing it with any applicable controller to controller standard clauses or similar terms forming part of an applicable certification scheme (which shall apply when replaced by attachment to this Agreement).

15.7. This clause **Error! Reference source not found.**5 shall remain in force without limit in time.

16. INTELLECTUAL PROPERTY

16.1. This Agreement does not affect the ownership or transfer any interest in Intellectual Property Rights in any Background IPR which is not or in any other technology, design, work, invention, software, data, technique, Know-how, or materials which is not Project IPR. The Intellectual Property Rights in any Background IPR will remain the property of the Party which contributed them to the Project(s) (or its licensors). No licence to use any Background IPR is granted or implied by this Agreement except the rights expressly set out in this Agreement.

16.2. Each Party grants to the other Parties a non-exclusive, personal, royalty-free licence during the applicable Project Period to use its Project IPR in relation to a Project to the extent necessary for the other Parties to carry out their obligations in relation to that Project.

16.3. Subject to clause 14.6 at the end of the applicable Project Period, a Party licensed to use Project IPR under clause 16.2 shall cease to use that Project IPR and shall return any physical embodiment of the Project IPR (including any copies) in its possession or control to the owning party.

16.4. Each Party shall immediately give written notice to the other Parties of any actual, threatened, or suspected infringement of any Party's IPR (including Project IPR) used in connection with a Project of which it becomes aware.

16.5. The individual Projects may contain more Project specific clauses relating to IPR.

16.6. In addition to the rights granted in clauses 14.2 and notwithstanding clause 16.3 and subject to clause 16.7, All parties acknowledge and agree that as an academic Party, the University and each of its employees and students will have the irrevocable, royalty-free right to use any of the Project IPR for academic and research purposes.

16.7. Notwithstanding clause 16.6, and in relation to any Hosted Studies, the Parties represent and warrant that they will not attempt to seek commercial advantage or infringe the IPR of the other {arty or any third party, nor knowingly allow any third party to do so and any such exploitation of

any IPRs is subject to the terms and conditions of any agreements governing any Hosted Studies.

16.8. Nothing in this Clause 16 shall be construed so as to prevent or hinder a Party from using its Know-How or Project IPR generated during the performance of a Project in the furtherance of its normal activities, to the extent that such use does not result in the disclosure or misuse of Confidential Information or the infringement of any IPRS, or Know-How of any third party, without the prior written consent of that third party, or would cause a Party to be in breach of any obligations that it is bound to under any Hosted Study agreement.

16.9. The Parties will agree a strategy for any proposed exploitation of any IPRs.

16.10. Non-Project IPRs:

16.10.1. the Parties agree that any Non-Project IPRs created for the purposes of the CHP, including any CHP branding and logos pursuant to this Agreement will be jointly owned between the Parties

17. ACADEMIC PUBLICATION AND IMPACT

17.1. The parties acknowledge that the Projects undertaken by or with the University are in pursuance of a primary charitable purpose; that is the advancement of education through teaching and research. Therefore, notwithstanding any other provision of this Agreement, any employee or student at the University (whether or not involved in the Project) may, provided that a Party has not given notice to restrict the Publication pursuant to clauses 17.3 and 15:

17.1.1. discuss work undertaken as part of a Project in the University's seminars, tutorials and lectures; and

17.1.2. publish any Background IPR and/or any Project IPR of any of the Parties.

17.2. The University will submit in writing to other Parties (as the case may be, depending on who owns the Intellectual Property Rights in any Project IPR and to whoever has contributed any Background IPR to the Project) details of any Project IPR and any Background IPR which any employee or student of the University intends to Publish, at least 30 days before the date of the proposed submission for Publication.

17.3. A Party owning any Background IPR and/or any Project IPR may restrict such Publication by the University by:

17.3.1. **delaying Publication:** the Party can require the University to delay Publication for up to [insert period] months to allow time to seek patent or other protection for the Intellectual Property Rights in any Background IPR and/or Project IPR.

17.3.2. **preventing Publication of Confidential Background IPR:** the Party can prevent the Publication of any confidential Background IPR that:

17.3.2.1. cannot be protected by patent or other Intellectual Property Right; or

17.3.2.2. can be protected, but the Party chooses not to seek protection.

17.4. Notwithstanding the above, the Parties acknowledge and agree that a Party may prevent the Publication of any Background or Project IPR if in the reasonable opinion of a Party, such Publication by the University would result in the disclosure or misuse of Confidential Information or the infringement of any IPRS, or Know-How of any third party, without the prior written consent of that third party, or would cause a Party to be in breach of any obligations that it is bound to under any Hosted Study agreement.

17.5. In order to restrict Publication pursuant to clause 17.3 and/or 17.4, the Restricting Party must submit a notice ("**Restriction of Publication Notice**") to the University. Such notice must be given within 30 days after receipt of details of the proposed Publication. If a Restriction of Publication Notice is not received within that period, the proposed Publication may proceed, subject to the following exceptions:

17.5.1. Confidential Background IPR: Publication of another Party's Background IPR that constitutes their Confidential Information is prohibited unless explicit written consent for such Publication has been obtained from that Party.

17.5.2. Third-Party IPR: Publication is also prohibited if any Background IPR or Project IPR is subject to the prior written consent of any third party, and such consent has not been secured; and/or

17.5.3. Hosted Study Agreements: such publications would cause a Party to be in breach of any Hosted Study Agreement.

17.6. Each of the Parties acknowledges that the University is required by its funders to demonstrate their impact on society and agrees to provide to the University any information the University reasonably requests in order to allow it to demonstrate the impact provided that, under or pursuant to this clause:

17.6.1. the University will not be entitled to receive or disclose any other Party's Confidential Information or any information which identifies or allows any living individual to be identified; and

17.6.2. the information requested and disclosed under or pursuant to this clause will be general in nature.

18. CHP BRANDING AND LOGOS

18.1. Each Party acknowledges and agrees that by signing this Agreement, it shall permit the other Parties to use its name or the name of any of its key Personnel, or its logo, in any press release or advertising, or for any other promotional purpose related to this Agreement, or any Projects

(if permitted by any separate Project Agreements or funding agreements), or any other CHP activities.

18.2. The Parties shall not use a Party's name or logo or the name of any of its key personnel for any press release or advertising, or for any other promotional purpose that is not related to this Agreement, a Project or any other CHP activities.

18.3. Neither Party will use a third party's name or logo or any name of the key personnel belonging to a third party, in any press release or product advertising, or any other promotional purpose relating to the CHP or otherwise, without first obtaining that third party's written consent.

18.4. The Parties acknowledge and agree that in relation to clauses 18.1 and 18.3, any Party's name and logo or that of any third party must be used only in accordance with that Party's or a third party's Branding Guidelines, made available upon request and as amended from time to time.

19. FREEDOM OF INFORMATION

19.1. The Parties acknowledges that each of them is subject to the requirements of the FOIA and the Environmental Information Regulations. The Parties shall:

19.1.1. provide all necessary assistance and cooperation as reasonably requested by each Party to comply with their obligations under the FOIA and EIRs;

19.1.2. transfer to the relevant party all Requests for Information relating to this Agreement that it receives as soon as practicable and in any event within 2 Working Days of receipt;

19.1.3. provide each Party with a copy of all Information belonging to the Parties requested in the Request For Information which is in its possession or control in the form required within 5 Working Days (or such other period as the Parties may reasonably specify)

19.1.4. not respond directly to a Request for Information unless authorised in writing to do so by the relevant partner.

19.2. Each Party acknowledges that it may be required under the FOIA and Environmental Information Regulations to disclose Information (including Commercially Sensitive Information) without consulting or obtaining consent from the others. The Parties shall take reasonable steps to notify each other of a Request for Information (in accordance with the Cabinet Office's Freedom of Information Code of Practice issued under section 45 of the FOIA) to the extent that it is permissible and reasonably practical for it to do so but (notwithstanding any other provision in this Agreement) the Parties shall be responsible for determining in their absolute discretion whether any Commercially Sensitive Information and/or any other information is exempt from disclosure in accordance with the FOIA and/or the EIRs.

20. ANTI-BRIBERY

20.1. Each Party shall in relation to this Agreement and the Programme:

20.1.1. comply with all applicable laws, statutes, regulations, and codes relating to anti-bribery and anti-corruption including but not limited to the Bribery Act 2010 ("Relevant Requirements");

20.1.2. have and shall maintain in place throughout the term of this Agreement its own policies and procedures, including but not limited to adequate procedures under the Bribery Act 2010, to ensure compliance with the Relevant Requirements and will enforce them where appropriate; and

20.1.3. promptly report to the other Parties any request or demand for any undue financial or other advantage of any kind received by it in connection with the performance of this Agreement.

20.1.4. Breach of this clause 20 shall be deemed a material breach under clause *26.2*

21. *WARRANTIES*

21.1. Each Party warrants that:

21.1.1. it has full power and authority to carry out the actions contemplated under this Agreement; and

21.1.2. its entry into and performance under the terms of this Agreement will not knowingly infringe the Intellectual Property Rights of any third party or cause it to be in breach of any obligations to a third party; and

21.1.3. so far as it is aware, all information, data and materials provided by it under this Agreement will be accurate and complete in all material respects, and it is entitled to provide the same to the other without recourse to any third party.

21.2. Except as expressly provided in this Agreement, there are no conditions, warranties, or other terms binding on the Parties with respect to the actions contemplated by this Agreement. Any condition, warranty or other term in this regard that might otherwise be implied or incorporated into this Agreement, whether by statute, common law or otherwise, is, to the extent that it is lawful to do so, excluded by this Agreement.

22. INDEMNITY

22.1. In this clause, a reference to an **indemnified party** shall include that Party's subsidiaries, and the provisions of this clause shall be for the benefit of that Party and each such subsidiary, and shall be enforceable by each such subsidiary, in addition to the Party.

22.2. Each Party (**indemnifying party**) shall indemnify the other Parties (**indemnified party**) against all liabilities, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with:

22.2.1. any claim made against the indemnified party for actual or alleged infringement of a third party's Intellectual Property Rights arising out of or in connection with:

22.2.2. the indemnified party's use in accordance with this Agreement of Intellectual Property Rights licensed to it by the indemnifying party under clause 06; or

22.2.3. the receipt or use by the indemnified party of Inputs or other items or services provided by the indemnifying party in relation to a Project;

22.3. This indemnity shall not cover the indemnified party to the extent that a claim under it results from the indemnified party's negligence or wilful misconduct.

22.4. Liability under this indemnity is conditional on the indemnified party discharging the following obligations. If any third party makes a claim, or notifies an intention to make a claim, against the indemnified party which may reasonably be considered likely to give rise to a liability under this indemnity (**Claim**), the indemnified party shall:

22.4.1. as soon as reasonably practicable, give written notice of the Claim to the indemnifying party, specifying the nature of the Claim in reasonable detail;

22.4.2. not make any admission of liability, agreement or compromise in relation to the Claim without the prior written consent of the indemnifying party (such consent not to be unreasonably conditioned, withheld or delayed), provided that the indemnified party may settle the Claim (after giving prior written notice of the terms of settlement (to the extent legally possible) to the indemnifying party, but without obtaining the indemnifying party's consent) if the indemnified party reasonably believes that failure to settle the Claim would be prejudicial to it in any material respect;

22.4.3. give the indemnifying party and its professional advisers access at reasonable times (on reasonable prior notice) to its premises and its officers, directors, employees, agents, representatives or advisers, and to any relevant assets, accounts, documents and records within the power or control of the indemnified party, so as to enable the indemnifying party and its professional advisers to examine them and to take copies (at the indemnifying party's expense) for the purpose of assessing the Claim; and

22.4.4. subject to the indemnifying party providing security to the indemnified party to the indemnified party's reasonable satisfaction against any claim, liability, costs, expenses, damages, or losses which may be incurred, take such action as the indemnifying party may reasonably request to avoid, dispute, compromise or defend the Claim.

22.5. If a payment due from the indemnifying party under this clause is subject to tax (whether by way of direct assessment or withholding at its source), the indemnified party shall be entitled to receive from the indemnifying party such amounts as shall ensure that the net receipt, after tax, to the indemnified party in respect of the payment is the same as it would have been were the payment not subject to tax.

22.6. Nothing in this clause shall restrict or limit the indemnified party's general obligation at law to mitigate a loss it may suffer or incur as a result of an event that may give rise to a claim under this indemnity.

23. INSURANCE

23.1. The Parties acknowledge and agree that, at all times during the term of this Agreement:

23.1.1. NHS partners will remain members of the Welsh Risk Pooling Scheme or any subsequent Welsh Risk Pool arrangements and as such applies the NHS indemnity to its activities which are covered by this Agreement; and

23.2. The University undertakes that during the term of this Agreement and for a period of [PERIOD] years thereafter, it shall either self-insure or maintain in force, with a reputable insurance company, professional indemnity insurance in an amount not less than £[AMOUNT] for claims arising from a single event or series of related events in a single calendar year, and shall, on the other Party's request, produce both the insurance certificate giving details of cover and the receipt for the current year's premium.

23.3. Each Party shall notify the other if any policy is (or will be) cancelled or its terms are (or will be) subject to any material change.

24. LIMITATION AND EXCLUSION OF LIABILITY

24.1. The limits and exclusions in this clause reflect the insurance cover the Parties have been able to arrange for themselves, respectively.

24.2. References to liability in this clause include every kind of liability arising under or in connection with this Agreement including but not limited to liability in contract, tort (including negligence), misrepresentation, restitution or otherwise.

24.3. A Party may not benefit from the limitations and exclusions set out in this clause in respect of any liability arising from its deliberate default.

24.4. Nothing in this Agreement shall limit any liability under clause 192 (Indemnity).

24.5. Nothing in this clause shall limit a Party's payment obligations to the others under this Agreement.

24.6. Nothing in this Agreement limits any liability that cannot legally be limited, including liability for:

24.6.1. death or personal injury caused by negligence;

24.6.2. fraud or fraudulent misrepresentation; and

24.6.3. breach of the terms implied by section 12 of the Sale of Goods Act 1979 or section 2 of the Supply of Goods and Services Act 1982 (title or quiet possession).

24.7. Subject to clause 21.3 (no limitations in respect of deliberate default), clause 21.4 (no limitation of payment obligations), clause 21.5 (liability under identified clauses) and clause 21.6 (liabilities which cannot legally be limited), a Party's total liability to the other Parties under or in connection with this Agreement shall not exceed £[AMOUNT].

25. INTENTION TO TERMINATE

25.1. Subject to clause 02 , in the event that any Party (the "Initiating Party") contemplates the termination of either a Project Schedule or this Agreement, the Initiating Party shall provide prompt written notification to the other Parties, detailing its intention to terminate. The Parties shall then engage in good faith discussions for a period of not less than 30 days from the date of such notification, or such other period as mutually agreed, to explore the intention to terminate and to agree upon a managed wind-down of activities under either a Project Schedule or under this Agreement and its impact on any separate Project Agreements.

25.2. Notwithstanding any other provision in this Agreement, the Parties acknowledge and agree that their paramount duty of care is to patients participating in Projects supported by CHP. Accordingly, each Party shall, at all times, act in accordance with the safety and efficacy of such research and in the best interests of the safety and well-being of all such patients. No Party shall take any action, including but not limited to the termination of a Project Schedule or of this Agreement, if to do so would be contrary to the safety or best interests of such patients, or would compromise the integrity or continuity of ongoing Projects critical to patient safety. The Parties shall cooperate fully to ensure the continued safety and care of patients and the ethical conduct of Projects, even in circumstances contemplating termination.

25.3. The Parties further acknowledge their respective obligations to third parties, including but not limited to sponsors of Projects supported by CHP, and funders (collectively, "Third-Party Stakeholders").

25.4. In considering any termination of this Agreement, or any action that may impact the continuation of individual Project Schedule activities, each Party shall be mindful of and take all reasonable steps to mitigate any adverse impact on its obligations to Third-Party Stakeholders. The Parties shall collaborate to inform relevant Third-Party Stakeholders of any potential termination or significant changes to the Agreement in a timely and appropriate manner, and to agree upon a coordinated approach to minimise disruption to Projects and funding arrangements. This includes, where necessary and reasonably practicable, assisting with the orderly transfer of responsibilities or data to ensure compliance with existing agreements with Third-Party Stakeholders.

26. TERMINATION OF PROJECTS

26.1. Subject to clause 25 (Intention to Terminate) , the grounds and procedures for terminating the Agreement as a whole specified in clause 237 (Termination of Agreement) apply mutatis mutandis to a Project Schedule, and a Party to a Project Schedule may terminate it in accordance with such clause.

26.2. For the purposes of this clause, in relation to a Project Schedule, a material breach means:

26.2.1. a breach of any of the obligations set out in **Error! Bookmark not defined.Error! Reference source not found.**; or

26.2.2. a breach that has a serious effect on the benefit that the terminating Party would otherwise derive from the Project.

26.3. A Party may terminate a Project Schedule on giving not less than 4 months' written notice to the other Parties.

26.4. Termination of a Project Schedule in accordance with this clause shall have the effect that:

26.5. the terminated Project Schedule shall be severed from the Agreement, which shall otherwise remain in full force and effect; and

26.6. the provisions of clause 25925 (Consequences of Termination) shall otherwise apply (mutatis mutandis) in relation to the Project Schedule.

27. TERMINATION OF AGREEMENT

27.1. Subject to clause 25 , (Intention to Terminate) without affecting any other right or remedy available to it, a Party may terminate this Agreement with immediate effect by giving written notice to the other Party if:

27.1.1. the other Party fails to pay any amount due under this Agreement on the due date for payment and remains in default not less than 90 days after being notified in writing to make such payment;

27.1.2. the other Party repeatedly breach any of the terms of this Agreement in such a manner as to reasonably justify the opinion that its conduct is inconsistent with it having the intention or ability to give effect to the terms of this Agreement.

27.1.3. if any warranty given by the other Party in clause 21 of this Agreement is found to be untrue or misleading;

27.1.4. in accordance with clause 30 (Force Majeure).

27.2. For the purposes of **Error! Bookmark not defined.Error! Reference source not found.**, a material breach means:

27.2.1. a breach of any of the obligations set out in **Error! Bookmark not defined.**3; or

27.2.2. a breach that has a serious effect on the benefit which the terminating Party would otherwise derive from this Agreement.

28. SURVIVAL

28.1. On termination of this Agreement, the following clauses shall continue in force:

28.1.1. clause 1 (Interpretation);

28.1.2. clause 11 (Invoicing and Payment);

28.1.3. clause 12 (Set-Off);

28.1.4. clause 13 (Confidentiality)

28.1.5. clause 15 (Data Protection);

28.1.6. clause 016 (Intellectual Property);

28.1.7. clause 19 (Freedom of Information);

28.1.8. clause 21.1.2 and clause 21.2 (Warranties);

28.1.9. clause 22 (Indemnity);

28.1.10. clause 23 (Insurance);

28.1.11. clause 2124 (Limitation and Exclusion of Liability);

28.1.12. clause 26 (Termination of Projects);

28.1.13. clause (Survival);

28.1.14. clause 2529(Consequences of Termination);

28.1.15. clause 2630(Force Majeure);

28.1.16. clause 32 (Entire Agreement);

28.1.17. clause 35 (Notices);

28.1.18. clause 36 (Severance);

28.1.19. clause 37 (No Partnership or Agency);

28.1.20. clause 38 (Rights and Remedies);

28.1.21. clause 39 (Waiver);

28.1.22. clause 41 (Third Party Rights);

28.1.23. clause 4044(Mediation);

28.1.24. clause 45 (Governing Law); and

28.1.25. clause 46 (Jurisdiction).

28.2. Termination of this Agreement shall not affect any rights, remedies, obligations, or liabilities of the Parties that have accrued up to the date of termination, including the right to claim damages in respect of any breach of the Agreement which existed at or before the date of termination.

28.3. On termination of this Agreement, each Project Schedule then in force at the date of such termination shall continue in full force and effect for the remainder of the applicable Project Period, unless earlier terminated in accordance with the terms of this Agreement.

29. CONSEQUENCES OF TERMINATION

29.1. In the event of the termination of a Project Schedule or of this Agreement for any reason whatsoever, each Party shall remain fully obligated to, and shall continue to, deliver its commercial obligations and other commitments in relation to all Project Schedules which commenced or were formally committed to prior to the effective date of such termination. For the avoidance of doubt, the termination of this Agreement shall not release any Party from its obligations or liabilities arising from or in connection with any Project Schedules commenced or formally committed to prior to the effective date of such termination.

29.2. Upon the effective date of termination of this Agreement, the Parties shall cease to enter into any new Projects Schedules pursuant to CHP and/or this Agreement or the legacy partnership it represents. Any new Project Schedules initiated after the effective date of termination shall require a separate and distinct agreement between the relevant Parties, independent of this terminated Agreement.

29.3. On termination of this Agreement, unless such things are needed by it to perform its obligations under a Project Schedule (and only until the end of such time), each Party shall, and shall use all reasonable endeavours to procure that its Representatives shall, no later than 7 days after termination of this Agreement:

29.3.1. return or destroy (as directed in writing by the other Party) any documents, handbooks, or other information or data provided to it by the other Party for the purposes of this Agreement. If reasonably required by the other Party, it shall provide written evidence (in the form of a letter signed by it no later than 7 days after termination of this Agreement) that these have been destroyed and that it has not retained any copies of them;

29.3.2. return all of the other Party's equipment and materials, failing which, the other Party may enter the relevant premises and take possession of them. Until these are returned or repossessed, that Party shall be solely responsible for their safe keeping;

29.3.3. cease all licences and permissions granted under this Agreement;

29.3.4. promptly return to the other any Confidential Information of the other Party, including any copies thereof;

29.3.5. cease use of a Party’s name, name of any of their key personnel or logo or that of any third party; and

29.3.6. cease use of the name and logo of the CHP.

30. FORCE MAJEURE

30.1. A Party shall not be in breach of this Agreement nor liable for delay in performing, or failure to perform, any of its obligations under this Agreement if such delay or failure results from events, circumstances or causes beyond its reasonable control. In such circumstances the affected Party shall be entitled to a reasonable extension of the time for performing such obligations. If the period of delay or non-performance continues for 2 months the Party not affected may terminate this Agreement by giving 14 days' written notice to the affected Party.

31. ASSIGNMENT AND OTHER DEALINGS

31.1. A Party shall not assign, transfer, mortgage, charge, subcontract, delegate, declare a trust over or deal in any other manner with any or all of its rights and obligations under this Agreement without the prior written consent of the other Parties (such consent not to be unreasonably withheld or delayed).

32. ENTIRE AGREEMENT

32.1. This Agreement constitutes the entire agreement between the Parties and supersedes and extinguishes all previous agreements, promises, assurances, warranties, representations, and understandings between them, whether written or oral, relating to its subject matter.

32.2. Each Party agrees that it shall have no remedies in respect of any representation or warranty (whether made innocently or negligently) that is not set out in this Agreement. No Party shall have any claim for innocent or negligent misrepresentation based on any statement in this Agreement.

33. CONFLICT

33.1. Where there is a conflict between the provisions of this Agreement, and a separate Project Agreement, the Project Agreement shall prevail.

34. VARIATION

34.1. No variation of this Agreement shall be effective unless it is in writing and signed by the Parties (or their authorised representatives). The terms of any variation should be proposed via the Liaison Committee.

34.2. Any variation of this Agreement agreed by the Parties in accordance with clause 0 shall be deemed to apply to all future Project Schedules entered into after the date of such variation but shall not apply to Project Schedules already in force at that date unless such variation specifically so provides.

35. NOTICES

35.1. A notice given to a Party under or in connection with this Agreement shall be in writing and sent to the Party at the address or email address given in this Agreement or as otherwise notified in writing to other Party.

35.2. This clause 31.2 sets out the delivery methods for sending a notice to a Party under this Agreement and, for each delivery method, the date and time when the notice is deemed to have been received (provided that all other requirements of this clause have been satisfied, and subject to the provisions of clause 31.2.4):

35.2.1. if delivered by hand, at the time the notice is left at the address;

35.2.2. if sent by pre-paid first-class post or other next working day delivery service providing proof of postage, at 9.00am on the second Business Day after posting;

35.2.3. if sent by email, at the time of transmission.

35.2.4. If deemed receipt under clause 31.2 would occur outside business hours in the place of receipt, it shall be deferred until business hours resume. In this clause, **business hours**

means 9.00 am to 5.00 pm Monday to Friday on a day that is not a public holiday in the place of receipt.

35.3. This clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

36. SEVERANCE

36.1. If any provision or part-provision of this Agreement is or becomes invalid, illegal, or unenforceable, it shall be deemed deleted, but that shall not affect the validity and enforceability of the rest of this Agreement.

36.2. If any provision or part-provision of this Agreement is deemed deleted under clause 0, the Parties shall negotiate in good faith to agree a replacement provision that, to the greatest extent possible, achieves the intended commercial result of the original provision.

37. NO PARTNERSHIP OR AGENCY

37.1. Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Parties, constitute any Party the agent of another Party, or authorise any Party to make or enter into any commitments for or on behalf of any other Party.

37.2. Each Party confirms it is acting on its own behalf and not for the benefit of any other person.

38. RIGHTS AND REMEDIES

38.1. Except as expressly provided in this Agreement, rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

39. WAIVER

39.1. A waiver of any right or remedy under this Agreement or by law is only effective if given in writing and shall not be deemed a waiver of any subsequent breach or default.

39.2. A failure or delay by a Party to exercise any right or remedy provided under this Agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict any further exercise of that or any other right or remedy. No single or partial exercise of any right or remedy provided under this Agreement or by law shall prevent or restrict the further exercise of that or any other right or remedy.

40. COUNTERPARTS

40.1. This Agreement may be executed in any number of counterparts, each of which when executed shall constitute a duplicate original, but all the counterparts shall together constitute the one Agreement.

40.2. Transmission of an executed counterpart of this Agreement (but for the avoidance of doubt not just a signature page) by email (in PDF, JPEG, or other agreed format) shall take effect as the transmission of an executed "wet ink" counterpart of this Agreement. If this method of

transmission is adopted, without prejudice to the validity of the Agreement thus made, each Party shall on request provide the other with the "wet ink" hard copy original of their counterpart.

40.3. No counterpart shall be effective until each Party has executed at least one counterpart.

41. THIRD PARTY RIGHTS

41.1. This Agreement does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement.

41.2. The rights of the Parties to rescind or vary this Agreement are not subject to the consent of any other person.

42. FURTHER ASSURANCE

42.1. Each Party shall and shall use all reasonable endeavours to procure that any necessary third Party shall, promptly execute and deliver such documents and perform such acts as may reasonably be required for the purpose of giving full effect to this Agreement.

43. COSTS

43.1. Each Party shall pay its own costs incurred in connection with the negotiation, preparation, and execution of this Agreement and any documents referred to in it.

44. MEDIATION

44.1. If a dispute or difference arises between any or all of the Parties in relation to any aspect of this Agreement, the Parties shall consult in good faith via the CHP's coordination groups and hierarchy in an attempt to come to an agreement in relation to the disputed matter. Where the dispute is not resolved, the matter will be referred to senior or executive officers for resolution.

44.2. Where there is a dispute between NHS organisations and such dispute cannot be resolved in accordance with clause 0 Organisation Representatives (or their representatives), shall be referred to the Welsh Ministers for resolution pursuant to section 7(6) of the National Health Service (Wales) Act 2006.

44.3. If any dispute arises in connection with this Agreement between the Parties and cannot be resolved pursuant to clause 0, the Parties agree to enter into mediation in good faith to settle such a dispute and will do so in accordance with [the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the Parties within 14 working days of notice of the dispute, the mediator will be nominated by CEDR. To initiate the mediation a Party must give notice in writing (ADR notice) to the other Party, referring the dispute to mediation. A copy of the referral should be sent to CEDR.

44.4. If there is any point on the logistical arrangements of the mediation, other than nomination of the mediator, upon which the Parties cannot agree within 14 working days from the date of the ADR Notice, where appropriate, in conjunction with the mediator, CEDR will be requested to decide that point for the Parties having consulted with them.

44.5. Unless otherwise agreed, the mediation will start not later than 28 working days after the date of the ADR notice. The commencement of a mediation will not prevent the Parties commencing or continuing court proceedings.

45. GOVERNING LAW

45.1. This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales as it applies in Wales.

46. JURISDICTION

46.1. Each Party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

This Agreement has been entered into on the date stated at the beginning of it.

Signed for and on behalf of

Velindre University NHS Trust

……..

Authorised Signatory

Name:

Position:

Signed for and on behalf of

Cardiff & Vale University Health Board

……..

Authorised Signatory

Name:

Position:

Signed for and on behalf of

Cardiff University

……..

Authorised Signatory

Name:

Position:

Partneriaeth Ymchwil Canser Caerdydd | Cardiff Cancer Research Partnership

Appendix 1

CHP and CCRP Partnership Agreements

Trust Board

24th September 2026

Background

- History of successful partnership working between organisations:
  - Velindre University NHS Trust
  - Cardiff & Vale University Health Board
  - Cardiff University
- Cardiff Cancer Research Partnership (CCRP) & Cardiff Health Partners (CHP) – high value partnerships with significant Executive sponsorship across all three organisations.
- Although both CCRP and CHP have been ongoing for some time, it is an important step in the maturity of the arrangements for each respective organisation to consider approving a tri-party partnership agreement.

This slide deck provides:

1. Background and context for CHP
2. Background, history and context for CCRP
3. Summary of Agreements for approval today

1. Cardiff Health Partners

WHY : To enable system- wide health transformation that no single organisation can deliver alone- improving population health, reducing inequalities and relieving pressure on acute

WHO : Cardiff's anchor institutions working together as the vehicle for health innovation- anchored in Cardiff for global impact

WHAT : A system transformation engine that brings partners together to align priorities, remove barriers and enable change

CHP Missions - 2026-2035

Mission 1	Mission 2	Mission 3	Mission 4
Healthier Lives for Healthier Futures	**Transform care closer to home**	**Closing the Health Gap**	**Advance research, innovation, talent and prosperity**
Advance population health through prevention, behaviour change, early intervention and evidence-based approaches that help people live healthier lives for longer	Develop integrated models of community care, enabled by digital and service innovation, to help people live well at home, remain independent and reduce avoidable hospital use.	Improve outcomes for underserved communities through co-creation, inclusive research, innovation and place-based approaches that address the root causes of poor health and reduce inequalities.	Advance research, innovation, education and digital capability to develop future talent, strengthen the workforce and shape a sustainable future for health and wellbeing

The three founding organisations

Cardiff and Vale UHB | **Cardiff University** | **Velindre UNHS Trust**

The vehicle for health innovation, anchored in Cardiff and connected for global impact

Values

- **Act Together** — One system, shared purpose, momentum
- **Every Voice Matters** — Diverse insight ensuring real impact
- **Open, Ethical & Accountable** — Integrity in partnership
- **Lead with Care and Foresight** — Decisions today for healthier futures

Strategic Missions

- **Mission 1** — Healthier Lives for Healthier Futures
- **Mission 2** — Transform Care Closer to Home
- **Mission 3** — Closing the Health Gap
- **Mission 4** — Advance Research, Innovation, Talent and Prosperity

Goals

- **Goal 1** — Stimulate Innovation
- **Goal 2** — Enable Translational Research
- **Goal 3** — Develop a future ready workforce
- **Goal 4** — Foster regional collaboration
- **Goal 5** — Accelerate health for our community and reduce inequality
- **Goal 6** — Drive Economic growth and regeneration

Current Leader Programmes

Next Generation Cancer Care
- CCRP
- Cancer Discovery Centre

Brain Health
- Intracranial Advanced Therapies Hub
- HEB Brain Facility

Precision medicine

Under consideration…

Cross-Cutting Enablers

Clinical Academics | **Joint Research Office** | **Data and Samples**

CHP Current Leader Programmes

Next-generation cancer care
The Cardiff Cancer Research Partnership has launched multiple early and late phase cancer clinical trials, including industry led and translational studies. Acting as a gateway for trial portfolios across South-East Wales, the Partnership streamlines access and collaboration.

Brain Therapies
Cardiff is home to a distinctive set of imaging capabilities at CUBRIC (Cardiff University Brain Research Imaging Centre) and is among a select group of global centres delivering first in-human intracranial advanced therapies, supported by world class imaging, genomics, and surgical expertise.

Precision medicine capabilities
Cardiff brings together ATMP delivery and a national genomics backbone to accelerate precision medicine, linking MRI-guided neurosurgery, the Wales Genomic Health Centre at Cardiff Edge, and federated data and biobanks to move from discovery to adoption at

Cross Cutting Enablers

Joint Research Office

Clinical Academics

Data and Sample Sharing

….and more being identified approach continues to matures

2. Cardiff Cancer Research Partnership

- Cardiff Cancer Research Partnership (CCRP) is a dynamic partnership between:
  - Cardiff and Vale University Health Board
  - Velindre University NHS Trust
  - Cardiff University

- The CCRP provides a single front door to expertise and facilities spanning haematological and solid tumour cancers - from early discovery phase through to complex and late phase clinical trials.

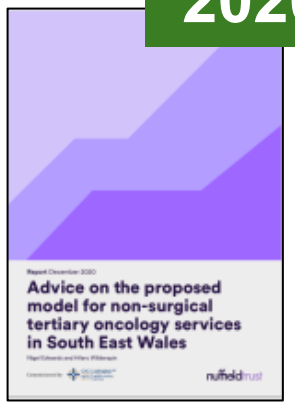
- A team of expert clinicians and researchers is at the forefront of advancing cancer research and transforming patient outcomes.

- With strong partnerships across the cancer research community in Wales we are ideally placed to develop the next generation of cancer treatments.

- Developing and trialling new drugs and therapies into the NHS is key to delivering better health outcomes for patients in the future.

CCRP – A Key Strategic Asset Delivered

2020 → **2026**



The Nuffield report (2020) proposed *"a hub for research activity and include collaboration with haemato-oncology research as part of the [proposed] model"*

8 CCRP trials currently open
plus 1 in setup and 1 active & closed to recruitment

Developing new cross-site pathways

e.g. **PASenger** clinical trial recently opened- new oncology bispecific pathway developed across VCC & UHW

Taking research from Cardiff University labs to the patient







VUNHST & CAVUHB working together to deliver a greater breadth of trials
(Oncology & Haematology, plus widening capability to help deliver entire portfolios –e.g. BioNTech

Prof Alan Parker, Cardiff University

Dr Magda Meissner PI - ATTEST trial

CCRP Current Arrangements

- CCRP is currently operating under an initial Heads of Terms (HoT) agreement signed in 2024
- The HoT's has been further developed into a fuller Partnership Agreement
- The work of the CCRP focuses on:
    i. Clinical Trials
    ii. Discovery and Translational Research
- CCRP is making cross organisational working more seamless
- The Trust has taken responsibility as the Programme Management Office and also the banker for CCRP
- Partnership Agreement – linked to Strategic and Operational Plan, and planning cycle.

CCRP Partnership Agreement

- Developed in partnership between the organisations
- NWSSP- Legal Services have been doing the drafting

CCRP

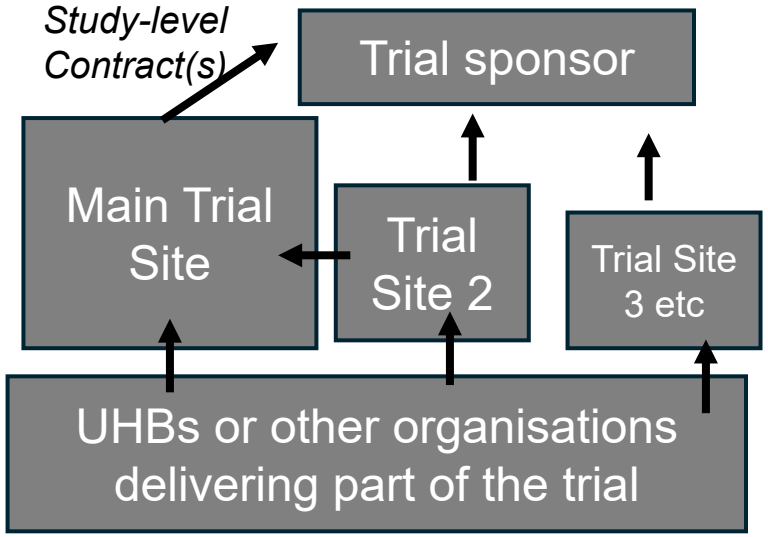
Partnership Agreement – no assets, no directly employed staff

Clinical Trial (1) | Research Trial (1) | Clinical Trial (2) | Clinical Trial (3)

Research and Clinical Trials is where the staff, assets and risks are managed on a trial-by-trial basis. It is expected that in most cases Trials cover own costs. All NHS Organisations have cover under the Welsh Risk Pool.

There are separate study- level contracts/SLAs between the Trust and the sponsor, and/or with other orgs. delivering part of the trial.
These have precedence over CCRP Partnership Agreement.

Process overseen by MHRA



Partneriaeth Ymchwil Canser Caerdydd | Cardiff Cancer Research Partnership

Developing the Agreements

Cardiff Health Partners | Partneriaid Iechyd Caerdydd

HoT's

High Level – not considered legally binding Talked about principles and matters that would be put in place

CCRP Partnership Agreement

Legally Binding, sets out far greater detail on key matters

CCRP Partnership Agreement

Greater detail across important areas

Secures funding for Trust PMO Team

Velindre to report in funding

CHP Agreement

More Strategic and based around 3 main strategic themes

In Summary

- Legally Binding Partnership Agreements which the Trust can leave.
- CAVUHB Medical Director and Vice Chancelor of CU already agreed to sign CCRP and CHP Agreements (agreed governance process in these organisations).
- Annual Plans will follow the signing of the CCRP Partnership Agreement must be agreed by all parties.
- CCRP is already operating under the HoT's and the Partnership Agreement gives greater clarity and protection.
- The detailed contracting and financing will happen at an individual project level – not in the partnership space and overseen by stringent RD&I processes and oversight.
- There are existing workforce risks which are managed, this agreement does not exacerbate these.

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	**Partnership Agreements for Cardiff Health Partnership (CHP) and the Cardiff Cancer Research Partnership (CCRP)**
Reference of proposal:	
Details of Board / Committee the paper is being presented to and when:	Executive Management Board – 24/8/2026

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEEP Quality Standards).

Quality Standard *Click each icon for its definition*	**Overall Impact**			**Key points and rationale**
	Positive (+1) / Neutral / Negative (-1)	**Level of impact High (3) Medium (2) or Low (1)**	**Impact score (product of previous columns)**	

Lauren
22/09/2026 16:56:59

	+1	2	+2	The cross-site research studies made possible by the CCRP and wider research-related activity CHP will enable both play a key role in delivering safe cancer care to patients both in South East Wales and globally, by establishing safe and effective treatment regimes for novel treatments and therapies. The specialist skills and experience that Trust staff build in safely delivering these novel treatments also support and facilitate their safe deployment as standard NHS treatment once the trial has been completed and the drug approved for routine NHS use.
	+2	2	+4	The trials supported by CCRP and wider research activity supported by CHP enable Trust clinicians to learn about and help develop cutting edge treatments. This in turn supports the Trust to deliver person-centred, evidence-informed, and resource-wise care. Research also provides participating patients with an opportunity to access novel treatments years before they are approved for routine NHS use, enabling the Trust to deliver timely and tailored treatments to those patients.
	+1	2	+2	The novel treatments available via clinical trials are often more effective than routine NHS treatments (for example, Immunotherapies and other advanced treatments). The cross-site clinical trials delivery enabled by the CCRP partnership agreement in particular enables more Trust patients to access these new therapies.
	+1	2	+2	Most or all of the clinical trials delivered by the CCRP are or will be funded by industry, while CHP will seek to bring large funding awards to the Cardiff region. This makes the research capability supported by the CCRP a highly efficient way of delivering care to patients, reducing the NHS funds required to deliver this care, and freeing up finite NHS resources.
	+1	2	+2	Several aspects of the CCRP and CHP will help to ensure an equitable provision of clinical trials across the region and Wales as a whole. For example, novel therapies developed by the CCRP will enable Welsh patients to access these in Cardiff rather than having to travel to more geographically distant centres in England.

Fear, Lauren
14/09/2026 16:56:59

Person ganolog Person centred	+1	2	+2	The CCRP and CHP helps provide Trust patients with the latest cancer treatments and therapies via novel clinical trials, particularly those that require facilities or expertise at or from CAVUHB or Cardiff University. This enables a patient-centred approach by making treatments available that best meet a patient's needs, even if that treatment is not yet routinely available as standard NHS care.
Overall impact	Whilst subservient to individual trial agreements, the CCRP Partnership Agreement will enable greater access for Velindre patients to cutting-edge cancer care via trials that can only be delivered at least in part on the acute UHW setting. The CHP Agreement will facilitate wider research-related developments, such as research that spans cancer and other key areas (e.g. precision medicine), as well as enabling the Trust to compete with other UK regional NHS/academic research partnerships to access significant funding opportunities.			

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard *Click each icon for its definition*	**Amount of activity required High (3), Medium (2) or Low (1)**	**Key points and actions to achieve the changes required**
Arweinyddiaeth Leadership	2	Both CCRP and CHP will extend research leadership at the Trust, by enabling the Trust and its staff to be involved with or lead regional cancer research activity. This includes new opportunities to take part in or lead cross-site clinical trials or translational research, as well as taking a regional and all-Wales leadership role in the development and deployment of next generation cancer treatments. The CHP in particular is ideally placed to enable the Trust to play a leadership role at a national level, generating opportunities for Trust staff to develop and deploy their leadership skills.

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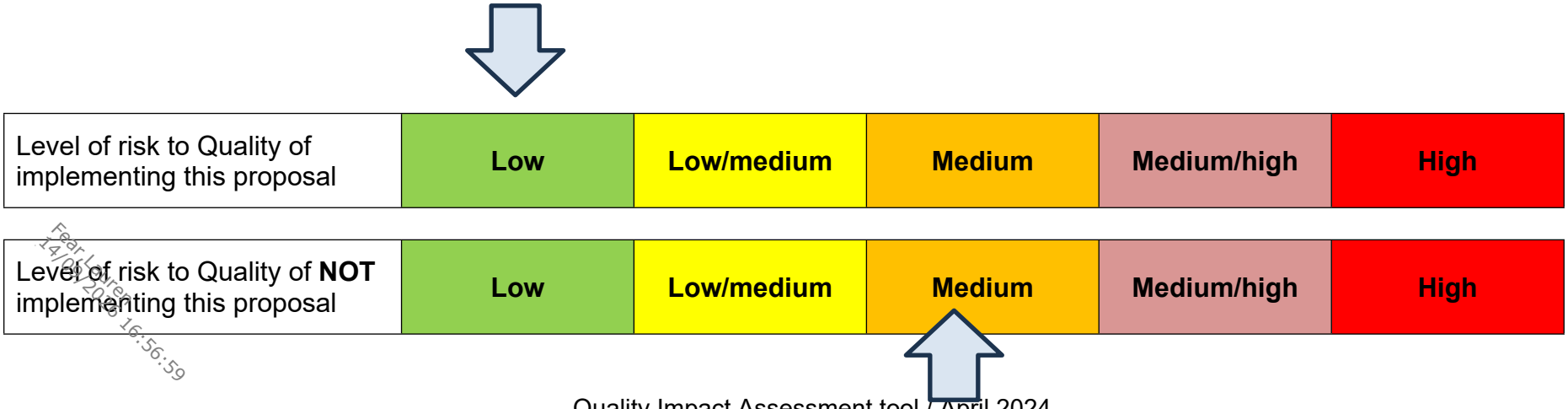
Gweithlu Workforce	2	The CCRP and CHP partnership agreements will help embed and expand the partnership working between the Trust, CAVUHB and Cardiff University. This will help expand and develop the cross-flow of staff, knowledge and expertise across the three organisations, bringing new opportunities for Trust staff (e.g. accessing clinical academic and translational research opportunities. The CCRP agreement will also support the embedding and development of the CCRP's specialist cross-site workforce, learning from CAVUHB and Cardiff University clinical and academic researchers, and spreading good practice across the three organisations. This will help both to make clinical trials more effective and support the deployment of novel therapies into wider NHS cancer services.
Diwylliant Culture	2	Research studies are by their nature new and innovative. The CCRP and CHP will help further embed research within the Trust's culture, increasing the opportunities for Trust patients and staff to participate in research. This, and the ability to access facilities and expertise from across the Cardiff region, will also aid the Trust in its ambition to secure Organisation of European Cancer Institutes (OECI) accreditation.
Gwybodaeth Information	2	Formalising CCRP and CHP activities via partnership agreements will help both entities grow and embed their activities across the Trust, CAVUHB and Cardiff University. This will help produce new, cross-site or regional processes, guidance and training documents to make it easier, faster and more efficient to do new research in both cancer and other priority areas.
Gwella, dysgu ac ymchwil Learning, improvement and research	2	Research-active healthcare organisations provide improved quality of care and outcomes for their patients. The CHP and CCRP a key foundation to expand the Trust's capacity in cancer and other research, including enabling some trials that the Trust would otherwise be unlikely to be able to offer its patients. They also provide mechanism to expand the Trust's translational research capability, developing discoveries made in University laboratories into treatments delivered to Trust patients. This not only develops new treatments for patients, but enables clinical and academic researchers to collaborate and learn from one another, speeding up the process of laboratory research informing patient care, and NHS treatments and resources informing the next generation of laboratory research.

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14/09/2026 16:56:59

Ymagwedd systemau cyfan Whole systems approach	2	The trials enabled by the CCRP and CHP helps ensure that the gathering and dissemination of learning on novel cancer treatments can take place at Velindre. They increase the Trust's ability to lead and work on a regional basis, and across the entire spectrum of the research journey, from laboratory bench to NHS patient bedside. They also provide a key vehicle for strengthening and deepening relationships with CAVUHB, Cardiff University and industry.
Overall amount of activity required	Medium The amount of activity required to support individual trials will continue to be governed by individual, study-specific agreements. The CCRP partnership agreement provides for the continuation of the CCRP's Core team (Project Management Office), which will now be jointly funded by the three partner organisations, rather than solely via Velindre's charity (as was previously the case), thereby helping to reduce potential future funding pressure on the charity.	

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?
Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)



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Describe the main risks to Quality of implementing this proposal?
Describe the main risks to Quality of NOT implementing this proposal?

Main risks to Quality of implementing this proposal:

- The CCRP Partnership Agreement reflects a continuation of working arrangements that have already been developed under its Heads of Terms. Implementing the agreement therefore represents a continuation of current working arrangements.
- The CHP agreement is based closely on the CCRP agreement, reflecting a consistent approach to partnership working. While both entities are relatively new, the CHP is the newer of the two, and has the wider scope; its working arrangements are therefore still in development. The CHP agreement provides a framework to help develop and embed these working arrangements; the agreement has been drafted at a high-level and with flexibility to evolve operational processes as the CHP matured. However, these working arrangements, will need to be monitored to ensure that these are developed in line with the provisions and spirit of the partnership agreement, and avoid the risk of scope creep.
- Governance and monitoring of a larger research portfolio (as CHP and CCRP mature and realise new research opportunities) may increase research complexity and the potential for error could increase if not carefully managed.

Main risks to Quality of NOT implementing this proposal?

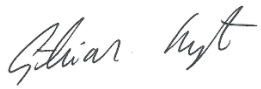
- The Trust would be left overseeing CCRP activity under its existing HoT agreement, and with no formal agreement for CHP. This risks an insufficient governance framework as both CHP and CCRP mature and expand.
- Not implementing the proposal would risk signalling to CAVUHB and Cardiff University that the Trust is not committed to the partnership working ethos and ambitions set out in CHP and CCRP's respective strategic visions and plans. This would risk weakening the partnerships and could result in scaling back of delay to joint projects.
- We will not achieve OECI accreditation without sustaining and increasing our cancer research activity, enabled through this proposal.
- Fails to help increase access for Welsh patients to new/novel cancer treatments and therapies, perpetuating inequities with the offerings of other UK cancer centres.
- Loss of credibility with commercial/pharmaceutical and non-commercial/academic partners, potentially damaging Trust reputation as a cancer research centre.
- Loss of opportunities to lead or take part in regional working, leading to missing out on potential significant external investment.

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Part 3: Developing and signing off this Quality Impact Assessment

QIA completed by / on date	QIA operationally agreed by / on date	QIA clinically agreed by / on date
Rhyd Owen 27/08/2026		

Executive clinical review and sign off (if required)

Clinical Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
<Name, role and date>	*Gillian Knight: Interim Executive Director of Nursing, Allied Health Professionals and Health Science*  07/09/2026	*<Name, role and date>*

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EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	**Creation of Partnership Agreements for Cardiff Health Partners and Cardiff Cancer Research Partnership**		
Manager	Rhyd Owen		
Date of meeting with OD Manager – ED&I	Reviewed on 7/9/26		
Date of submission	3/9/26		
Date of next review			
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	**Creation of Partnership Agreements for Cardiff Health Partners (CHP) and Cardiff Cancer Research Partnership (CCRP)**
1.2	Who owns it?	Jacinta Abraham (SRO)
1.3	What is the aim of the change(s)?	To further formalise partnership working arrangements between VUNHST, Cardiff University and Cardiff and Vale UHB
1.4	Who is affected most by the change?	A small team (1.7WTE) of VUNHST-employed staff operating as the operations function for the CCRP
1.5	How does this topic fit into the wider context of the organisation?	It supports the Trust's objectives around more collaborative working with both UHB and University partners, helping to achieve strategic aim 3 in Destination 2033 of making the Trust "*a beacon for research, development and innovation* "
1.6	Who is undertaking the EQIA	Rhyd Owen (Cancer R&D Strategy lead and CCRP Operations lead)
1.7	When will you start and end the EQIA?	Start: 1/9/26 End: tbc
2.1	What data is available to help inform the EQIA?	CHP and CCRP partnership agreement. CCRP activity and financial data CHP and CCRP Board minutes

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2.2	What information is still needed?	None
2.3	How will missing data be collected?	
2.4	What is considered relevant information and data?	Both CHP and CCRP Partnership Agreements provide a more formal framework to govern partnership working activity already underway between the three parties, and help extend it in future. However, individual clinical trials (and likely any other individual projects) between the partners will still be subject to individual study-level contractual agreements, which have priority over the partnership agreements. Therefore, the partnership agreements in and of themselves do not have particular EQIA implications; if/where an individual trial/project does, then this would need to be subject to a project-level EQIA at that point.

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3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle-aged people* *Older people* *Other…*			**X**	There is no identified impact on age; the framework resulting from the partnership agreements will be equally applicable to patients or staff of any age. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			**X**	There is no identified impact on disability; the framework resulting from the partnership agreements do not vary depending on a level of disability. Where individual projects may have an impact on a particular group, and/or require particular arrangements in terms of accessibility this will be considered separately for that project (e.g. in a project-specific EQIA)	
Gender re-assignment *Would this affect those in/post-transition differently?*			**X**	There is no identified impact on this characteristic. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	

Part of item 14 - 25/26 - 15.05.25 - 32

Marriage or civil partnership *Are single people affected differently?* *Are married people or civil partners treated differently?*			**X**	The provisions in the agreements are equally applicable to staff of any such status.	
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			**X**	Existing arrangements and responsibilities for the employing organisation will remain, and be unchanged by either partnership agreement.	
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			**X**	The framework resulting from the partnership agreements will be equally applicable to patients or staff of any race. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			**X**	The framework resulting from the partnership agreements will be equally applicable to patients or staff from any religious group or status. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	
Sex/Gender *Does it only apply to men / women?*			**X**	The framework resulting from the partnership agreements will be equally applicable to patients or staff of any and	

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24/09/2026 16:56:32

Could this affect one group more than the other?				all genders. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			**X**	The framework resulting from the partnership agreements will be equally applicable to patients or staff of any sexual orientation. Where individual projects may have an impact on a particular group, this will be considered separately for that project.	
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*			**X**	The partnership agreements do not in and of themselves impact on any particular socio-economic group. Individual studies (e.g. research with a rural component) may affect some groups differently; how to accommodate this (e.g. how to ensure inclusive communication).will need to be considered by the relevant project-level (e.g. in a project-specific EQIA)	
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?* *1. Does the subject treat the Welsh*			**X**	Neither agreements make any substantive change to existing Welsh language-responsibilities and arrangements; existing Welsh language responsibilities will continue. In addition, individual future projects will consider Welsh language requirements as applicable.	

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language less favourably than the English language? *2. Have you considered the Cultural opportunities / Promotion of the project? E.g. literature / Visual art representing Welsh artists* *3. Are you assured that all aspects of this project / policy etc has considered the needs of Welsh speakers?* *If yes, identify the specifics If no, state what should be included.*					

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14/09/2026 16:56:32

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	1. No major change
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	Not applicable
4.3	Could be policy be implemented in a different way to avoid negative impact?	Not applicable
4.4	How will this change promote equality of access and equality of opportunity?	It will help make it easier for Velindre to open clinical trials which require acute patient care facilities at UHW in particular (which Velindre cannot otherwise open). Many of these types of treatments would otherwise not be available in Wales This will increase the range of new treatments that Velindre cancer patients can access, particularly those who are unable to travel outside Wales to access such trials otherwise.
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	Not applicable

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14/09/2026 16:56:32

5.1	What do you have so far?	There is already a Heads of Terms (HoT) agreement in place for the CCRP. The CCRP Partnership agreement has built on this, working with NWSSP lawyers to develop the HoT into a Partnership agreement. The CHP Partnership agreement is in turn based closely on the CCRP model, but provides a wider scope (i.e. similar partnership working but with a scope beyond cancer). The agreements are a framework within which individual joint projects and other collaborative activity will emerge; these will need to be subject to their own EQIA as appropriate., given the particular subject area, aims and staff/patient/population impact of that particular project. As such, the Partnership Agreements in and of themselves are not anticipated to have any such impact.
5.2	Have any themes emerged?	n/a
5.3	What do people have to say about our work?	n/a
5.4	How will you consult widely on your topic?	We have consulted with relevant departments/functions across each partner organisations
5.5	Who will you consult with?	We have already closely involved NWSSP legal & risk, plus a variety of executives, research leads, clinical and academic researchers, governance, R&D support, finance, partnership and other staff from across VUNHST, CAVUHB and Cardiff University.
5.6	How long will the consultation stage last?	Already completed
6.1	The action plan must appropriately evidence the decision for one of the following policy options:1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	

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6.2	What will you do with the comments or information you have gathered from your consultations?	n/a
6.3	How did the consultation help guide new policy?	Our engagement outlined above has already shaped the existing draft agreements.
6.4	Will you make any changes to the draft report you produced?	n/a
7.1	Confirm actions	1) Review CCRP and CHP governance and project management arrangements to ensure that future CHP and CCRP projects assess equality, accessibility, Welsh language and inclusion requirements as part of project planning and governance. 2) Consider EQIAs for individual CHP and CCRP project-level activities and completed EQIA where necessary.
8.1	Establish timetable for reviewing actions and refreshing the assessment	1) Target date for completion: 31/12/26 2) As required (based on which projects are commenced and when).

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14/09/2026 16:56:32

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1	Review CCRP and CHP governance and project management arrangements to ensure that future CHP and CCRP projects assess equality, accessibility, Welsh language and inclusion requirements as part of project planning and governance.	To be considered by CCRP Project Board and CHP Programme Team	Considered by 31/12/26 Any process or policy revisions to be completed by 28/2/27	Low To be undertaken by existing programme & governance teams
2	Consider EQIAs for individual CHP and CCRP project-level activities and completed EQIA where necessary.	To be considered by CCRP Project Board and CHP Programme Team	ongoing	Low CCRP – to be undertaken by existing Operations team CHP: to be undertaken by CHP Operations function (to be confirmed)

Strategic Alignment

	Future Generations Act Wellbeing Objectives	Links to Objective
1	A prosperous Wales	☐
2	A resilient Wales	☐
3	A healthier Wales	☒
4	A more equal Wales	☐
5	A Wales of more cohesive communities	☐
6	A Wales of vibrant culture and thriving Welsh language	☐
7	A globally responsible Wales	☐

Page 331 of 527 14/01/2026 16:56:32

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X

Lead Officer

08/09/2026

X

Equality & Diversity Manager

Signed by: Michelle Fowler (mi120281)

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Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

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TRUST BOARD		
FLEET MODERNISATION PROGRAMME BUSINESS JUSTIFICATION CASE 2026-27		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Daniel Sinderby, Project Manager, Transformation Management Office, NWSSP	
PRESENTED BY	Linsay Payne, Deputy Director of Finance and Corporate Services, NWSSP	
REPORT SPONSOR	I, **Choose an item**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	28/07/2026	Fleet Modernisation Programme Board
	07/08/2026	NWSSP Director of Finance & Corporate Services
	27/08/2026	NWSSP Formal Senior Leadership Group
	15/09/2026	NHS Wales Shared Services Partnership Committee
	The Fleet Modernisation Programme Business Case was approved by the Velindre Trust Board in November 2025. The Year 1 Business Justification Case was approved in 2025 by the Chair and Managing Director of Shared Services in line with the Scheme of Delegation as the value was <£1M.	
ONWARD SCRUTINY ROUTE	Submission to Welsh Government following Trust Board approval.	
PURPOSE OF THE REPORT	**FOR APPROVAL**	
	The Trust Board is asked to: • **APPROVE** the Year 2 Business Justification Case and associated capital funding request of £1.290m, excluding VAT, following approval by the Shared Services Partnership Committee and prior to submission to Welsh Government; • and in doing so, **AUTHORISE** the Chief Executive Officer to approve the associated purchase order.	
EXECUTIVE SUMMARY	This paper seeks Trust Board approval for the Year 2 Business Justification Case and associated capital funding request of £1.290m, excluding VAT, to replace 22 fleet vehicles by 31 March 2028.	

	The Fleet Modernisation Programme has successfully completed the delivery of the Year 1 BJC, with 19 Battery Electric Vehicles procured and 27 vehicles identified for decommissioning. This Year 2 BJC demonstrates the need to continue modernising the fleet to improve operational resilience, reduce maintenance and fuel costs, and support NHS Wales and Welsh Government decarbonisation objectives. It sets out the case for the recommended option, which proposes a mix of BEVs and PHEVs, confirms alignment with decarbonisation and operational priorities, and provides assurance on procurement, affordability, delivery and benefits realisation. The recommended option is the most proportionate approach, balancing affordability, benefits and risk, whilst recognising current charging infrastructure constraints and operational requirements. Key risks relating to funding approval, vehicle availability, procurement and delivery timescales, charging infrastructure capacity and workforce adoption have been identified, with appropriate mitigations in place through established programme governance and risk management arrangements. The proposal is expected to reduce vehicle downtime, maintenance and fuel costs, deliver approved cash-releasing savings of £49k by 31 March 2028, and contribute to the longer-term transition towards a lower-emission fleet.
ACTION / DECISION	The Trust Board is asked to: • **APPROVE** the Year 2 Business Justification Case and associated capital funding request of £1.290m, excluding VAT, following approval by the Shared Services Partnership Committee and prior to submission to Welsh Government; • and in doing so, **AUTHORISE** the Chief Executive Officer to approve the associated purchase order.
ADDITIONAL RESOURCES	Appendix 1- Fleet Modernisation Programme – Year 2 Business Justification Case
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:	
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.	
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):	
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.	

QUALITY AND SAFETY IMPLICATIONS

This report impacts one or more of the following Six Domains of Quality:

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

See Appendix 3 - Quality Impact Assessment for further details.

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA completed - document provided as an appendix to this report

See Appendix 3 - Quality Impact Assessment for further details.

The modernisation of the fleet has a direct impact on the quality, safety and operational sustainability and effectiveness of health and care services. Delivering many of the clinical and pathological testing samples for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care.

Modernising the fleet through the replacement of vehicles with BEVs/ULEVs improves the efficiency, reducing the cost per mile, whilst also removing carbon emissions at the tail pipe for the vehicles being replaced.

The new vehicles will reduce vehicle downtime through effective rightsizing and therefore increase operational efficiency, resilience, and timeliness, whilst also beginning to align the NWSSP fleet to both the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan.

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

The EQIIA has been completed for the Programme, and it was fed back that the project team has considered the protected characteristics, providing both comprehensive and thoughtful analysis.

In relation to the socio-economic duty assessment this was covered within the Programme Business Case that was submitted to Welsh Government on 1 December 2025. Air quality improvements from replacing ICE vehicles with ULEVs/BEVs directly benefit communities in polluted, deprived areas, helping reduce health inequalities, especially respiratory and cardiovascular conditions. This supports better access to health and mental health services by improving the environment in which services are delivered. The programme could create new job opportunities in EV maintenance, infrastructure, and logistics, therefore through inclusive recruitment and training, it supports people from disadvantaged backgrounds to access better employment and career progression. Offers

upskilling and retraining for existing NHS staff helping them adapt to new technologies and improve long-term earning potential.		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Fleet Modernisation Programme – Year 2 Business Justification Case
	Appendix 2	Commitment of Expenditure Form
	Appendix 3	Quality Impact Assessment

FLEET MODERNISATION PROGRAMME BUSINESS JUSTIFICATION CASE 2026-27

KEY CONSIDERATIONS

1. SITUATION

The proposal seeks approval of the BJC which requests capital funding of £1.290m (excluding VAT) from Welsh Government to procure, convert and mobilise 22 vehicles by the 31 March 2028. The proposed replacement fleet consists of 5 Battery Electric Vehicles (BEVs) and 17 Plug-in Hybrid Electric Vehicles (PHEVs) enabling the programme to continue delivering operational, financial and decarbonisation benefits while maintaining service continuity across Wales.

The current fleet includes a range of operational vehicle types, including standard vans, dual liner vans, temperature-controlled vehicles, specialist conversions, emergency rapid response vehicles and heavy goods vehicles. These vehicles support a broad range of Health Courier Service requirements, including the movement of pathology samples, blood products, pharmaceuticals, medical equipment and other essential healthcare items.

This Business Justification Case follows the approved Year 1 Business Justification Case aligning to the PBC, through which 19 BEVs were procured and 27 vehicles identified for decommissioning, including vehicles classed as Beyond Economical Repair (BER) or Vehicle Off Road (VOR). The service now operates a fleet of 288 vehicles, comprising 188 owned and 100 leased vehicles, with an average age of 7 years and annual maintenance costs of approximately £0.460m. Although the fleet has begun to modernise, a number of older vehicles continue to generate high maintenance costs, increased downtime and reduced operational resilience, creating a clear business need to continue the planned annual replacement cycle.

The proposed investment will help reduce carbon emissions, improve operational resilience, lower running costs and support the continued transition towards a predominantly Battery Electric Vehicle and Ultra Low Emission Vehicle fleet, in line with the NHS Wales Decarbonisation Strategic Delivery Plan and Welsh Government's Net Zero Strategic Plan.

2. BACKGROUND

The Health Courier Service provides vital logistical support to frontline NHS services across Wales, including hospitals, clinics, GP practices, pharmacies, schools and immunisation programmes, operating where required on a 24-hour, 365-day basis.

The Fleet Modernisation Programme was established to support the replacement of ageing fleet assets through annual Business Justification Cases, allowing investment decisions to remain aligned with service requirements, available technology, infrastructure capacity and wider national decarbonisation priorities.

Replacement decisions have been informed by a fleet replacement profiling process, considering factors such as vehicle age, net book value, mileage, maintenance costs, condition assessment scores and emissions standards. This supports an evidence-based approach, ensuring that vehicles are replaced where they are no longer fit for purpose or represent poor value for money.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

Five options were assessed within the Business Justification Case, ranging from a “Do Nothing” option through to a “Do Maximum” replacement option. The lower-cost options (1 & 2) reduced immediate capital expenditure but did not adequately address vehicle reliability, maintenance costs, operational resilience or decarbonisation requirements as they focus primarily on the Beyond Economical Repair vehicles and only meets some of the fleet replacement profile criteria. Higher replacement options (3, 4 & 5) delivered greater fleet modernisation and emissions reductions but required significantly higher investment, with the Do Maximum exceeding Programme cost tolerance for the financial year. These options were also considered disproportionate to current operational requirements and infrastructure capacity, therefore option 3 was identified as the preferred way forward. It provides the most balanced approach between affordability, benefits and risk, targeting the highest-priority vehicles whilst maintaining operational resilience and supporting decarbonisation objectives by replacing vehicles that are Beyond Economical Repair, over 9 years old, in poor condition and/or generating high maintenance costs or mileage.

Option 3 requires £1.290m excluding VAT and will replace 22 vehicles. This option is considered proportionate because it targets the least reliable and most expensive vehicles within the fleet, supports reduced maintenance costs, improves reliability, contributes to reduced emissions and smooths the overall age profile of the fleet without compromising service delivery.

The proposed vehicle mix of Battery Electric Vehicles and Plug-in Hybrid Electric Vehicles reflects current operational requirements and infrastructure constraints. The Business Justification Case identifies that a full Battery Electric Vehicle transition is not currently suitable for all Health Courier Service routes due to mileage, charging availability, operational range, rural and remote service coverage, emergency requirements and the need to maintain continuity of patient-critical services.

The expected benefits include compliance with the NHS Wales Decarbonisation Strategic Delivery Plan and Welsh Government’s Net Zero Strategic Plan, a reduction of CO2 emissions, reduced vehicle downtime, annual fuel cost and scheduled maintenance costs reductions by 31 March 2028.

3.2 SUMMARY OF MATTERS FOR CONSIDERATION

The preferred option to be progressed is to replace vehicles that are BER and those that are older than 9 years and in either poor condition and/or with high maintenance costs/mileage.

The vehicles identified for replacement have been subject to the fleet replacement profile established as part of the programme, which assesses vehicle age, condition, mileage, maintenance costs, net book value and emissions standard to ensure replacement funding is directed towards the highest-priority fleet assets. This provides a transparent, objective and evidence-based approach to fleet investment by prioritising vehicles that are Beyond Economical Repair, approaching end of life, in poor condition, or generating disproportionate maintenance and operational costs.

Benefits have been captured within the project's benefits log, benefits realisation plan and benefits map. Cash releasing benefits have been quantified and approved by NWSSP Finance, realising a total saving of £49k by 31 March 2028. The benefits have been based on the mixture of Battery Electric Vehicles (BEVs) and Plug-in Hybrid Electric Vehicles (PHEVs).

The proposed vehicle replacement has taken into consideration NWSSP's current EV charging infrastructure and wider fleet the planned development of charging infrastructure. Whilst work is commencing to plan future charging infrastructure requirements, current infrastructure capacity and operational constraints have been considered when determining the proposed vehicle mix. This ensures that vehicle procurement remains deliverable within existing infrastructure capabilities whilst maintaining operational resilience and supporting a phased transition towards a predominantly battery electric fleet over time.

PHEVs have been included within the proposed fleet mixture recognising that a full BEV solution is not currently suitable for all operational routes due to infrastructure, range and service delivery requirements. PHEVs provide a practical transition technology, supporting emissions reduction and decarbonisation objectives whilst maintaining the operational resilience required to deliver patient-critical services across Wales.

Overall, the proposed investment represents a balanced and evidence-based approach to fleet replacement, targeting those vehicles that present the greatest operational, financial and environmental challenges. The recommended option supports continued service resilience, delivers approved cash-releasing and non-cash-releasing benefits, contributes towards NHS Wales decarbonisation objectives, and aligns vehicle replacement activity with both current operational requirements and existing infrastructure capacity. Approval of the Business Justification Case will enable the Fleet Modernisation Programme to continue the planned transition towards a lower-emission fleet whilst maintaining the reliable delivery of patient-critical services across Wales.

3.3 FINANCIAL IMPLICATIONS

- Source of funding: Welsh Government
- Type of funding: Capital funding
- Scale of change: £1.290m capital
- Type of change: Business as usual improvement

Further detail is outlined in the Appendices.

3.4 LEGAL IMPLICATIONS

There are no specific legal implications related to the activity outlined in this report.

3.5 PEOPLE IMPLICATIONS

There are no staffing implications arising as a result of the activity outlined in this report.

3.6 WELSH LANGUAGE IMPLICATIONS

There are no Welsh Language implications related to the activity outlined in this report.

3.7 RISKS / REPUTATIONAL IMPLICATIONS

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

Operational Risks

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- **APPROVE** the Year 2 Business Justification Case and associated capital funding request of £1.290m, excluding VAT, following approval by the Shared Services Partnership Committee and prior to submission to Welsh Government;
- and in doing so, **AUTHORISE** the Chief Executive Officer to approve the associated purchase order.

Business Justification Case
Project - Fleet Modernisation Plan 2026/27

Capital Investment/Purchase Request

NWSSP

Supply Chain Logistics and Transport

Project Team:

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Governance Route:

	Name	Signature	Date
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Approved by:	Programme Board	J Irvine T Chatfield P Board	28/07/2026
Approved by:	Alison Ramsey	A Ramsey	07/08/2026
Noted by:	Formal Senior Leadership Group (SLG)		27/08/2026
Approved by:	Neil Frow		01/09/2026
Approved by:	Shared Services Partnership Committee		15/09/2026
Approved by:	Velindre Trust Board		24/09/2026

Contents

1. THE CASE FOR CHANGE 4
2.1 Spending Objectives....4
2.2 Existing Arrangements 5
2.3 Business Need 7
2.4 Risks 10
2. Strategic alignment and Duty of Quality....16
3.1 NWSSP Strategic Outcomes and Duty of Quality alignment....17
3.2 All Wales Capital Plan (AWCP) Objectives 19
3. OPTIONS ANALYSIS 20
4.1 Options Appraisal....20
4.2 Recommended Option....26
4.3 Main Benefits....30
4. PROCUREMENT ROUTE....30
5. FUNDING AND AFFORDABILITY....35
6. DELIVERY ARRANGEMENTS 36
7.1. Governance & Milestones 36
7.2. Project Controls 37
7.2.1. Benefits....38
7.2.2. Risks & Issues....38
7.2.3. Actions & Decisions 38
7.2.4. Quality Assurance & Lessons Learned 39
7.2.5. Scope 39
7. APPENDIX....40

List of tables:

No.	Table Description	Page
1	Spending Objectives	5
2	Recent years profile of vehicle purchases	6
3	Number of NWSSP EV chargers and parking bays	7
4	Risks	12
5	Duty of Quality	19
6	AWCP Objectives	21
7	Main Benefits	33
8	Cost and Funding for the Recommended Option	39
9	Revenue Projections for the Recommended Option	40

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INTRODUCTION

This Business Justification Case (BJC) is the second of five to be submitted under the Fleet Modernisation Programme within NHS Wales Shared Services Partnership (NWSSP), requesting the second-year Capital funding requirements for the replacement of vehicles as outlined in the Fleet Modernisation Programme Business Case (PBC) submitted to Welsh Government on the 01 December 2025.

The BJC recommends option 3 from the shortlist, requesting £1.290m (excluding VAT) to procure, convert and mobilise 22 vehicles, consisting of a mixture of 5 Battery Electric Vehicles (BEVs) and 17 Plug-in Hybrid Electric Vehicles (PHEVs), by the 31st March 2028 to realise the substantial benefits identified.

NWSSP continues to support the statutory Health Boards and NHS Trusts in Wales, so that they may in turn, focus on more effective local delivery of front-line services. NHS Wales Supply Chain and Logistics and Transport (SCLT) forms part of the Procurement Services Division within NWSSP.

Within SCLT, the NHS Wales Health Courier Service (HCS) supports front line services across Wales, operating where required 24 hours a day, 365 days a year providing vital logistical support services for Primary and Unscheduled Care in Hospitals, Clinics, Surgeries, GP Practices, Pharmacies, Schools (Immunisation programmes) etc.

Following on from the approval of the initial project business justification case for year one of the Fleet Modernisation Programme, the service now operates a fleet of 288 vehicles, down from 306 in the previous financial year, consisting of 188 owned and 100 leased vehicles, with an average age of 7 years and an annual maintenance cost of £0.460m.

There is opportunity to continue to mitigate part of these costs, whilst reducing carbon emissions and increasing operational resilience. This can be achieved through the mobilisation of the vehicles requested, replacing 22 of the older higher carbon emission vehicles would allow for the realisation of multiple cash releasing benefits outlined within this BJC whilst also supporting the NHS Wales Decarbonisation Strategic Delivery Plan.

To support the realisation of these benefits and the Fleet Modernisation Programme's vision to have a predominantly Battery Electric Vehicle (BEV) and Ultra Low Emissions Vehicle (ULEV) fleet, together with the supporting charging infrastructure, and that meets the requirements of the NHS Wales Decarbonisation Strategic Delivery Plan wherever practicably possible, annual BJCs will continue to be submitted to Welsh Government over the lifecycle of the programme. These objectives will also play a part in

delivering on Welsh Government's Net Zero Strategic Plan for 2030, and the submission of continued annual BJCs will ensure that the benefits realisation of the remaining 8 years of the Programme's vision remains aligned with wider national priorities. This approach will continue to allow for the effective optimisation of fleet vehicles whilst considering emerging technologies in a rapidly changing space and ensuring that the preferred options offer value for money.

1. THE CASE FOR CHANGE

2.1 Spending Objectives

Table 1: The project's spending objectives align to the following drivers for intervention

Driver	Spending Objective
Effectiveness	**SO1:** to improve the quality of public services by delivering better social outcomes, new policy initiatives, whilst achieving operational targets.
Efficiency	**SO2:** to improve the delivery of public services by investing in modern vehicles, resulting in a more robust fleet and reducing annual revenue costs (fuel and maintenance).
Economy	**SO3:** to improve the use of government funding by spending on innovative technologies, sharing the Fleet equitably across Wales and providing local employment for the economy through the potential for local conversion and routine vehicle maintenance.
Compliance	**SO4**: to meet statutory, regulatory or organisational requirements and accepted best practice such as health and safety legislation, UKAS, Good Distribution Practice standards, Welsh Government's Net Zero Strategic Plan and NHS Wales Decarbonisation Strategic Delivery Plan.
Replacement	**SO5:** to ensure business continuity via the re-procurement of assets in line with the current fleet capacity and procurement guidelines whilst demonstrating economical sustainability.
Decarbonisation	**SO6:** To reduce NHS Wales's carbon emissions investing in ultra-low emissions vehicles (ULEV) and battery electric vehicles (BEV).

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2.2 Existing Arrangements

Capital expenditure from the Programme Business Case budget ensured that 19 BEVs could be procured within the first year of the Programme, alongside the decommissioning of 27 vehicles including some that were classed as Beyond Economical Repair (BER) or Vehicle Off Road (VOR). The deployment of these vehicles will also allow HCS to off hire 8 leased vehicles, reducing the size of the fleet without compromising the quality of the service. At the time of writing, the BER vehicles will have been disposed of at auction and the 8 leases will have been terminated by the 31 March 2027.

The fleet currently comprises of a range of vehicles including:

· Standard Van – Small/Medium/Large Wheelbase (SWB/MWB/LWB)
· Dual Liner Van (Passenger Capable)
· Standard Van – Small/Medium/Large (SWB/MWB/LWB with Temperature Controlled enablement)
· Luton Van with Tail Lift
· Specialist Vehicle Conversion (e.g. Pharmacy, Waste Services, Hermetically Sealed)
· Emergency Rapid Response Vehicles (Blue Light capable)
· HGV – Over 7.5t including 15t, 18t and 22t

Table 2: Recent years profile of vehicle purchases

Vehicle Type	2021/22	2022/23	2023/24	2024/25	2026/27	Total
MWB	30	0	0	17	17	64
LWB	3	0	0	0	0	3
Luton	1	0	0	0	0	1
HGV	0	0	0	0	0	0
Blue Light	5	0	0	0	0	5
Specialist	0	3	3	2	0	8
Total	**39**	**3**	**3**	**19**	**17**	**81**

Charging Infrastructure

Since 2021 HCS, has seen the introduction of Electric Fleet, to include Medium Wheelbase Vans. There are currently 49 EV/Hybrids (43 BEVs and 6 PHEVs) within the fleet representing 17%.

To enable the use of Battery Electric Vehicles (BEVs), NWSSP have installed a mix of Twin chargers and single bay chargers (81 parking spaces) across our national sites. These were procured in phases and in readiness for the future further adoption of BEVs, with the majority of the contract being awarded to Pod Point. The Pod Point EV chargers are provided with the accompanying software that records all usage data, which aids with managing the fleet locations. In addition to Pod Point, several chargers installed at IP5 Newport and Matrix House in Swansea, were procured through a separate supplier, Intelligent Charging Systems (ICS). To support the charging infrastructure and charging capacity, 110v shorelines have been installed at key sites including 14 at Matrix House and 4 at IP5.

Currently 43 spaces across NWSSP are being utilised for fleet operations resulting in 39 available bays remaining before further charging infrastructure will be required to accommodate the increased total of BEVs within the fleet. However, this figure represents a theoretical maximum capacity, as staff are not permanently based at IP5, Picketston or Nantgarw HQ, and all Matrix House bays are expected to be occupied from September 2026 when vehicles approved under the Year One BJC are introduced into service. Consequently, the practical availability of charging bays is lower than indicated and future infrastructure expansion will be required to support increased BEV utilisation.

Table 3: Existing number of NWSSP EV chargers and parking bays

Site	Units	Total Bays	BEV's on site	Available Bays	Year 1 Vehicles
ALDER HOUSE*	2	4	4	0	0
BRIDGEND STORES	2	4	3	0	0
CWMBRAN & DUPONT	2	4	6	-2	0
DENBIGH STORES	2	4	3	1	0
IP5 Newport	16	32	7	25	7
MATRIX HOUSE	10	20	9	11	9
PICKETSTON*	2	4	0	4	0
WESTPOINT	4	7	9	-2	0
HQ – NANTGARW*	1	2	0	2	0
VICTOR BASE	N/A*	N/A*	1	N/A*	0
BRONLLYS*	N/A*	N/A*	1	N/A*	0
Grand Total	**41**	**81**	**43**	**39**	**16****

*Non HCS bases

**One vehicle at Bronllys relies on non-NWSSP EV charging infrastructure

Maintenance

HCS continues to operate a Planned Preventative Maintenance (PPM) scheme, reflective of that of Welsh Ambulance Services University NHS Trust (WAST), where every vehicle dependant on role type undergoes a safety inspection at a set number of days. Where vehicles are not under warranty, maintenance itself is provided through WAST, at an average cost of £1,825 per Internal Combustion Engine (ICE) vehicle or £1,169 per BEV.

The benefits of this PPM approach are that:

· Workshop loading can be planned, enabling resources to be matched to workload.
· Operational managers have advance notice of vehicle extraction.
· All aspects of vehicle and equipment maintenance can be co-ordinated reducing the number of times fleet recalls a vehicle.
· Improved efficiencies and less downtime.
· Reduced cost through protracted servicing intervals.
· Reduced unplanned maintenance and improved reliability.

Telematics and Fleet Management

HCS continue to utilise an Asset/Fleet Management System (FleetCheck) to monitor the lifecycle of the entire fleet. It incorporates all fixed costs and variable operating expenses, as well as details of vehicle age, mileage, service history, compliance, incidents/accidents and Co2 output.

This information was used to establish those vehicles requiring to be decommissioned and will be essential when reviewing fleet optimisation as part of the wider programme.

Depreciation

Once procured the vehicle is depreciated on a straight line basis over the vehicle's useful economic life which is 7 years for both ICE & BEV vehicles. The wider fleet modernisation programme intends to explore this fleet replacement profile model to see where it can be improved and extended, further demonstrating the commitment of HCS and NWSSP to offer value for money.

2.3 Business Need

For NWSSP to continue to operate effectively it must have a fleet capable of delivering a high-quality and reliable service. The fleet must support the service in their work by providing a fit for purpose environment for the workforce and associated transport requirements.

To be compliant with the NHS Wales Decarbonisation Strategic Delivery Plan, as of November 2025, HCS will need to further modernise the current fleet through the procurement of replacement vehicles that meet the future modern standard of zero emission Battery Electric Vehicles (BEV) and where that is not possible, Hybrid or Ultra-Low Emission Vehicles (ULEV) as a minimum, wherever practicably possible. Additionally, all ICE vehicles procured must meet the European (Euro) emissions standards, which set legally binding limits on exhaust pollutants. Since September 2015, this requires compliance with Euro 6 for all new petrol and diesel vehicles. Euro 6 significantly reduces harmful emissions, particularly nitrogen oxides (NOx), with limits of 0.08 g/km for diesel and 0.06 g/km for petrol vehicles, supporting improved air quality and public health outcomes. BEVs and ULEVs inherently mitigate these requirements due to their zero or significantly reduced tailpipe emissions. Vehicles older than 2016, that are Euro5 standard, can continue to be used so long as they continue to pass their MOT emissions analysis.

Following the procurement of 19 new BEVs and 27 decommissioned vehicles in the previous year, the fleet is still rightsized above requirements, with vehicle rotation used to allow for routine maintenance and servicing to be completed without impacting service delivery. Where vehicles are BER, this continues to have an impact on operational resilience and efficiency, reducing the ability to provide consistent fulfilment and increasing the required milage of the remainder of the fleet.

Under this BJC we are requesting the capital funding to procure 22 vehicles, including 7 as replacements for the Euro 5 standard, that are either BER or have higher than expected maintenance costs outlined above. These will need to be procured, converted and deployed by 31st March 2028.

As with the year one Business Justification Case, the Vehicles within the fleet have been subjected to a replacement profiling process (Appendix 1) to determine which vehicles require replacement. This process has been developed to safeguard the delivery of value and ensure that we are only replacing vehicles that are no longer fit for purpose or BER.

The vehicles have been suggested for replacement, both ICE and BEV, following the mentioned assessment that considers vehicle age, Net Book Value, mileage, annual maintenance costs, the internal condition assessment score, and the expected emissions standard.

Following the assessment, and prior to replacement, any vehicles that have been identified as no longer meeting the requirements of the local service provision need will be relocated to an alternative base where possible.

All decisions regarding the decommissioning of vehicles will be reviewed and approved by the Head of HCS following the fleet replacement process completion. Only when vehicles have been approved for decommissioning will any request for replacement vehicles be made and it is not the intention of this programme to increase the fleet size and associated annual revenue costs.

If approved, new vehicles will be subject to vehicle conversion, which will typically include ply lining, camera installation, roof solar system, auxiliary battery system, sign writing. More costly conversions include the installation of ramps, winches and load locks or dual zone ambient fridges.

Additionally, vehicles will be fitted with the vehicle tracking system and linked to the fleet management system and logistics scheduling system, improving data availability for reporting and analytics on fleet utilisation and operating costs to support the use of data led decision making to improve the whole life cost. This will benefit the planning, management, and ongoing assessment of vehicle performance and will be utilised for fleet management oversight. With the improvement in this data, appropriate adjustments can be made to the operating schedules taking into consideration the newly available fleet whilst continuing to meet the demands of the services HCS provide.

Consideration was given to the inclusion of Transforming Access to Medicines (TrAMS) vehicles within this business case. It was determined that TrAMS vehicles are subject to separate funding arrangements and service agreements, therefore fall outside the scope of the programme's procurement and funding model. TrAMS vehicles require specialist conversions that differ from the standard vehicle specification therefore the requirement for those vehicles will be progressed through the TrAMs South East Hub Full Business Case, submitted to Welsh Government in August 2026. Progression within the TrAMS Programme and funding route will ensure that operational requirements and associated costs are appropriately managed.

Accounting for the existing BEVs within the fleet, there are currently 39 charging bays available overnight across HCS sites within Wales. To maximise potential benefit realisation, the existing ICE fleet will need to be relocated as required to help accommodate the new BEVs at the sites that have the available charging infrastructure.

If funding is approved, the new vehicles will be integrated into our current fleet and charging infrastructure, and there is no requirement, or subsequent request for capital funding in 2026/27, to develop our charging infrastructure as part of this BJC.

Overall, the investment will support the delivery of outcomes such as:

· Replacement of the fleet with the latest BEV Technology, which is compliant with the relevant decarbonisation agendas, such as the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan.
· The replacement of existing Euro5 vehicles that have exceeded their fleet maintenance lifecycle primarily with BEV or ULEV, increasing our operational efficiency and resilience whilst reducing our revenue costs.
· Improving vehicle utilisation and fleet optimisation through the capturing of information to support data led decision making.
· Improved employee wellbeing, retention, and recruitment, as we move towards higher levels of BEV/ULEV adoption.
· Increased workforce capabilities as NWSSP offer vehicle specific driver training to support adoption.
· Time based servicing and robust vehicle maintenance arrangements to safeguard vehicle operators whilst improving vehicle longevity and efficiency.
· Move to smaller and lighter vehicles where possible.

2.4 Risks

Table 4: Risks

	Risk Description	Risk Rating	Contingency
Vehicle Replacement	Capital requirements not supported	High	Reduced vehicle replacement – this will impact the vehicle efficiency and reliability due to increased downtime, compromising service delivery. This risks the decarbonisation strategy as being undeliverable unless larger requests for capital are authorised at later stages of the programme.
	Market Forces mean suitable chassis or vehicle types are not	High	Review options to rotate fleet to optimise vehicle usage and allocate BEV/ULEV to maximise

	Risk Description	Risk Rating	Contingency
	available, whether it be through market development or worldwide supply chain issues		reductions in carbon emissions while the market catches up.
	Crown Commercial Discounts changes, or conversion costs increase adjusting indicative costing.	High	Explore alternative suppliers or reduce number of vehicles procured within guidelines.
	Budget overspend	Low	Vehicles procured with NWSSP via competitive tendering exercises.
	Programme slippage	Medium	Milestones defined in BJC and managed via Prince 2 methodology
	If vehicles are not delivered on time, arrive with defects, or procurement lead times increase due to supply chain constraints, then delivery milestones and operational targets will slip, resulting in underperformance against targets, reduced financial savings, increased maintenance of ageing assets, additional resource required to resolve	Medium	Maintain close communication with the supplier to ensure alignment on contract terms, support timely governance processes, and enable delivery against an agreed schedule, with implementation supported through phased deliveries and commissioning.

	Risk Description	Risk Rating	Contingency
	issues, increased vehicle hire, and higher likelihood of breakdowns.		
	Downtime during de-commissioning of motorised vehicle for EVs.	Low	Align decommissioning of motorised vehicles and onboarding of EVs timescales.
	If vehicle, battery, or infrastructure costs increase due to market volatility, funding uncertainty, or delays in financial approvals, then planned procurement and delivery activity may need to be reduced or rescheduled, resulting in affordability challenges, budget pressure, scope reduction, delayed benefits realisation, and potential programme rescoping	Medium	Focus on ongoing monitoring of the market, effective cost and contract management, and regular reviews of requirements over time.
Infrastructure	Internal infrastructure capacity.	Low	Relocate fleet across NWSSP's estate to maximise usage of the charging capacity. Manage BEV procurement in line with infrastructure capacity subject to staff buy in and consultation.

	Risk Description	Risk Rating	Contingency
	Cyber-attack on external infrastructure payment system.	Medium	Escalate and resolve with appropriate governance. Install non smart chargers.
	OCP Costs to transfer staff bases	Medium	Due to the replacement of vehicles, a cost may emerge to OCP staff to IP5 due to the purchase of 6 BEVs. This may result in contract changes, base changes for the staff and re-scheduling. There is a risk that the funding required is higher than anticipated resulting in insufficient funding.
	If the existing EV charging infrastructure remains inadequate due to charging capacity limitations (including reliance on 7kW chargers that require vehicles to remain connected overnight) and the current Pod Point network operates without a maintenance and support contract, then charging assets may become unavailable, unreliable or	Medium	Transition from older Pod EV charger sites to newer Fuse sites, agreeing a standard operating procedure (SOP) for charger usage and maintenance, developing a clear understanding of fleet locations and requirements, and ensuring contingency through offsite charging using fuel cards in emergency situations.

	Risk Description	Risk Rating	Contingency
	insufficient to support operational demand, resulting in vehicle downtime, reduced fleet availability, disruption to service delivery, and a lack of stakeholder confidence in the charging infrastructure supporting fleet electrification.		
	If electric vehicle performance is reduced due to cold weather, high auxiliary power usage, or limited charging availability, then vehicle range may be insufficient to complete planned schedules, resultin g in loss of driver confidence, increased anxiety, incomplete routes, patient service impact, reputational damage, and reduced acceptance of EVs.	Medium	Driver training, effective route planning, use of evidence-based learning, and implementation of a robust trial period to ensure suitability and continuous improvement.

	Risk Description	Risk Rating	Contingency
	If EV components, maintenance capability, or after-sales support for specific electric vehicle models is limited, then vehicles may be unavailable for extended periods, resulting in increased Vehicle Off Road (VOR) time, operational disruption, increased rental or replacement vehicle costs, and additional pressure on local management teams.	Medium	Ongoing monitoring of maintenance support while recognising reliance on the supplier network, alongside acknowledging that this remains an area of uncertainty at present.
	If staff are resistant to change, including the operation of electric vehicles, range anxiety, or relocation requirements, then organisational change processes may be required, resulting in reduced morale, workforce tension, grievances, redeployment activity, loss of	Medium	Ongoing monitoring of staff morale, staff training, and evidence-based learning, supported by regular briefings and ensuring that infrastructure is effectively managed.

	Risk Description	Risk Rating	Contingency
	staff, increased sickness absence, lengthy recruitment exercises, and additional costs such as protected pay and travel.		
	If the number of keyless entry enabled vehicles increases without appropriate security controls, then the risk of unauthorised access, key cloning, and vehicle or consignment theft will increase, resulting in adverse incidents, unlawful activity, reputational damage, increased insurance premiums, and additional costs to replace vehicles or lost consignments.	Medium	Ensure robust security procedures, supported by staff training, the use of tracking systems, and appropriate insurance to safeguard assets

2. Strategic alignment and Duty of Quality

The Fleet Modernisation forms part of the NWSSP Integrated Medium Term Plan 2026-29. It also aligns to the Duty of Quality and NWSSP Strategic Outcomes as follows.

3.1 NWSSP Strategic Outcomes and Duty of Quality alignment.

Table 5: NWSSP Strategic Outcomes and Duty of Quality (DoQ)

NWSSP Outcomes	Relatable DoQ Domains and Enablers	Fleet Modernisation Approach & Activity
Our Value - We will lead the way and command of others the changes required to address the climate change emergency and achieve decarbonisation targets	1 – Leadership 2 – Safe 6 – Effective 11 – Whole Systems Approach	A Fleet Replacement Profiling process has been developed to ensure vehicles are appropriately replaced with BEVs and ULEVs only.
Our Value - We will make bold investment decisions that drive transformation and add value	1 – Leadership 4 – Timely 7 – Information 11 – Whole Systems Approach	The development of the Fleet Replacement Profiling enables investment into transformation of the current fleet, improving value for money and vehicle longevity.
Our Value - We will utilise our resources efficiently and make a positive impact on a social and sustainable basis.	8 – Efficient	The BJC for this financial year is investing in technologically enhanced vehicles resulting in lower carbon emissions, reduced fuel costs and maintenance, reduced noise pollution and improved air quality.
Our Value - We will spearhead opportunities to grow investment in the foundational economy across Wales as an increasing proportion of our supply chain.	2 – Safe 5 – Culture 6 – Effective 9 – Equitable	By deploying an increased number of BEVs there will be opportunities to utilise services from across Wales in areas of maintenance, EV charging, and EV charging Infrastructure.
Our Services - We will drive innovation, setting the standard	6 – Effective 2 – Safe 3 – Workforce 7 – Information	The development of the Fleet Replacement Profiling drives innovation within current

NWSSP Outcomes	Relatable DoQ Domains and Enablers	Fleet Modernisation Approach & Activity
for good practice, and enhance our processes through automation.		fleet management and the adoption of FleetCheck. The replacement profiling enhances the process via clearly defined criteria, which will become best practice for NWSSP, and prevent the decommissioning of any fit for purpose vehicles.
Our Services - We will be data driven, sharing intelligence with our partners to influence decision making across NHS Wales.	4 – Timely 6 – Effective 7 – Information 8 – Efficient	The Fleet Replacement Profiling process is driven by the data required through the defined criteria. The fleet management System FleetCheck, will support data led decision making as HCS improves efficiency measures.
Our People - We will create opportunities for our current and future staff to maximise their potential and nurture our talent pipeline	3 – Workforce 5 – Culture 10 – Person Centred 12 – learning, Improvement & Research	The introduction of additional BEVs will create opportunities for drivers to be trained to use modern technology
Our People - We will increase the diversity of our workforce and advance the use of the Welsh Language in all that we do	3 – Workforce 5 – Culture 9 – Equitable	Welsh Language signage and briefings will be used wherever needed.
Our People - We will promote physical, social, mental, and financial wellbeing throughout the organisation to support our staff.	1 – Leadership 2 – Safe 9 – Equitable 10 – Person Centred	The investment in contemporary and modern vehicles will provide a fit for purpose working environment for the drivers across the

NWSSP Outcomes	Relatable DoQ Domains and Enablers	Fleet Modernisation Approach & Activity
		organisation promoting improved physical, social, mental, and financial wellbeing.
Our People - We will listen and learn from our staff to co-produce innovative solutions with our partners	1 – Leadership 3 – Workforce 5 - Culture	Staff involvement has been integral to the development of this BJC and opinions on selected options will be taken and included as part of solutions development and wider planning activities. Additional change Management actions are planned to be undertaken to support this, and wider service adoption.

3.2 All Wales Capital Plan (AWCP) Objectives

Table 6: AWCP Objectives

Fit with investment AWCP objectives	
Objective	Response
Objective 1: Ensure quality, safety and operational sustainability of health and care services, prioritising areas with the greatest health and care needs, reducing inequalities to facilitate high standards of care.	The efficiency and reliability of the fleet has a direct impact on the quality, safety and operational sustainability of health and care services. Delivering many of the clinical and pathological testing for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care.
Objective 2: Support the shift in focus towards prevention by providing more integrated services, in convenient and accessible settings	A fit for purpose, right sized fleet, will be ready to support this shift in focus. Utilising the newly procured vehicles to deliver the essential goods required for effective service delivery to the convenient and accessible locations suggested.

Fit with investment AWCP objectives	
Objective	Response
for the population to take more responsibility for their own health & wellbeing.	
Objective 3: Transform services through innovation, technology, and improved ways of working, to deliver more efficient processes to support resilience, improved experiences, and outcomes	The telematics, fitted into the vehicles, working alongside our fleet system FleetCheck and logistics scheduling system Cleric will allow for the smarter delivery of services, enabling HCS to make data led decisions that support streamlined service delivery and fleet optimisation, bridging potential gaps in the supply chain and improving outcomes for both care providers and patients.
Objective 4: Deliver value for money by increasing the efficiency and quality of the estate, while improving the effectiveness of services for the population and workforce, targeting investment in long term priorities, aligning to environmental strategies, whilst minimising nugatory spend.	This acquisition improves the efficiency of the existing fleet, reducing the cost per mile, whilst also removing all carbon emissions at the tail pipe for the vehicles being replaced. The new vehicles will reduce vehicle downtime and therefore increase operational efficiency and resilience, whilst also beginning to align the NWSSP fleet to both the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan.

3. OPTIONS ANALYSIS

4.1 Options Appraisal

Option 1: Do Nothing (Business as Usual)

Do not replace vehicles this financial year.

Total Costs excluding VAT:	£0.00
Advantages	Disadvantages
• Delay in upfront capital requirement • No capital spend for WG	• Increased servicing and maintenance costs • Reduced vehicle efficiency – increased running costs • Reduced vehicle reliability – increased off road time

	• Poor public perception (old, outdated, unreliable vehicles) • Negative impact on staff (old, outdated, unreliable vehicles) • Does not support the development of clinical operational models as required by Health Boards/Trusts • Increased Carbon Footprint & Co2 emissions • Will not meet NHS Wales Decarbonisation Strategic Delivery Plan • Will not be progressing towards Welsh Government's Net Zero Strategic Plan • Future year pressure on capital funding requirements
Conclusion: This option does not sufficiently meet the spending objectives as the service will continue to operate the current standard of vehicles within the fleet. Therefore, HCS will not be progressing towards the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan and will not be improving the efficiency of the fleet resulting in no reductions in the spend of public money. Doing nothing does not enable the benefits outlined specifically relating to reducing emissions, reducing fuel/maintenance costs or reducing the number of vehicles leased by NWSSP. This option raises risks associated with increasing maintenance costs as the fleet continues to age, increased carbon emissions due to growing inefficiencies and potential to increase vehicles downtime due to breakdowns.	

Option 2: Do Minimum
Replace only fleet vehicles beyond economic repair (BER) – 6 vehicles

Total Costs excluding VAT:	£335,603
Advantages	Disadvantages
• Improved fleet optimisation (efficient and economic)	• Limits number of vehicles to those BER • Does not take into consideration decarbonisation objectives, emissions.

• Able to respond to emerging technologies quickly • Supports the development of clinical operational models as required by Health Boards/Trusts • Meets Decarbonisation strategy	
Conclusion: As the minimum option for replacing the fleet, this starts to progress towards the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan. Replacing the BER vehicles, that are currently not on the road, takes initial steps towards improving the efficiency of the fleet as these vehicles will be replaced with operational lower emission vehicles. This option works towards the spending objectives of compliance, efficiency, effectiveness, replacement and decarbonisation and the benefits relating to reducing emissions, reducing fuel/maintenance costs and reducing the number of vehicles leased by NWSSP, reducing vehicles downtime and noise/air pollution by the utilisation of BEV and ULEV. The risks associated with this option include growing inefficiencies with the rest of the operational fleet.	

Option 3: Intermediate

Replace vehicles that are BER and those that are older than 9 years and in either poor condition and/or with high maintenance costs/mileage – 22 vehicles

Total Costs excluding VAT:	£1,290,478
Advantages	Disadvantages
• New vehicles meet Decarb strategy • Reduction in maintenance costs on older vehicles • Reduction in carbon emissions • Reduced cost per mile • Reduction in emissions at tailpipe for approximately	• High initial capital requirements to bring profile in line • Potentially constrained by current EV infrastructure on rural routes meaning some reliance on external charging infrastructure due to BEV range, hence the reliance on PHEVs for these schedules

500,000 miles per year/800,000 kilometres. • Improved telematics • Improved fleet optimisation • Reduced age profile of the fleet (efficient and economic) • Able to respond to emerging technologies quickly • Supports the development of clinical operational models as required by Health Boards/Trusts	• Potential skill gaps requiring training
Conclusion: The first intermediate option for replacing the fleet progresses towards the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan. Replacing the BER vehicles, some of which are not currently road worthy, improves the efficiency of the fleet as these vehicles will be replaced with operational vehicles that have reduced emissions. Taking this option forward not only replaces those vehicles that are BER but includes those that are not economically viable/efficient due to the poor condition and high maintenance costs. This option meets the spending objectives of compliance, efficiency, effectiveness, replacement and decarbonisation and the benefits relating to reducing emissions, reducing fuel/maintenance costs and reducing the number of vehicles leased by NWSSP, reducing the number of road traffic accidents, reducing vehicles downtime and noise/air pollution by the utilisation of ULEV and BEV. The risks associated with this option are the timescales to procure and convert the vehicles are constrained due to the increased number of vehicles and there is also a constraint with the current EV infrastructure capacity.	

Option 4: Intermediate

Replace BER and those older than 9 years and that are in poor condition and/or have high maintenance costs/milage, together with a selection of vehicles older than 8 years with extremely high maintenance costs last year. – 24 vehicles

Total Costs excluding VAT:	£1,428,450
Advantages	Disadvantages
• New vehicles meet Decarb strategy • Reduction in maintenance costs on older vehicles	• High initial capital requirements to bring profile in line • Charging Infrastructure development.

• Reduction in carbon emissions • Reduced cost per mile • Removing emissions at tailpipe for approximately one million miles per year • Improved telematics • Improved fleet optimisation • Reduced age profile of the fleet • Able to respond to emerging technologies quickly • Supports the development of clinical operational models as required by Health Boards/Trusts	• Potential skill gaps requiring training
Conclusion: The second intermediate option for replacing the fleet, continues to take steps towards the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan. Replacing the BER vehicles takes steps towards improving the efficiency of the fleet as these vehicles will be replaced with operational lower emission vehicles. This option works towards the spending objectives of compliance, efficiency, effectiveness, replacement and decarbonisation and the benefits relating to reducing emissions, reducing fuel/maintenance costs and reducing the number of vehicles leased by NWSSP, reducing vehicles downtime and noise/air pollution by the utilisation of ULEV and BEV. This is achieved by not only replacing those vehicles that are BER and at the end of the fleet replacement profile lifecycle, but also those older vehicles with higher maintenance costs than those of a similar age have been brought forward to reduce the current spend on maintenance. The risks associated with this option are high capital costs, charging capacity, timescales for procurement to contract award/deployment of converted vehicles and an increased change for the workforce.	

Option 5: Do Maximum

Replace all vehicles BER and those older than 8 years (in poor condition and/or high maintenance costs/milage) – 31 vehicles

Total Costs excluding VAT:	£1,846,092
Advantages	Disadvantages

• Fleet within current recommended maintenance lifecycle. • Able to respond to emerging technologies quickly • Equalised / predictable spend • Extending life cycle – lower overall purchase costs due to shorter individual vehicle life cycle • Able to respond to emerging technologies quickly • Good public perception of NWSSP (new, modern vehicles) • Positive impact on staff morale (new, modern reliable vehicles) • Supports the development of clinical operational models as required by Health Boards/Trusts	• Very high upfront capital requirements to smooth profile • Short term – inefficiencies associated with extending life cycles • Places a 'big bang' approach for future capital spend with future high cost in a single year • Charging Infrastructure development.
Conclusion: The do maximum option for replacing the fleet, provides the quickest progress towards the Welsh Government's Net Zero Strategic plan and the NHS Wales Decarbonisation Strategic Delivery plan due to the highest number of vehicles to be replaced per year, though with significant capital requirements. Replacing the BER vehicles, takes steps towards improving the efficiency of the fleet as these vehicles will be replaced with operational lower emission vehicles. This option meets the spending objectives of Effectiveness, Efficiency, Economy, Compliance, Replacement, Decarbonisation and the benefits relating to reducing emissions, greatly reducing fuel/maintenance costs and reducing the number of vehicles leased by NWSSP, reducing vehicles downtime, driver safety/reduction in accidents and noise/air pollution by the utilisation of ULEV and BEV. This is achieved by not only replacing those vehicles that are BER and but also all vehicles exceeding fleet maintenance lifecycle (with subsequently higher maintenance costs) which not only reduces the current spend on fuel/maintenance but smooths the overall age profile of the entire fleet. The risks associated with replacing all the vehicles at the end of the maintenance lifecycle impact the workforce and that the current infrastructure may not have the capacity for a full BEV replacement required in the short-term. The workforce will go through significant change as the ICE vehicles are replaced with BEV/ULEVs which will require business change management activities and training to completed to ensure a smoother transition. If this option is deferred to subsequent years in the programme that will provide the timescales required to invest further into the EV charging	

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capacity across the sites to maximise the number of BEVs that can be procured within the financial year or allow for the phased adoption/integration.

4.2 Recommended Option

Option 3

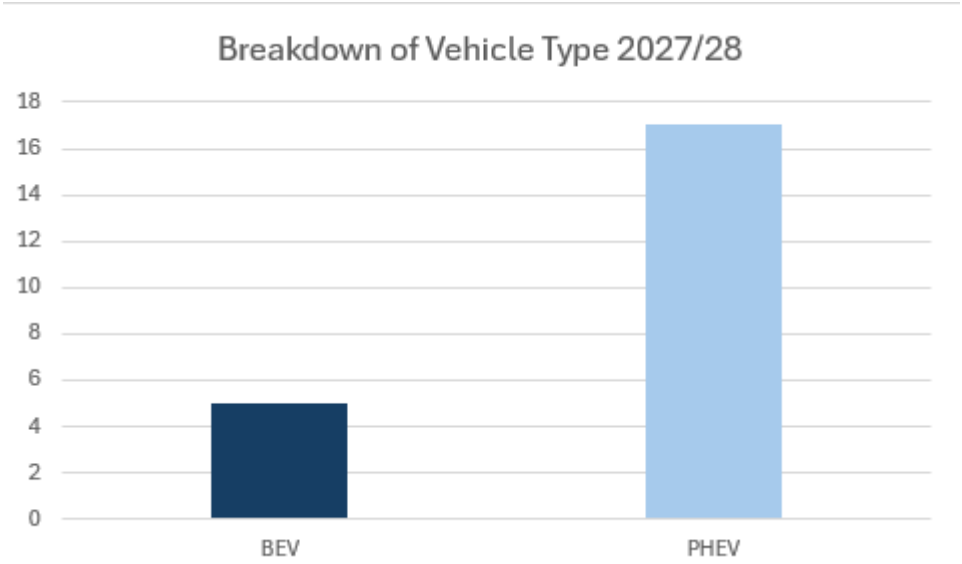
Option 3 is recommended as it provides a balanced approach between cost and benefit, focusing investment on the vehicles most in need of replacement (BER, over 9 years old, and those with very high maintenance costs).

Option 3 ensures that funding is targeted where it will have the greatest impact, by removing the least reliable and most expensive vehicles from the fleet. It will lead to lower maintenance costs, improved reliability, reduced emissions and smoothing the overall age profile of the fleet without compromising the delivery of the service.

This option has been selected over the other options as it provides the most proportionate response to the challenges within the fleet. Not replacing vehicles would lead to increasing maintenance and running costs, reduced reliability, and a negative impact on staff and public perception. It also prevents progress towards the decarbonisation strategies and creating financial pressure in future years. Lower options, such as Option 2, does not go far enough to address the issues of ageing vehicles, high mileage, and ongoing costs, meaning many inefficient vehicles would remain in use. The Do Maximum option (Option 5) requires significantly higher upfront funding and potentially additional charging infrastructure, increasing affordability and delivery risks.

Appendix 2 outlines the vehicles that have been tested against the fleet replacement profiling and meet the criteria to be replaced this financial year. All of the vehicles recommended for replacement exceed the recommended maintenance lifecycle age, with 6 out of the 22 to be replaced not meeting the Euro 6 compliance criteria. There are multiple vehicles that have continued to be in service due to conditions being sufficient however many of these have now been taken off the road and/or significantly reduced operations at local NWSSP sites.

Overall, Option 3 provides a more practical and deliverable solution that improves fleet performance, supports decarbonisation, and reduces ongoing costs, while keeping financial and delivery risks at a manageable level. As of the time of writing, the 22 vehicles suggested within this option would be 5 BEV and 17 PHEV, as shown below:



Those vehicles slightly outside of the scope of this option based on the Fleet Replacement profile criteria will be picked up in the year 3 of the programme in 2027/28. This will continue to be assessed throughout the lifecycle of the wider programme to ensure that the fleet replacement profiling continues to deliver the best value for money.

PHEV Justification

Health Courier Service (HCS) operates a critical transport network that supports the movement of pathology samples, blood products, pharmaceuticals, medical equipment and other essential healthcare items across Wales. Vehicle selection must therefore prioritise operational reliability, service continuity and the ability to respond to fluctuating demands across urban, rural and remote locations.

Whilst NWSSP remains committed to reducing carbon emissions and supporting the wider NHS Wales decarbonisation agenda, a full transition to Battery Electric Vehicles (EVs) this year, is not currently suitable for all operational requirements within the HCS fleet.

Many scheduled routes involve significant daily mileage, often exceeding the practical operational range of some electric vehicles once real-world factors are considered. Vehicle range can be substantially affected by frequent stop-start deliveries as is essential for schedules; use of heating, air conditioning, and auxiliary systems; and adverse weather conditions, particularly during winter months, when lights, windscreens wipers etc. are in regular use.

Due to base charging infrastructure limitations, and the current inability to rotate vehicles on charging points overnight at this time, HCS preference for fleet replacement this year would be to procure predominately PHEV

vehicles with some BEVs ensuring alignment with the wider NHS Wales Decarbonisation Strategic Delivery Plan.

PHEVs offer the ability to undertake shorter journeys using electric power whilst retaining the assurance of a conventional fuel engine for extended routes or unforeseen operational demands. This removes the risk of range limitations affecting the delivery of time-sensitive services.

Although charging infrastructure continues to improve, coverage and accessibility remain variable, particularly in some rural and remote areas served by HCS i.e. Hywel Dda and Powys. The vast majority of the charging infrastructure across HCS bases are 7kw chargers which requires BEVs to be on charge for extended periods of time i.e. a 77kw battery found in the fleet of Maxus e-Deliver 7s will take 11 hours to charge which is typically overnight. Whilst we acknowledge there is more robust charging infrastructure in IP5, this is also limited to only six 22kw twin charging points however these also take 7-8 hours to charge a BEV. Operational vehicles frequently work across multiple NHS sites and geographical regions where dedicated charging facilities may be unavailable, occupied, or incompatible with operational schedules. The requirement to stop and recharge during working hours may also reduce vehicle availability and affect service efficiency. PHEVs avoid these constraints by enabling HCS Operatives to continue their journeys using the internal combustion engine when charging opportunities are limited, whilst still achieving emissions reductions through electric-only operation where practical.

As referenced, HCS supports critical healthcare functions that cannot be delayed due to vehicle charging requirements or range concerns. Emergency collections, urgent blood deliveries and unplanned requests can significantly increase journey distances at short notice. PHEVs provide greater operational flexibility by eliminating range anxiety; maintaining vehicle availability throughout extended shifts; supporting emergency and out-of-hours responses; reducing dependence on external charging infrastructure; and ensuring continuity of patient-critical services. This flexibility is particularly important where service delivery requirements can change rapidly and unpredictably.

PHEVs represent a pragmatic transitional technology which supports emissions reduction whilst maintaining service capability. A PHEV will generally take 2 hours to charge which we accept would continue to present an operational challenge to ensure vehicles are charged during operational working hours however this would present an opportunity to develop a role to facilitate charging rotation overnight where feasible if a viable funding stream is available. Where daily mileage permits, vehicles can operate predominantly on electric power, significantly reducing fuel consumption and carbon emissions. However, several operational sites do not have back-

up generator power sources and as such, if there were a power outage, PHEVs would ensure operational coverage in these circumstances. Unlike fully electric vehicles, PHEVs retain the ability to undertake longer journeys without operational restrictions.

HCS fully supports the transition to a zero-emission fleet. However, vehicle replacement must be aligned to operational requirements and service criticality. Whilst BEVs remain the preferred solution for appropriate schedules, PHEVs provide a practical interim solution for routes where current EV range, charging availability, and operational resilience present risks to service delivery. This approach allows HCS to continue reducing emissions whilst ensuring that service delivery and patient care are not compromised.

HCS recently undertook a pan Wales Schedule Requirements exercise which evaluated multiple variables by schedule to include mileage, type of service undertaken and details of auxiliary or additional equipment required i.e. temperature-controlled units, tail lifts etc. Whilst it is acknowledged there are schedules across Wales that are viable to transition to BEVs these are limited by the aforementioned charging infrastructure and power outage concerns, in those cases a revert to diesel vehicles will be implemented where required. In addition, due to some sites charging infrastructure and electrical capacity, operational management intervention is required to ensure vehicles are charged. Additional challenges include reliance on the low-powered charging infrastructure (7kw), insufficient parking space for charging expansion, and supporting electrical infrastructure limitations. These constraints will need to be addressed through targeted infrastructure investment, such as 110v shorelines, to enable further EV deployment

For operational areas where vehicles undertake high mileage, cover large geographical regions or support critical time-sensitive functions, PHEVs currently provide the most suitable balance between environmental performance and operational resilience. Whilst BEVs remain appropriate for lower-mileage, predictable routes with reliable charging access, PHEVs offer the flexibility, range assurance and business continuity required for a significant proportion of HCS's operations. Their adoption ensures the fleet can continue to deliver essential healthcare services safely, efficiently and reliably, while supporting the further adoption of BEV and the transition towards a lower-carbon transport model in later stages.

Conclusion

In conclusion, Option 3 has identified an optimal number of vehicles to replace this financial year, based on the specified replacement criteria. It aligns fully with the agreed spending objectives and supports the ongoing

decarbonisation strategies within Welsh Government and NWSSP, by replacing said vehicles with a mixture of BEVs and PHEVs (appendix 3).

4.3 Main Benefits

Table 7: Benefits

Heading	Benefit Type	Benefit
Decarbonisation	Qualitative	Compliance with the NHS Wales Decarbonisation Strategic Delivery Plan, Transportation initiatives and aligning with the Welsh Government's Net Zero Strategic Plan.
	Quantifiable	To achieve a reduction of approximately 2865 grams per kilometre of Co2 emissions by 31st March 2028.
Operational	Non-cash releasing	To reduce the total vehicle downtime by approximately 2900 days.
	Cash releasing	To reduce annual fuel costs by approximately £46k.
	Cash releasing	To reduce annual scheduled maintenance costs by approximately £3k.
Socio-economic	Quantifiable	Reduce noise pollution by between 4 and 10 decibels per slow moving vehicle.
	Qualitative	Improve air quality in congested areas and in and around hospitals and depots.
	Qualitative	Improve driver safety, the monitoring of driver behaviours and a reduction in accidents.
	Cash releasing	Reduced percentage of leased vehicles within the fleet.

4. PROCUREMENT ROUTE

Procurement has reviewed the available routes to market for the vehicle purchase and conversion requirement outlined within this Business Justification Case.

Based on the agreed requirements, available framework arrangements and required delivery programme, Procurement recommends a direct award under Lot 2 of the Government Commercial Agency RM6244 – Purchase of Standard and Specialist Vehicles Framework Agreement.

Recommended route – RM6244 direct award

RM6244 was established under the Public Contracts Regulations 2015 and is available until 28th November 2026. Lot 2 covers light and medium commercial vehicles up to 7.5 tonnes and allows contracts to be awarded either by direct award or following a further competition.

The Government Commercial Agency (GCA) Fleet Portal provides access to vehicle specifications and current indicative base vehicle or chassis pricing. This enables the available options to be reviewed and the most appropriate vehicle to be identified before the final price and ordering arrangements are confirmed with the relevant supplier.

Unlike some alternative frameworks, RM6244 does not operate a fixed supplier ranking requiring a direct award to be made to the highest-ranked supplier. Once the preferred vehicle has been identified, Procurement can contact the relevant framework supplier to confirm:

- The final vehicle or chassis price
- The cost of the required conversion
- Vehicle and converter availability
- Warranty and after-sales arrangements
- Proposed lead times
- The delivery programme

This information will be shared with HCS and the project team to support an informed decision based on total cost, operational suitability, availability and lead time. The recommended supplier and total contract value will then be progressed through the necessary project, financial and procurement approvals before the call-off contract is awarded.

Where more than one vehicle option remains under consideration, Procurement will use Fleet Portal pricing and where necessary, indicative cost information from the relevant supplier to help HCS and the project team assess affordability and select the preferred vehicle chassis. If formal competing quotations are required from multiple suppliers to determine the successful supplier, the procurement will be undertaken as a further competition rather than treated as a direct award.

Benefits of the recommended route

The main benefits of using RM6244 are:

- It provides an established and compliant route under the Public Contracts Regulations 2015.
- Framework suppliers and contractual terms have already been competitively established.
- The Fleet Portal provides visibility of vehicle specifications and indicative pricing.
- The direct award process is not restricted by a fixed supplier ranking.
- The vehicle and conversion can be supplied as a complete delivered solution.
- It requires less time and resource than a further competition or open-market tender.
- Vehicle and converter availability can be confirmed before the order is placed.
- It reduces the risk of losing vehicle production or converter build slots while a longer procurement process is completed.

Requirements of the recommended route

Before a direct award is completed, Procurement will:

- Ensure that the final vehicle and conversion requirements are sufficiently clear.
- Confirm that the requirement falls within the scope of RM6244 Lot 2.
- Use the Fleet Portal to review suitable vehicles and indicative pricing.
- Obtain confirmation of the final vehicle price, conversion cost and delivery programme from the relevant supplier.
- Document the value-for-money and direct award rationale.
- Obtain the necessary internal approvals.
- Complete the appropriate RM6244 order form and call-off documentation before the framework expires.

The direct award must be conducted in accordance with the terms, conditions and call-off procedures of the RM6244 framework. A new open-market tender, formal evaluation panel and statutory standstill period will not be required, provided the award remains within the framework's direct award procedure.

Alternative framework – TPPL

Procurement has also considered the TPPL and Hertfordshire County Council Vehicle Purchase Framework, reference TPPLHCCOP03. This framework was established under the Public Contracts Regulations 2015 and is available until 30th April 2027.

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TPPL provides an established and compliant route with access to a broad range of vehicle suppliers. It also remains available for longer than RM6244.

TPPL suppliers are ranked and a direct award must be made to the highest-ranked supplier under the relevant lot. Where the highest-ranked supplier cannot provide the required solution or where comparison between suppliers is required, a mini-competition would need to be undertaken. This would require additional documentation, a supplier response period, evaluation and governance approval.

TPPL therefore remains a viable alternative but provides less flexibility than RM6244 and may require additional time and administration.

Alternative route – open-market procurement

Procurement has also considered undertaking a new open-market competition. This would be conducted under the Procurement Act 2023 and would allow any interested supplier to tender.

The principal benefit would be the opportunity to create wider competition, which could potentially result in a slightly lower vehicle or conversion price. It would also allow Procurement to establish bespoke evaluation criteria specifically for this requirement.

An open-market exercise would require:

- Development and approval of a complete tender pack
- Publication of a UK4 Tender Notice
- A suitable tender response period
- Management of supplier clarifications
- Appointment of a suitably experienced evaluation team
- Individual evaluation and formal moderation
- Provision of assessment summaries to tenderers
- Publication of a UK6 Contract Award Notice
- A mandatory standstill period of at least eight working days
- Publication of a UK7 Contract Details Notice following contract signature

Allowing for document preparation, tendering, evaluation, approvals and standstill, an open-market procurement would be likely to take approximately 16 weeks from approval of the final specification to contract award.

Although wider competition could potentially secure a lower price, the additional work, resource requirements and timescale would increase the

risk of losing available vehicle and converter build slots. As indicative vehicle pricing is already visible through the Fleet Portal, any additional saving achieved through an open-market exercise is unlikely to be sufficient to outweigh these disadvantages.

Replacement GCA framework

GCA is replacing RM6244 with RM6382 – Purchase of Standard and Specialist Vehicles. RM6382 is being established as an open framework under the Procurement Act 2023 and will provide access to standard, converted and specialist vehicles through awards with or without competition.

The tender process for RM6382 is currently ongoing, with framework award expected in Autumn 2026. As it is not yet available, it cannot currently be relied upon as the primary route but may provide a suitable contingency if an award under RM6244 cannot be completed before 28th November 2026.

Risks and mitigations

Risk: RM6244 expires before the call-off is awarded.

Mitigation: Procurement will prioritise the supplier selection and approvals to ensure that the call-off contract is awarded before 28th November 2026. RM6382 and TPPL will be retained as alternative routes.

Risk: Final prices differ from the indicative Fleet Portal prices.

Mitigation: The selected supplier will be required to confirm the final vehicle and conversion price, including the period for which the quotation remains valid, before approval is sought.

Risk: The selected supplier cannot meet the conversion or delivery requirements.

Mitigation: Conversion capability, converter capacity, warranty arrangements and proposed lead times will be confirmed before the supplier recommendation is finalised.

Risk: The proposed engagement becomes a competition between suppliers.

Mitigation: Procurement will follow the RM6244 direct award procedure and document the basis of selection. Where formal comparative bids are required, the exercise will be conducted as a further competition.

Risk: Vehicle or conversion lead times increase following award.

Mitigation: The call-off contract will include an agreed delivery programme, appropriate milestones and regular contract-management arrangements. Phased deliveries may be agreed where this supports timely implementation.

Procurement recommendation

Having considered the available options, Procurement recommends a direct award under RM6244 Lot 2.

This route provides the best balance of compliance, value for money, flexibility, administrative efficiency and delivery certainty. The recommendation remains subject to confirmation of the final price, conversion arrangements and lead times, completion of the necessary approvals and award of the call-off contract before 28th November 2026.

5.1 NEXT STEPS

Procurement activity will commence following approval of the Business Justification Case, confirmation of funding and agreement of the final requirements. The principal steps required to complete the procurement are set out below.

The principal stages will be:

- Review of suitable vehicle options and indicative pricing through the Fleet Portal
- Confirmation of the final vehicle price, conversion cost and lead time
- Consideration of the information by HCS and the project team
- Completion of the required approvals
- Award of the RM6244 call-off contract before 28th November 2026

Following contract award, delivery will be managed against the programme agreed with the appointed supplier.

5. FUNDING AND AFFORDABILITY

Table 8: Cost and Funding for the Recommended Option

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Recommended Option		Option 1	Option 2	Option 3	Option 4	Option 5
Numbers						
1	Vehicle Purchases	0	6	22	24	31
1	Capital Requirements (£'s excluding VAT)	0	335,603	1,290,478	1,428,450	1,846,092

Recommended Option		Option 1	Option 2	Option 3	Option 4	Option 5
		£	£	£	£	£
Capital Expenditure						
1	Capital Requirements (£'s including VAT)	0	402,724	1,548,574	1,714,140	2,215,310
4	**Total Capital Costs**	**0**	**402,724**	**1,548,574**	**1,714,140**	**2,215,310**
Revenue Expenditure						
7	Maintenance (annual saving)	0	0	-3,278	-4,590	-5,901
8	Insurance (annual cost)	0	1,297	4,756	5,188	6,701
9	Fuel (annual Saving)	0	-7,531	-46,444	-56,486	-72,804
11	**Total Revenue Costs/(Savings)**	**0**	**-6,234**	**-44,967**	**-55,887**	**-72,004**
Total Expenditure						
12	**Total Project Costs (Capital & Revenue)**	**0**	**396,489**	**1,503,608**	**1,658,253**	**2,143,306**
Funding						
13	Capital funding	0	402,724	1,548,574	1,714,140	2,215,310
14	Revenue funding	0	-6,234	-44,967	-55,887	-72,004
17	**Total funding**	**0**	**396,489**	**1,503,608**	**1,658,253**	**2,143,306**

Revenue Costs/Savings are included as annual and there may be a part year effect depending on the date the vehicles become operational.

Revenue Generation (if applicable)

The revenue projection comes from the sale of the decommissioned vehicles through auction. The anticipated value is expected to be £1400 per vehicle as a minimum.

Table 9: Revenue Projections for the Recommended Option

Recommended Option		Option 1	Option 2	Option 3	Option 4	Option 5
Revenues						
1	Sales and other Revenue	0	-8,400	-30,800	-33,600	-43,400

6. DELIVERY ARRANGEMENTS

7.1. Governance & Milestones

The delivery arrangements of this business justification case will operate in line with the Programme Business Case and required governance routes.

The Programme has been formally established in line with best practice (Managing Successful Programmes) and overseen and managed by the NWSSP Transformation Management Office (TMO).

This business justification case and Year 2 project will report directly to the Programme Board and therefore no subsequent Project Board is needed.

The Programme Governance/Board is as follows:

Jonathan Irvine (NWSSP – Procurement & HCS)
Tony Chatfield (NWSSP – HCS)
Sarah Jacobs (NWSSP - HCS)
Joseph Price (NWSSP - HCS)
David Jenkins (NWSSP - Health Courier Services)
Simon Russell (NWSSP-SES)
Claire Watkins (NWSSP - Finance)
Joe Draper-Orr (NWSSP – Finance)
Gemma Matuszczyk (NWSSP - Finance)
Ian Emptage (NWSSP - Procurement Services)
Jack Gilmore-Jones (NWSSP - Finance)
Jonathan Nettleton (NWSSP - Corporate Services)
Tim Knight (NWSSP - PPI - TMO)
Daniel Sinderby (NWSSP - PPI - TMO)

To ensure timely delivery of the 2026/27 fleet replacement vehicles, a project plan has been developed in line with PRINCE2 best practice. Milestones for Year Two are to be delivered by the 31 March 2028 and have been broken down as follows:

- BJC development
- BJC approval
- Capital funding secured
- Procurement
- Conversion
- Delivery of fleet replacement

Approval/endorsement of the business justification case will follow Welsh Government's governance route for Capital funding:

- Approved by Programme Board
- Approved by NWSSP Director of Finance and NWSSP Director of Procurement
- Noted by NWSSP Senior Leadership Group
- Approved by NWSSP Managing Director and SSPC Chair of the Board
- Approved by Velindre Trust Board
- Approved by Welsh Government

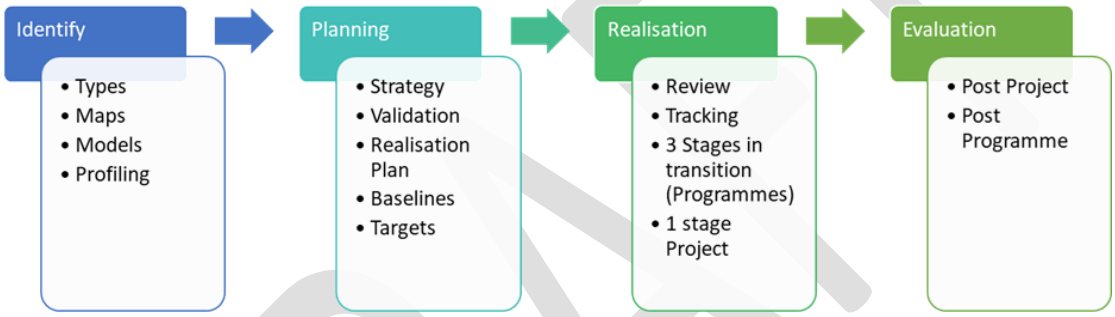
7.2. Project Controls

Monthly Programme Board meetings have been established to monitor progress against time, cost, quality, scope, and benefits realisation, which the annual BJCs and Programme Business Case (PBC) will drive.

Project Team meetings have been established to monitor progress against the project plan and stage plan activities to ensure effective completion of the tasks required to deliver the outcomes highlighted throughout the BJC.

7.2.1. Benefits

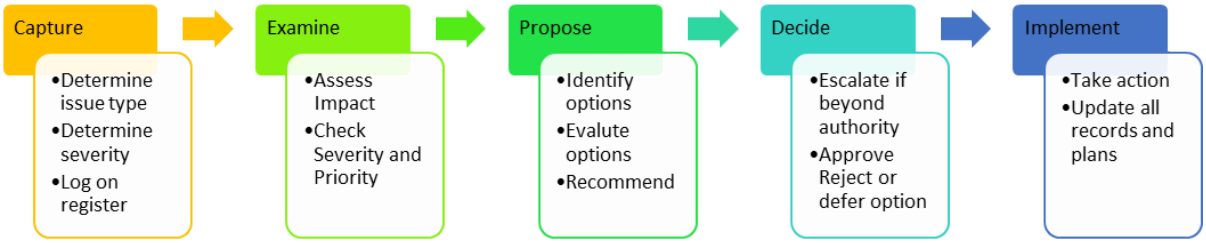
Benefits outlined within this business case have baseline measures and have been mapped (Appendix 4) and profiled accordingly. A benefits realisation plan will be developed to ensure the outcomes are achieved upon approval.



7.2.2. Risks & Issues

A Programme Risks, Actions, Issues and Decisions (RAID) Log will be maintained throughout the programme and will include all RAID information for the 2026/27 project.

Risks and issues will be overseen by the Programme/Project Managers and Programme Team whilst being recorded within the programme RAID log. Risks and issues will be managed in line with the NWSSP risk protocol at project level and reported to Programme Board by exception, however any risk/issues that had direct impact to the delivery of the Programme will be escalated and recorded within the Programme Risk Register/Issues log.



7.2.3. Actions & Decisions

Actions will be logged and tracked through the programme RAID log to ensure continual progress through the procurement, delivery and deployment stages. The actions will be continually reviewed at project level and Programme Board actions will be reviewed at the monthly meetings.

Decisions will be recorded within the programme RAID log throughout the lifecycle of the project/programme. Decisions will be managed at project level in line with the agreed tolerances however any project level decisions that need additional governance will be escalated to the Programme Board for approval. Programme Board decisions will be managed and reviewed at the monthly meetings.

7.2.4. Quality Assurance & Lessons Learned

Quality assurance will be monitored through the established processes at all stages of the programme/annual projects. Programme Board leads representing Finance, Procurement, Estates, Corporate Services and HCS will sign-off and approve the routes taken to obtain funding, procure the vehicles fairly and complicitly, and ensure that the vehicles are fit for purpose.

A lessons learned log will be utilised to ensure continuous improvement, inform decision-making, knowledge sharing and the avoidance of repeating mistakes throughout the delivery of the programme.

7.2.5. Scope

Specifications have been produced for every type of vehicle that is being replaced, along with the conversion/fitting of specialist equipment. These specifications will be used as acceptance criteria for this year's replacement. The scope of this financial year is to replace 22 vehicles and will continue to be monitored through the procurement and delivery stages. Any deviations from the original scope will need to be agreed by the Programme Board initially and decision's will be made on the appropriate governance route to achieve any requests for change.

In conclusion, this BJC will be supported by the appropriate governance arrangements and management of project outputs, to ensure that all vehicles replaced in this financial year are fit for purpose, provide benefits to the organisation and return the best value for money.

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7. APPENDIX

Appendix 1: Vehicle Replacement Profiling

Replacement Profiling

Does the predicted annual depreciation of a new asset exceed the cost of maintenace for the last finaincial year, or rolling 12 months of the existing asset?

ICE
Will the vehicle be older than 8 years at the time of replacement?
Is the capital asset value currently zero?
Is the milage over 250,000?
Is the vehicle condition score 4 or higher?
Is the vehicle failing the Euro6 emissions standard?

BEV
Will the vehicle be older than 6 years at the time of replacement?
Is the capital ssset value currently zero?
Is the milage over 250,000?
Is the vehicle condition score 3 or higher?
Are the results of the battery health assessment 80%?

If yes to all the above, please continue to the below. If two or more answers are no, then it is suggested that the vehicle is kept for another year.

Is it possible to switch this vehicle to a lower milage route?
Are we able to offer this vehicle to health organisations to put on to lower milage route?

Is it possible to switch this vehicle to a lower milage route?
Are we able to offer this vehicle to helth organisations to put on to lower milage route?

If no to the above then a discussion about the vehicles replacement should be scheduled.

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Appendix 2: Vehicles for replacement

Registration	Actual Mileage	Condition Score	Age 2027	Estimated Net Value 2027
CA15 HZF	212666	4	12	£0.00
CA66 UEK	215997	3	10	£0.00
CF13 HCP	220016	4	14	£0.00
CA66 UDW	225751	3	10	£0.00
CA66 UDT	230553	3	10	£0.00
CA66 PZC	235630	4	10	£0.00
CA66 UEC	254382	3	10	£0.00
CA66 UEH	263619	3	10	£0.00
CA66 UEB	265772	4	10	£0.00
CA66 UED	275713	4	10	£0.00
CA66 UEE	301863	4	10	£0.00
CA66 UEF	313617	4	10	£0.00
CA66 UDX	314732	3	10	£0.00
CA66 UDV	380948	3	10	£0.00
CN21 XKH*	56374	6	6	£0.00
DG13 UBP	53386	5	14	£0.00
CA66 UEG	246426	6	10	£0.00
CF68 EPN*	256393	6	8	£0.00
CE12 CLX	247620	5	15	£0.00
CE65 NXJ	158259	5	11	£0.00
DG13 UCO	73134	5	14	£0.00
YM16 CCD	96951	5	11	£0.00
Total				**22**

*These vehicles have been selected for replacement due to condition rather than age

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Appendix 3: Vehicles to procure 2026/27

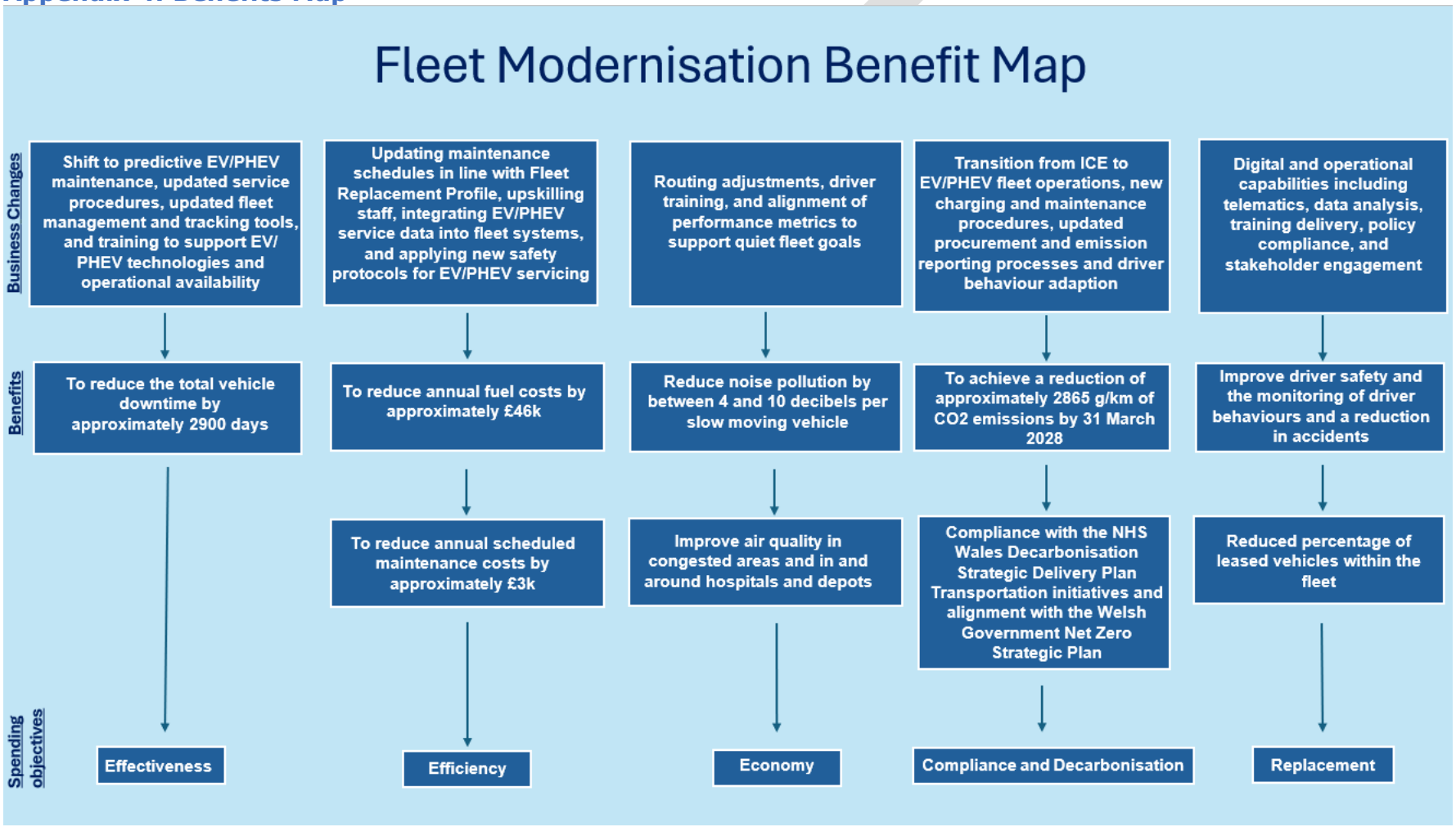
Vehicle Chassis	Trim	Type of Vehicle
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module & Blue Light Conversion
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module & Blue Light Conversion
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module

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TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
eSPRINTER 320 L2 ELECTRIC RWD	150kW 81kWh Pro Van Auto	LWB EV With Conversion & Ramp
E DELIVER 7 L2 ELECTRIC	150kW H1 Van 88kWh Auto	MWB EV with Full Conversion
E DELIVER 7 L2 ELECTRIC	150kW H1 Van 88kWh Auto	MWB EV with Full Conversion
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module
eSPRINTER 320 L2 ELECTRIC RWD	150kW 81kWh Pro Van Auto	LWB EV With Conversion & Ramp
E DELIVER 7 L2 ELECTRIC	150kW H1 Van 88kWh Auto	MWB EV with Full Conversion
TRANSIT CUSTOM 320 L2 PETROL FWD	2.5 PHEV 232ps H1 Van Trend Auto	MWB PHEV With Conversion & 50 Amp Body Builders Battery Module

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Appendix 4: Benefits Map



Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	FLEET MODERNISATION PROGRAMME ANNUAL BUSINESS JUSTIFICATION CASE (BJC) 2026-27
DIVISION / HOST ORGANISATION	NHS Wales Shared Services Partnership Health Courier Services
DATE PREPARED	18 August 2026
PREPARED BY	Daniel Sinderby, Project Manager
SCHEME SPONSOR	Jonathan Irvine, Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Fleet Modernisation Programme has been established to achieve a 10-year vision through two sequential five-year programmes. Annual Business Justification Cases will be developed enabling the replacement of ageing and uneconomical vehicles to deliver outcomes which reduce carbon emissions and annual revenue costs through the adoption of Battery Electric Vehicles (BEV) and Ultra Low Emission Vehicles (ULEV) wherever practicably possible.

This Business Justification Case (BJC) is the second of five cases to be submitted under the Fleet Modernisation Programme within NHS Wales Shared Services Partnership (NWSSP), requesting the second-year Capital funding requirements for the replacement of vehicles as outlined in the Fleet Modernisation Programme Business Case (PBC) submitted to Welsh Government on the 01 December 2025.

The Fleet Modernisation Programme has successfully completed the delivery of the Year 1 BJC, with 19 Battery Electric Vehicles procured and 27 vehicles identified for decommissioning.

This Year 2 BJC seeks approval for capital funding of £1.290m, excluding VAT, to replace 22 fleet vehicles by 31 March 2028. It sets out the case for the recommended option, which proposes a mix of BEVs and PHEVs, confirms alignment with decarbonisation and operational priorities, and provides assurance on procurement, affordability, delivery and benefits realisation.

The current fleet includes a range of operational vehicle types, including standard vans, dual liner vans, temperature-controlled vehicles, specialist conversions, emergency rapid response vehicles and heavy goods vehicles. These vehicles support a broad range of Health Courier

Service requirements, including the movement of pathology samples, blood products, pharmaceuticals, medical equipment and other essential healthcare items.

This Business Justification Case follows the approved Year 1 Business Justification Case aligning to the PBC, through which 19 BEVs were procured and 27 vehicles identified for decommissioning, including vehicles classed as Beyond Economical Repair (BER) or Vehicle Off Road (VOR). The service now operates a fleet of 288 vehicles, comprising 188 owned and 100 leased vehicles, with an average age of 7 years and annual maintenance costs of approximately £0.460m. Although the fleet has begun to modernise, a number of older vehicles continue to generate high maintenance costs, increased downtime and reduced operational resilience, creating a clear business need to continue the planned annual replacement cycle.

Within Supply Chain, Logistics, Transport and Laundry Services (SCLT), the NHS Wales Health Courier Service (HCS) supports frontline services across Wales, operating where required 24 hours a day, 365 days a year, and providing vital logistical support for primary and unscheduled care in hospitals, clinics, surgeries, general practitioner practices, pharmacies and schools, including immunisation programmes.

Following on from the approval of the initial project business justification case for year one of the Fleet Modernisation Programme, the service now operates a fleet of 288 vehicles, down from 306 in the previous financial year, consisting of 188 owned and 100 leased vehicles, with an average age of 7 years and an annual maintenance cost of £0.460m.

There is opportunity to continue to mitigate part of these costs, whilst reducing carbon emissions and increasing operational resilience. This can be achieved through the mobilisation of the vehicles requested, replacing 22 of the older higher carbon emission vehicles would allow for the realisation of cash releasing benefits outlined within this BJC whilst also supporting the NHS Wales Decarbonisation Strategic Delivery Plan.

To support the realisation of these benefits and the Fleet Modernisation Programme's vision to have a predominantly Battery Electric Vehicle (BEV) and Ultra Low Emissions Vehicle (ULEV) fleet, together with the supporting charging infrastructure, and that meets the requirements of the NHS Wales Decarbonisation Strategic Delivery Plan wherever practicably possible, annual BJCs will continue to be submitted to Welsh Government over the lifecycle of the programme. These objectives will also play a part in delivering on Welsh Government's Net Zero Strategic Plan for 2030, and the submission of continued annual BJCs will ensure that the benefits realisation of the remaining 8 years of the Programme's vision remains aligned with wider national priorities. This approach will continue to allow for the effective optimisation of fleet vehicles whilst considering emerging technologies in a rapidly changing space and ensuring that the preferred options offer value for money.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Objectives:

- To improve the quality of public services by delivering better social outcomes, new policy initiatives, whilst achieving operational targets.
- To improve the delivery of public services by investing in modern vehicles, resulting in a more robust fleet and reducing annual revenue costs (fuel and maintenance).
- To improve the use of government funding by spending on innovative technologies, sharing the Fleet equitably across Wales and providing local employment for the economy through the potential for local conversion and routine vehicle maintenance.
- To meet statutory, regulatory or organisational requirements and accepted best practice such as health and safety legislation, UKAS, Good Distribution Practice standards, Welsh Government's Net Zero Strategic Plan and NHS Wales Decarbonisation Strategic Delivery Plan.
- To ensure business continuity via the re-procurement of assets in line with the current fleet capacity and procurement guidelines whilst demonstrating economical sustainability.
- To reduce NHS Wales's carbon emissions investing in ultra-low emissions vehicles (ULEV) and battery electric vehicles (BEV).

The proposed investment will help reduce carbon emissions, improve operational resilience, lower running costs and support the continued transition towards a predominantly Battery Electric Vehicle and Ultra Low Emission Vehicle fleet, in line with the NHS Wales Decarbonisation Strategic Delivery Plan and Welsh Government's Net Zero Strategic Plan.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/04/2027
Expected End Date of Contract	31/03/2028
Contract Extension Options **(E.g. maximum term in months)**	Not applicable

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
Within the NWSSP IMTP	☒	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☒
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. do nothing'

3.1 Please state alternative options considered and reasons for declining

1. **Do Nothing (Business as Usual):** Do not replace vehicles this financial year.
2. **Do Minimum:** Replace only fleet vehicles beyond economic repair (BER) – 6 vehicles
3. **Intermediate:** Replace vehicles that are BER and those that are older than 9 years and in either poor condition and/or with high maintenance costs/mileage – 22 vehicles
4. **Intermediate:** Replace BER and those older than 9 years and that are in poor condition and/or have high maintenance costs/mileage, together with a selection of vehicles older than 8 years with extremely high maintenance costs last year. – 24 vehicles
5. **Do Maximum:** Replace all vehicles BER and those older than 8 years (in poor condition and/or high maintenance costs/mileage) – 31 vehicles

Reasons for declining:

1. Does not meet the spending objectives of the project as the service will continue to operate current vehicle standards of the fleet, not progress towards the Welsh Government or NHS Wales decarbonisation strategies and does not enable the planned benefits.
2. Does not fully meet the spending objectives of the project, only realising some of the identified benefits.
3. Not applicable as Option 3 is the recommended option.
4. Aligns with the spending objectives for the project, however, the risks relating to the number of vehicles outweigh the benefits due to the high upfront capital costs, charging infrastructure capacity limitations, timescales of the procurement and an increased change impacting the workforce.
5. The quickest progressions towards the Welsh Government and NHS Wales decarbonisation strategies, however, the risks relating to the number of vehicles outweigh the benefit due to the high upfront capital costs, charging infrastructure capacity limitations, timescales of the procurement and an increased change impacting the workforce.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Compliance with the NHS Wales Decarbonisation Strategic Delivery Plan, Transportation initiatives and aligning with the Welsh Government's Net Zero Strategic Plan. • To achieve a reduction of approximately 2865 grams per kilometre of Co2 emissions by 31 March 2028. • To reduce the total vehicle downtime by approximately 2900 days. • To reduce annual fuel costs by approximately £46k. • To reduce annual scheduled maintenance costs by approximately £3k. • Reduce noise pollution by between 4 and 10 decibels per slow moving vehicle. • Improve air quality in congested areas and in and around hospitals and depots. • Improve driver safety, the monitoring of driver behaviours and a reduction in accidents. • Reduced percentage of leased vehicles within the fleet.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
1. Increasing maintenance costs from an ageing fleet, reducing value for money. 2. Reduced vehicle reliability and increased downtime due to older vehicles remaining in service. 3. Failure to progress towards NHS Wales Decarbonisation Strategic Delivery Plan and Welsh Government Net Zero Strategic Plan objectives, delaying decarbonisation benefits. 4. Continued high fuel costs and vehicle running costs, reducing the opportunity to realise cash-releasing benefits. 5. Inability to remove the least economical vehicles from the service, resulting in ongoing operational inefficiencies and vehicle lifecycle costs	1. Continue Planned Preventative Maintenance (PPM) arrangements and routine vehicle servicing. 2. Continue vehicle rotation to maximise utilisation of available fleet. 3. Allocate existing BEV and ULEV vehicles to maximise emissions reductions wherever operationally possible. 4. Continue maximising deployment and utilisation across the fleet. 5. Relocate vehicles between sites and schedules where possible, according to operational need. 6. Continue to maintain current fleet. 7. Defer annual Business Justification Case.

6. Negative impact on staff wellbeing due to the continued use of older, outdated and unreliable vehicles. 7. Increased capital cost pressures due to deferred vehicle replacement. 8. Reduced vehicle replacement programme, increased downtime, reduced reliability, compromised service delivery and risk to achieving decarbonisation objectives, if capital funding is not supported.	

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
Based on the agreed requirements, available framework arrangements and required delivery programme, Procurement recommends a direct award under Lot 2 of the Government Commercial Agency RM6244 – Purchase of Standard and Specialist Vehicles Framework Agreement. RM6244 was established under the Public Contracts Regulations 2015 and is available until 28 November 2026. Lot 2 covers light and medium commercial vehicles up to 7.5 tonnes and allows contracts to be awarded either by direct award or following a further competition. The Government Commercial Agency (GCA) Fleet Portal provides access to vehicle specifications and current indicative base vehicle or chassis pricing. This enables the available			

options to be reviewed and the most appropriate vehicle to be identified before the final price and ordering arrangements are confirmed with the relevant supplier.

Unlike some alternative frameworks, RM6244 does not operate a fixed supplier ranking requiring a direct award to be made to the highest-ranked supplier. Once the preferred vehicle has been identified, Procurement can contact the relevant framework supplier to confirm:

- The final vehicle or chassis price
- The cost of the required conversion
- Vehicle and converter availability
- Warranty and after-sales arrangements
- Proposed lead times
- The delivery programme

This information will be shared with HCS and the project team to support an informed decision based on total cost, operational suitability, availability and lead time. The recommended supplier and total contract value will then be progressed through the necessary project, financial and procurement approvals before the call-off contract is awarded.

Where more than one vehicle option remains under consideration, Procurement will use Fleet Portal pricing and where necessary, indicative cost information from the relevant supplier to help HCS and the project team assess affordability and select the preferred vehicle chassis. If formal competing quotations are required from multiple suppliers to determine the successful supplier, the procurement will be undertaken as a further competition rather than treated as a direct award.

Benefits of the recommended route

The main benefits of using RM6244 are:

- It provides an established and compliant route under the Public Contracts Regulations 2015.
- Framework suppliers and contractual terms have already been competitively established.
- The Fleet Portal provides visibility of vehicle specifications and indicative pricing.
- The direct award process is not restricted by a fixed supplier ranking.
- The vehicle and conversion can be supplied as a complete delivered solution.
- It requires less time and resource than a further competition or open-market tender.
- Vehicle and converter availability can be confirmed before the order is placed.
- It reduces the risk of losing vehicle production or converter build slots while a longer procurement process is completed.

Requirements of the recommended route Before a direct award is completed, Procurement will: • Ensure that the final vehicle and conversion requirements are sufficiently clear. • Confirm that the requirement falls within the scope of RM6244 Lot 2. • Use the Fleet Portal to review suitable vehicles and indicative pricing. • Obtain confirmation of the final vehicle price, conversion cost and delivery programme from the relevant supplier. • Document the value-for-money and direct award rationale. • Obtain the necessary internal approvals. • Complete the appropriate RM6244 order form and call-off documentation before the framework expires. The direct award must be conducted in accordance with the terms, conditions and call-off procedures of the RM6244 framework. A new open-market tender, formal evaluation panel and statutory standstill period will not be required, provided the award remains within the framework's direct award procedure.
6.3 What is the approximate time line for procurement?
This route provides the best balance of compliance, value for money, flexibility, administrative efficiency and delivery certainty. The recommendation remains subject to confirmation of the final price, conversion arrangements and lead times, completion of the necessary approvals and award of the call-off contract before 28 November 2026.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Jonathan Irvine
Signature:	
Date:	21 August 2026

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £1,290k	**Including VAT (£k)** £1,548k
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Capital Requirement	£1,290k	N/A	N/A	N/A	£1,290k	£1,548k
Maintenance (annual saving)		N/A	N/A	N/A		-£3k
Insurance (annual cost)		N/A	N/A	N/A		£5k
Fuel (annual saving)		N/A	N/A	N/A		-£46k
Overall Total					**£1,290k**	**£1,504k**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The Programme has been formally established in line with best practice (Managing Successful Programmes) and

	overseen by the NWSSP Transformation Management Office (TMO). This business case and Year Two project will report directly to the Programme Board, where approval/endorsement will follow Welsh Government's governance route for Capital funding: • Approved by Programme Board • Approved by NWSSP Director of Finance and NWSSP Director of Procurement • Noted by NWSSP Senior Leadership Group • Approved by NWSSP Managing Director and SSPC Chair of the Board • Approved by Velindre Trust Board • Approved by Welsh Government Monthly Programme Board meetings have been established to monitor progress in line with PRINCE2 against time, cost, quality, scope, risks, issues and benefits which the annual BJCs and Programme Business Case (PBC) will drive.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jonathan Irvine, Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services
Signature:	Jonathan Irvine, Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services
Service Area:	Procurement and Health Courier Services
Date:	21 August 2026

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Fleet Modernisation Programme Board	28 July 2026
NWSSP Director of Finance & Corporate Services	07 August 2026
NWSSP Formal Senior Leadership Group	27 August 2026

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	Shared Services Partnership Committee - 15 September 2026
HTW – Senior Management Team	

Commented [DT1]: Do we update this with the Programme governance route or are these groups required to approve?

Commented [TH2R1]: Does it need to be amended for SLG and SSSPC dates?

Commented [DT3R1]: @Tony Chatfield (NWSSP - HCS) thanks, i'll put our governance structure in here

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	Fleet Modernisation Programme Business Justification Case 2026-27
Reference of proposal:	PR000337 / P2501
Details of Board / Committee the paper is being presented to and when:	SSPC – 15 September 2026 VTB – 24 September 2026

Part 1: Health and Care Quality Standards assessment

1a: Briefly outline how this proposal or strategic decision impacts on the delivery of healthcare services (in line with STEEEP Quality Standards).

Quality Standard *Click each icon for its definition*	**Overall Impact**			**Key points and rationale**
	Positive (+1) / Neutral / Negative (-1)	**Level of impact High (3) Medium (2) or Low (1)**	**Impact score (product of previous columns)**	
	+1	2	+2	The modernisation of the fleet has a direct impact on the quality, safety and operational sustainability and effectiveness of health and care services. Delivering many of the clinical and pathological testing for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care.

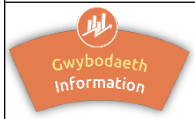
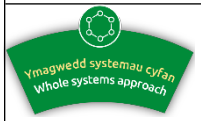
				The new vehicles will reduce vehicle downtime through effective rightsizing and therefore increase operational efficiency, resilience, and timeliness.
	+1	3	+3	The vehicles identified for replacement have been subject to the fleet replacement profile established as part of the programme, which assesses vehicle age, condition, mileage, maintenance costs, net book value and emissions standard to ensure replacement funding is directed towards the highest-priority fleet assets. This provides a transparent, objective and evidence-based approach to fleet investment by prioritising vehicles that are Beyond Economical Repair, approaching end of life, in poor condition, or generating high maintenance and operational costs.
	+1	2	+2	Modernising the fleet through the replacement of vehicles with Battery Electric Vehicles/Ultra Low Emission Vehicles improves the efficiency, reducing the cost per mile, whilst also removing carbon emissions at the tail pipe for the vehicles being replaced.
	+1	2	+2	The replacement fleet will deliver equitable working conditions for our drivers in relation to comfortable working environments and more efficient driving capability. The replacement of the fleet maintains the access for our stakeholders to an equitable service across NHS Wales.
				The modernisation of the fleet has a direct impact on the quality, safety and operational sustainability and effectiveness of health and care services. Delivering many of the clinical and pathological testing for analysis, essential goods and products needed to allow for the highest standards of care provision to patients in Primary and Unscheduled Care.

FINAL

Overall impact	The overall impact is assessed as positive. The proposal supports the continuity of patient-critical logistics services, including the transportation of pathology specimens, diagnostic materials and essential healthcare supplies. Improved fleet reliability will reduce the risk of delays that could adversely impact diagnostic turnaround times, clinical decision-making and patient pathways. The proposal supports the safe, timely, effective and efficient delivery of healthcare services through the replacement of high-priority fleet assets identified through the fleet replacement profile, improving operational resilience, reducing vehicle downtime. Transitioning to lower-emission vehicles contributes to wider sustainability strategies while maintaining the level of access to health services across Wales. Whilst some impacts are assessed as medium, the overall effect is considered to be positive with a high level of impact due to the scale of service, workforce, environmental and operational benefits delivered.

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

Quality Standard *Click each icon for its definition*	**Amount of activity required. High (3), Medium (2) or Low (1)**	**Key points and actions to achieve the changes required**
Arweinyddiaeth Leadership	3	The delivery arrangements of the business justification case will operate in line with the approved Programme Business Case and required governance routes. The Programme has been formally established in line with best practice (Managing Successful Programmes) and overseen and managed by the NWSSP Transformation Management Office (TMO). Approval of the business justification case will follow Welsh Government's governance route for Capital funding.

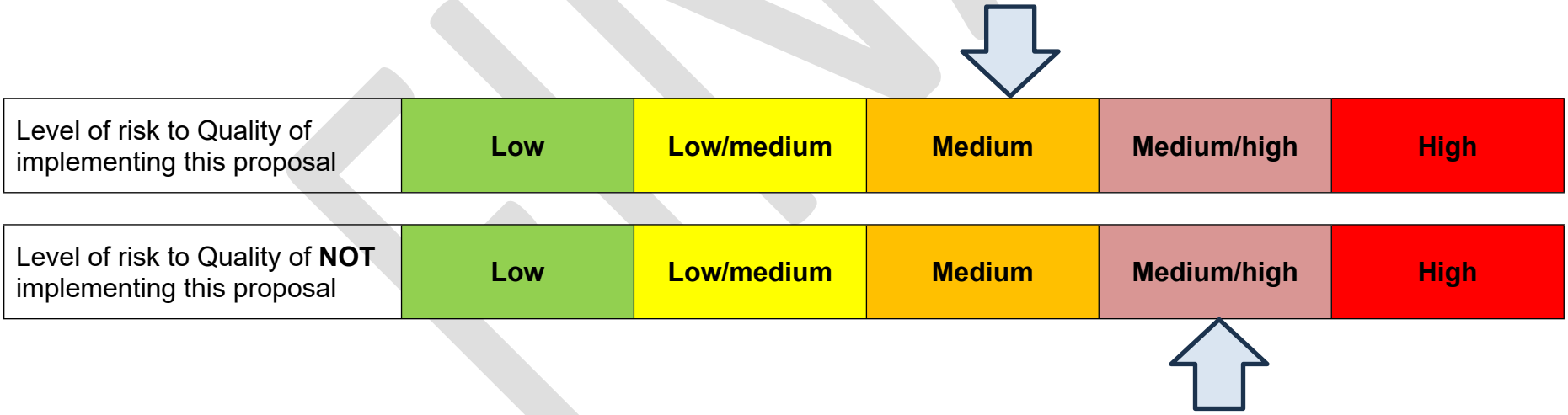
	2	The investment will provide staff with modern, reliable vehicles, improving safety, wellbeing and the working environment whilst reducing vehicle downtime and supporting effective service delivery. Investment in training, modern technologies and maintenance arrangements will ensure staff have the tools and support needed to work safely and effectively.
	1	The proposal supports a positive and inclusive culture by investing in staff wellbeing, training and engagement, providing modern tools and technology, and promoting continuous learning and improvement to enable staff to work safely, effectively and confidently.
	3	Investment decisions have been strengthened by data-driven decision making through fleet management and reporting, supported by established governance, risks and issues management and lessons learned processes to ensure effective oversight, accountability and benefits realisation.
	2	The project promotes continuous improvement through data-driven decision making, benefits realisation, lessons learned and the adoption of innovative vehicle technologies, ensuring investment decisions support long-term service transformation, operational efficiency and strategic objectives.
	3	The investment proposal supports improved service resilience, delivers approved cash-releasing and non cash-releasing benefits, contributes towards NHS Wales decarbonisation objectives, and aligns vehicle replacement activity with both current operational requirements and existing infrastructure capacity. Approval of the Business Justification Case will enable the Fleet Modernisation Programme to continue the planned transition towards a lower-emission fleet whilst maintaining the reliable delivery of patient-critical services across Wales.

FINAL

Overall amount of activity required	The overall implementation of the proposal requires a high level of activity due to the scale of vehicle replacement, procurement activity, delivery planning, operational transition, stakeholder engagement, and benefits realisation activities associated. The changes require programme governance, procurement and contract management, fleet deployment planning, workforce engagement, infrastructure planning where required, and the ongoing monitoring of financial, operational and environmental benefits. Although supporting arrangements are already established through the Fleet Modernisation Programme, significant effort is required to ensure successful delivery of the identified benefits, sustainability and efficiency improvements. Overall, the amount of activity required is High.

Part 2: High-level consideration of risk

Considering responses on all twelve Health and Care Quality Standards in Part 1, what level of risk to **Quality overall** is this proposal or strategic decision?
Slide the arrow to indicate the level of risk (recognise this is subjective until full risk assessment undertaken)



FINAL

Describe the main risks to Quality of implementing this proposal?
Describe the main risks to Quality of NOT implementing this proposal?

Risks to Quality of implementing this proposal

- Insufficient charging infrastructure or EV operational constraints may limit fleet availability and service flexibility.
- Procurement, supply chain or delivery delays may postpone the realisation of planned service improvements and efficiency gains.
- Workforce challenges associated with adopting new technologies and ways of working could affect staff confidence, wellbeing and operational effectiveness during implementation.
- Cost pressures may require changes to scope or delivery plans, potentially reducing the extent of quality, efficiency and environmental improvements achieved.
- Any disruption to fleet availability during transition and deployment of replacement vehicles could affect the timely movement of pathology samples, blood products, medicines or other critical healthcare materials. These risks should be mitigated through phased implementation, contingency arrangements and ongoing monitoring of service performance.

Risks to Quality of not implementing this proposal

- Failure to replace ageing vehicles may increase the risk of disruption to patient-critical logistics functions, potentially affecting the timely provision of diagnostic, treatment and support services across NHS Wales.
- Delays in vehicle replacement could result in continued use of ageing vehicles, increasing maintenance requirements and reducing operational resilience.
- Reduced fleet reliability and increased vehicle downtime may affect the timely and consistent delivery of critical healthcare logistics services.
- Negative impact on staff wellbeing from ageing vehicles.
- Ongoing operational inefficiencies affecting service quality.
- Reduced ability to meet environmental and decarbonisation objectives.

FINAL

Part 3: Developing and signing off this Quality Impact Assessment

QIA completed by / on date	QIA operationally agreed by / on date	QIA clinically agreed by / on date
Daniel Sinderby Project Manager (NWSSP Transformation Management Office) 20 August 2026	Jonathan Irvine Director of Procurement & HCS 21 August 2026	Martin Edwards Medical Director 22 August 2026

Executive clinical review and sign off (if required)

Clinical Executive 1 sign off / date	Clinical Executive 2 sign off / date	Clinical Executive 3 sign off / date
Martin Edwards Medical Director 22 August 2026		

FINAL

FINAL

TRUST BOARD		
Wales Infected Blood Support Scheme (WIBSS) Annual Report 2025-26		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Roxanne Davies, NWSSP Corporate Services Manager on behalf of Rebecca Nelson, NWSSP Director of Planning, Performance and Informatics	
PRESENTED BY	Lauren Fear, Director of Place, Portfolio and Partnerships	
REPORT SPONSOR	I, **Lauren Fear, Director of Place, Portfolio and Parnerships**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	01/07/2026	WIBSS Governance Group
	23/07/2026	NWSSP Formal Senior Leadership Group
	16/07/2026	Shared Services Partnership Committee
	Approved by WIBSS Governance Group on 1 July 2026 and subsequently noted by the NWSSP Formal Senior Leadership Group and Shared Services Partnership Committee.	
ONWARD SCRUTINY ROUTE	The report has been subject to appropriate scrutiny and is presented for assurance purposes only.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	The Scheme is subject to significant scrutiny as part of the Infected Blood Inquiry and judged to be delivering effectively for the beneficiaries.	
EXECUTIVE SUMMARY	The Wales Infected Blood Support Scheme (WIBSS) Annual Report 2025–26 is presented to the Board for noting and assurance, providing an update on delivery and the governance arrangements in place to support ongoing oversight of the Scheme. The Scheme is managed by NHS Wales Shared Services Partnership (NWSSP) and the Group governing the Scheme is chaired by the Trust's Director of Place, Portfolio and Partnerships.	
ACTION / DECISION	The Board is asked to **NOTE** the WIBSS Annual Report 2025-26, for assurance purposes.	

ADDITIONAL RESOURCES	See Appendix 1 - WIBSS Annual Report 2025-26.

RELEVANT TRUST STRATEGIC GOALS

This report addresses the following goal(s) within the Trust's strategic plan:

- Outstanding for quality, safety, and experience

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

RELEVANT TRUST WELLBEING GOALS

This report addresses the following wellbeing goal(s):

- A Healthier Wales
- A More Equal Wales

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

QUALITY AND SAFETY IMPLICATIONS

This report impacts one or more of the following Six Domains of Quality:

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

The Scheme is subject to significant external scrutiny on quality.

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision. There are no specific quality impacts arising from this report, which is presented for noting and assurance. The Scheme continues to be subject to established governance and oversight arrangements.

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report. An equality impact assessment is not required as the report is presented for noting and assurance and does not seek approval for a change in policy, service or function.

APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	WIBSS Annual Report 2025-26

KEY CONSIDERATIONS

1. SITUATION

The purpose of this report is to present the Wales Infected Blood Support Scheme (WIBSS) Annual Report 2025–26 to the Board for assurance.

2. BACKGROUND

WIBSS is administered by NHS Wales Shared Services Partnership (NWSSP), operating within the Velindre University NHS Trust hosting framework, on behalf of Welsh Government. The Scheme is overseen through established governance arrangements, with updates considered through the WIBSS Governance Group and the relevant NWSSP and Trust governance routes.

3. MATTERS FOR CONSIDERATION

The Board is asked to receive the Annual Report for assurance purposes, recognising the governance arrangements in place to oversee the Scheme and the continued reporting through the agreed governance route.

3.1 ASSESSMENT

The Annual Report provides an overview of the Scheme's delivery during 2025–26 and the arrangements in place to support effective oversight. No decision is required from the Board; the report is presented for assurance that appropriate governance remains in place.

3.2 FINANCIAL IMPLICATIONS

There is no direct impact on resources as a result of the activity outlined in this report. Compensation arrangements are administered through the Scheme and funded by Welsh Government.

3.3 LEGAL IMPLICATIONS

There are no specific legal implications related to the activity outlined in this report. Legal advice is sought where appropriate to support the operation and governance of the Scheme.

3.4 PEOPLE IMPLICATIONS

There are no staffing implications arising as a result of the activity outlined in this report.

3.5 WELSH LANGUAGE IMPLICATIONS

There are no Welsh language implications arising as a result of the activity outlined in this report. The WIBBS Annual Report 2025-26 has been developed in a bilingual format and will be published accordingly.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

There are no reputational implications arising out of the activity outlined in this report.

Relevant Strategic Risk - Board Assurance Framework (BAF)

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

Operational Risks

This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.

4. RECOMMENDATIONS FOR ACTION / DECISION

The Board is asked to receive the WIBSS Annual Report 2025-26, for noting and assurance purposes.

Cynllun Cynorthwyo Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Wales Infected Blood Support Scheme

Annual Report 2025-26



Cynllun Cynorthwyo Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme



Wales Infected Blood Support Scheme (WIBSS)

Annual Report 2025-2026

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

AND

VELINDRE CANCER SERVICES

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Canolfan Ganser Felindre
Velindre Cancer Centre

Cynllun Cynorthwyo Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

Contents

4 Introduction

4 Purpose of the Report

5 Key Matters Arising During 2025-26

5 The Infected Blood Inquiry Report

8 Governance Group

10 Financial Support

10 Appeals Process

11 Benificiaries Activity 2025-2026

12 Payment Rates 2025-2026

13 Child Payments 2025-2026

14 WIBSS Structure

15 Financial Report

16 Running Costs for 2025-2026

16 Performance Report

18 New Applications for Financial Support

18 Support and Assistance Grant Scheme

19 Welfare Rights Service

19 Estates Applications

19 Infected Blood Compensations Authority (ICBA)

19 Key Working

20 Newsletter

21 Case Study A

22 Case Study B

23 Psychology and Emotional Well-being Service

24 Things We Will Do in 2026-27

24 Acknowledgements

Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) provides support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the previous UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Wellbeing Service.

As of 31 March 2026, WIBSS supports 171 beneficiaries, including bereaved spouses and partners. The welfare team and wellbeing and psychological team support is also provided to wider family members of our beneficiaries.



Purpose of the Report

The purpose of the report is:

To provide an update on the finance and support services provided during 2025-26 as part of the Wales Infected Blood Support.

To detail the work carried out by WIBSS during 2025-26.

Key Matters Arising During 2025-26



Although staff continued agile working, home visits and face-to-face appointments were reinstated. There were no major changes to the service, the team continued to process additional interim compensation payments, on behalf of the UK Government and the additional Infected Blood Interim Estates Payments introduced in October 2025.

The setting up of the Infected Blood Compensation Authority (IBCA) by the UK Government, to administer the compensation payments, also involved significant involvement of the team. The setting up of IBCA has also had an impact on the beneficiaries. Some have been suspicious of communication received from IBCA and have contacted WIBSS for reassurance that it is legitimate, others have felt retraumatised, as they have had to retell their story, and have sort support from the wellbeing and psychology team.

Public Inquiry - The Infected Blood Inquiry (IBI)

This was an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970. It was Chaired by Sir Brian Langstaff.

WIBSS co-operated fully with the inquiry and responded to all Rule 9 requests within the required timeframe.

On 5 April 2023 the Chair published an interim report on compensation.

The UK Government and devolved administrations stated that they would consider the recommendations in this report, alongside the recommendations made in the final report.

Second Interim Report | Infected Blood Inquiry

On 3 February 2023, the Inquiry Chair closed the Inquiry's public hearings, explaining that he would now be focused on writing his report. Some additional hearings were held in July 2023.

The Inquiry's final report was published on 20 May 2024.

The Inquiry Report | Infected Blood Inquiry

On 21 May, the UK Government announced a Compensation Scheme and the setting up of a new Arm's Length Body (ALB) to administer the compensation scheme, called the Infected Blood Compensation Authority (IBCA).

[Infected Blood Compensation Scheme Summary - GOV.UK (www.gov.uk)]

The WIBSS website was updated with a link to the Infected Blood Compensation Authority landing page, the Final Report of the Infected Blood Inquiry Report and a link to information for the "worried well".

Publication of the final report and the announcement about the compensation scheme resulted in a significant increase in the number of calls to the WIBSS team from people known and unknown to us.

The Welsh Government confirmed no changes would be made to the current criteria of WIBSS. WIBSS continued to consider applications from those who met the criteria of the scheme. As agreed, across the four UK Governments, all the support schemes closed to new applications on 31 March 25.

In August 2024, the UK Government laid regulations to establish the Infected Blood Compensation Scheme, as required by the Victims and Prisoners Act 2024.

These regulations gave the Infected Blood Compensation Authority (IBCA) the powers to pay compensation through the Core Route to infected persons, both living and deceased, as set out in the Infected Blood Compensation Scheme Summary: August 2024. The Government expected the IBCA to begin making payments to infected persons by the end of 2024, and this expectation was achieved.

On 24 October 2024, IBCA launched the Infected Blood Interim Estates Payments (IBIEP). This was for estates of people who died when registered with a current Infected Blood Support Scheme (IBSS) or an Alliance House Scheme on or before 17 April 2024; the person who died, their bereaved partner or their estate had not already received an interim compensation payment of £100,000, and the person was living in the UK or Republic of Ireland at the time of their death.



The Welsh Government, on behalf of the UK Government, asked WIBSS to administer these applications for those estates where the infected deceased was infected in Wales.

A total of 37 Estates applications were processed to 31st March 2025. 23 were successful, totalling £2,300,000, 6 were rejected due to ineligibility and a further 8 were in progress as at the year-end date.

On 21st May 2025, the Welsh Government, on behalf of the UK Government, asked WIBSS, to make further interim compensation payments of £210,000 before the end of June. These payments were to living "infected" beneficiaries only. Letters were sent to those affected.

Before the payments were made a second letter was issued to beneficiaries to explain what the payment was for and how it will impact any future compensatory amount.

The payments were not to be means tested or carry any tax implications.

On 21 July 2025 the UK Government announced that a further interim compensation payment of £210,000 will be made to the estate representatives of an infected person who died as a result of receiving contaminated blood or blood products from the NHS.

A total of 81 additional Estates applications were processed to 31st March 2026. 73 were successful, totalling £15,730,000, 4 were rejected due to ineligibility and a further 4 were in progress as at the year-end date.

In addition to the estates works for UK Government, WIBSS has regular meetings with Welsh Government, UK Cabinet Office and IBCA regarding the setting up and administration of the new body.

Three data sharing agreements have been put in place to allow us to access the legacy data, the probate data and to share our data with IBCA, to enable it to start processing the compensation payment. All WIBSS beneficiaries were notified that to enable the compensation service to be as simple as possible, WIBSS would share all the information we hold about recipients of WIBSS payments with IBCA.

We stated the information we would share with IBCA would include details such as name, address and contact information, the type and severity of infection, and payments received to date.

The option to notify us if they did not want their data to be shared was also offered.

WIBSS is a member of the Welsh Government's Infected Blood Inquiry (IBI) Oversight Group which is tasked with ensuring that the recommendations are implemented in Wales where necessary. This includes 4 nations working.

As part of this work WIBSS and Welsh Government meet with Haemophilia Wales regularly to hear firsthand the issues and concerns of our beneficiaries and work together to resolve these or escalate to the 4 nations policy meetings.

On 31 March 2026, having fulfilled its terms of reference, the Infected Blood Inquiry closed. In response to the announcement of the closure, the UK Government stated that "The Inquiry's closure does not mean our work is over, and the Government remains committed to engaging with the community and acting on the Inquiry's findings".





Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG), through Velindre NHS Trust.

The WIBSS Governance Group is authorised to:

- Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance teams' remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR).
- It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It has a responsibility for:

- Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries' budgets and provisions.
- Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK.
- Implementation of Welsh Government policy.
- Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

The membership of the WIBSS Governance Group is as follows:

- Director of Place, Portfolio and Partnership
  Velindre University NHS Trust (Chair)
- Deputy Director, Head of Planning, Performance and Support Service
  Velindre Cancer Service
- Director of Planning, Performance and Informatics
  NWSSP
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Consultant Psychologist

During 2025-26 the Governance Group met twice on 18th June 2025 and 16th October 2025.



Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- Current members of the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme. These are set out in the Finance Section of this report and are also published on our website.

Home - WIBSS (wales.nhs.uk)

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

During 2025-26, one appeals panel was convened. The panel considered all the documentation received by WIBSS from the applicant and scrutinised the decision-making process of WIBSS.

The panel then considered all the evidence.

The panel also spoke to the appellant.

The appeal was not successful.

Beneficiaries' activity 2025-26

There are 171 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31st March 2026).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	**22**
Hepatitis C Enhanced Stage 1+	**74**
Hepatitis C Stage 2	**19**
HIV	**1**
HIV & Hep C Stage 1 (Co-infected)	**1**
HIV & Enhanced Stage 1+ (Co-infected)	**4**
HIV & Hep C Stage 2	**2**
Bereaved Spouse/Partner	**48***
Child Payments	**2**

**1 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/ partners.*

Payment Rates 2025-26

The levels of payments available to beneficiaries in 2025/26 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	**£23,294**
Hepatitis C Enhanced Stage 1+	**£35,327**
Hepatitis C Stage 2	**£35,327**
HIV	**£35,327**
HIV & Hep C Stage 1 (Co-infected)	**£47,952**
HIV & Enhanced Stage 1+ (Co-infected)	**£55,518**
HIV & Hep C Stage 2 (Co-infected)	**£55,518**
Child Payment; 1st Child	**£3,000**
Child Payment; 2nd & Subsequent Children	**£1,200**

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on or before the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. A new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage 1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment.

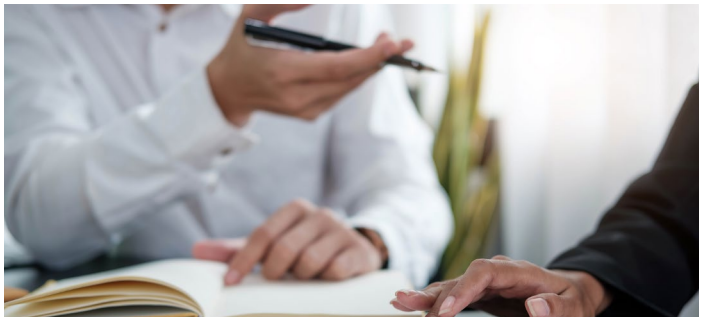
A new applicant who had already progressed to Hepatitis C Stage 2 would receive a £70,000 lump sum payment.

A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500.

With effect from 1st October 2025, WIBSS closed to new applications for bereaved partners. All bereaved partners and estates now need to apply directly to the Infected Blood Compensation Authority (IBCA), who are responsible for paying out the entitled compensation.

https://www.gov.wales/sites/default/files/publications/2025-11/welsh-infected-blood-support-scheme-directions-changes-october-2025.pdf

The estate of a deceased infected beneficiary will, however, be able to apply for a funeral grant of up to £4,500. The funeral grant payment will be deducted from any compensation payment made in respected of the deceased infected person by the IBCA.



Child Payments 2025-2026



Child payments were introduced by Welsh Government, via WIBSS, with effect from 1st January 2023. These discretionary payments are only available to those beneficiaries in Wales and England, although the payments made to EIBSS beneficiaries are means tested, those in Wales are not.

The payment is intended for the care and support of a child/children, up to the age of 18 or 21, if in full-time education, who are either the biological child or form part of the household of an infected beneficiary.

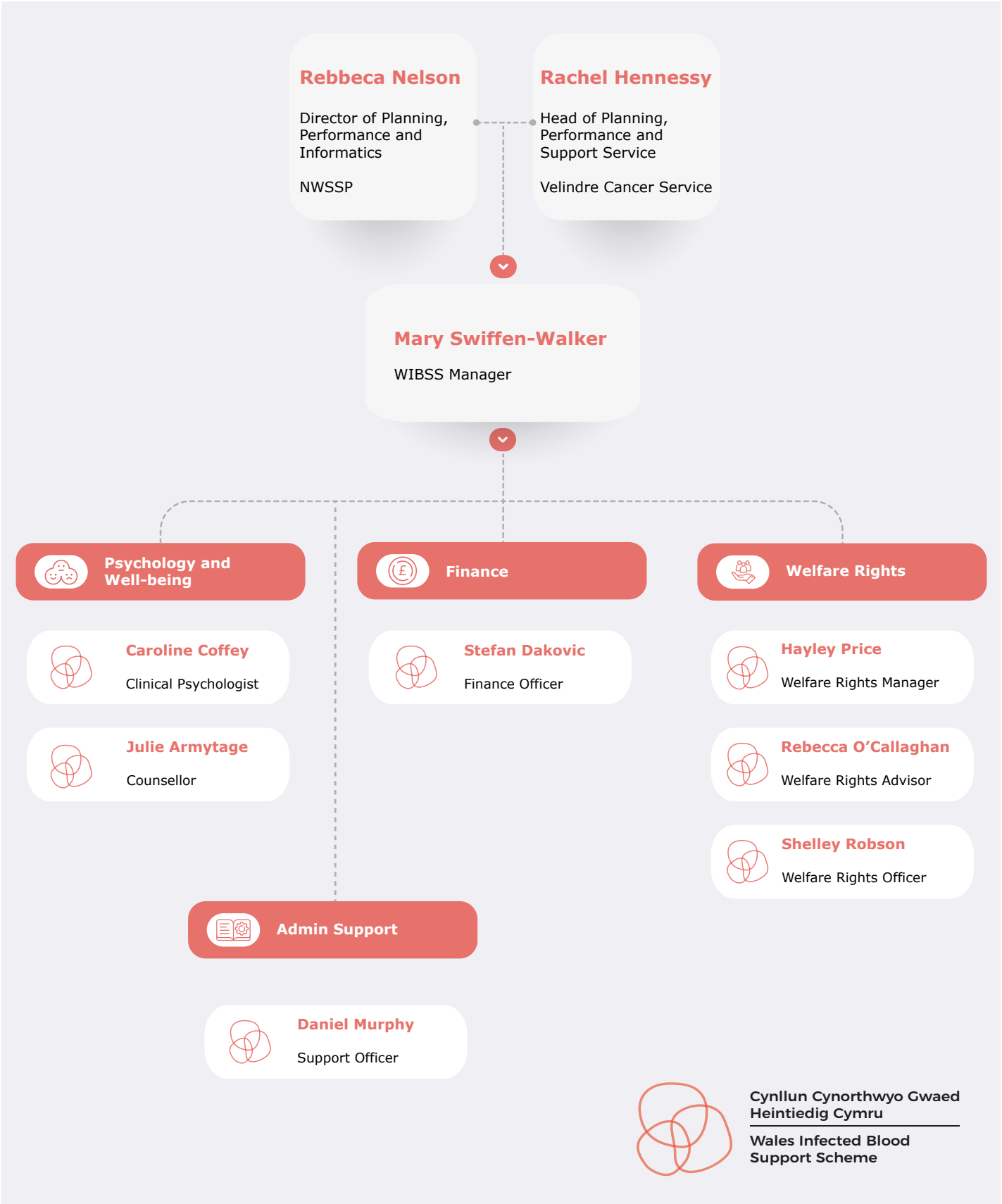
WIBSS child payments are £3,000 for the first child, and £1,200 for the second and subsequent children.

As of 31st March 2026, the total cost of child payments is £7,200. This relates to 3 children paid to 2 beneficiaries. Payments are being paid monthly or quarterly.

Once a beneficiary has agreed they compensation package, with IBCA, either through the Core Route or Adjusted Route, these payments cease.

WIBSS Structure

The day-to-day WIBSS team consists of eight members of staff, led by the WIBSS Service Manager.



Financial Report

The table below summarises the claims expenditure for 2025-26.

The regular payments to beneficiary figure for 2025-26 has reduced compared to the 2024-25 comparative figure due to 57 beneficiaries deregistrating from WIBSS after settling their compensation claim with the Infected Blood Compensation Authority via the Core Compensation route. These costs include widows and small grants payments.

These costs include widows and small grants payments.

WIBSS Claims Expenditure	2025-26	2024-25
No. of Beneficiaries	171	231
Regular Payments	£6,834,527	£8,348,078
£100K Interim Compensation Payments	£400,000	£800,000
£210K Additional Living Infected Compensation Payments	£0	£38,850,000
Estates Interim Compensation Payments and Legal Cost Reimbursement	£16,675,803	£3,100,609
Total Payments to Beneficiaries	**£23,910,330**	**£51,098,687**

Please note the figures above have been subject to in year movements i.e., new applications, deaths in year, ad hoc requests etc.

NWSSP provide the Health and Social Services Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme i.e., claims expenditure, is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Running Costs for 2025-26

A summary of the running costs for 2025-26 is set out below with a 2024-25 comparative:

WIBSS Running Costs	2025 -26	2024-25
Pay	£336,112	£297,177
Expenditure	£14,155	£13,131
Total	**£350,267**	**£310,308**

**The increase in pay costs for 2025/26 is due to the NHS pay award in August 2025, and due to additional increased WTE staffing costs as a result of the Infected Blood Inquiry.*

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Descriptor of Key Performance Indicator	2025-26 Target	Status
Responding to Welsh Government & General correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information requests within required deadlines	In-line with Trust Policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with appeals within set time limits	1 appeal held in 2025/26	100%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date.	100%

Description of Key Welfare Rights Incidents	Status
Total Welfare Rights Cases opened in previous 12 monts	» 38
Income generated for beneficiaries (1st April 2022 - 31st March 2026)	» £91,482
Outstanding Outcomes March 2026	» NS ESA (Support group) element » 2 PIP claims » 1 Tax credit review - Compliance » 1 x PIP MR
Appeals and Onward Referrals	» 8 Referrals to WIBSS Wellbeing Service » 1 x PIP Tribunal » 4 x Mortgage support letters » 7 x DWP Compliance support letters » 1 x Referral to local Health advocacy service » 1 x referral to local Age Cymru



New Applications for Financial Support

The Wales Infected Blood Support Scheme (WIBSS) closed to new applications for anyone who has historically been infected with hepatitis C, HIV or both, from NHS blood or blood products on 31 March 2025.

WIBSS had one application from a bereaved partner in 2025/26. Newly bereaved partners in cases where the infected person was already a scheme member, and died between 1 January 2025 and 31 March 2025, had the option to apply to the WIBSS, for support payments, up to three months from the date of death. This was to allow a grace period after the 31 March 2025 deadline for new applications.

Support and Assistance Grants Scheme

In 2025-26 WIBSS did not receive any applications for support. This compared to five applications in 2024-25.

The level of small grant applications has decreased in 2025/26 due to 57 beneficiaries opting to deregister from the WIBSS scheme after receiving their full compensation payment from the Infected Blood Compensation Authority (IBCA) and a further 104 beneficiaries who opted to settle their compensation claim by taking the adjusted route. Once compensation has been agreed, beneficiaries are no longer eligible to apply for support and assistance grants.

Welfare Rights Service

Estates Applications



The Welfare team continues to assist with the processing of Infected Blood Interim Estate Payments (IBIEP) claims, checking applications are completed correctly, all the required evidence is included, recording the application onto a monitoring spreadsheet, checking the infected deceased was registered with a legacy scheme or IBSS, checking the with the probate office the probate matched and issuing the appropriate letters. The welfare team continues to deal with requests for support on how and where to find the application forms, how to apply for probate and what evidence was needed to support an application.

Infected Blood Compensation Authority (IBCA)

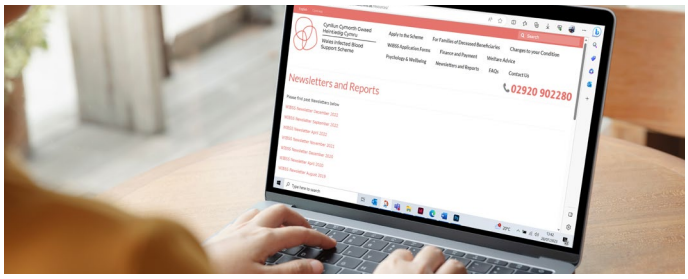
The welfare rights team continue to receive calls from beneficiaries and non-beneficiaries regarding IBCA, however this has decreased over the last 6 months. The welfare rights team receive calls to check that their IBCA invite is authentic and questions about the next cohort to be considered, alongside the process of claiming. Many find it confusing having different WIBSS and IBCA reference numbers and stressful sharing information with a new organisation, with people who are unaware of their circumstances.

Those who have taken core route have reported that they relied on the support provided by the Welfare Rights team, particularly with migration to Universal Credit etc. Beneficiaries who have not gone through their IBCA claim and those who took the adjusted route have also expressed concern over losing a Welfare Rights service in January 2027.

Key Working

The welfare team continued to receive calls from individuals wanting help or advice on issues including migrating to Universal Credit, often starting a compliance review. Compliance reviews in 2025/26 grew due to the migration deadline and were practically difficult for beneficiaries as they would often need to prove where their compensation funds came form as they migrated and again after their IBCA claim was finalised. The Welfare team continue to offer benefit checks to ensure beneficiaries are receiving all the benefits they are entitled to claim. The welfare team often speak to beneficiaries who are low, and or anxious. These people would be offered emotional support by signposting to the wellbeing and psychology service.

Newsletter



Newsletters were sent out quarterly to all beneficiaries who had opted to receive them. They were sent out electronically or by post, depending on preference. They continued to be available on the WIBSS website.
Home - WIBSS (wales.nhs.uk).

Newsletters this year provided information on the following:

- Revised Payment Rates
- Help with Energy and Water Costs
- Welfare Rights Support
- Psychology & Wellbeing Service
- Infected Blood Compensation Authority Updates
- WIBSS closing date
- Fraud and Scams Information
- Pension Credit
- Money Safety Information
- Online Safety Advice and Organisations
- Digital literacy support organisation





Case Study A

The Welfare Right team referred A to the WIBSS wellbeing team after talking to A's family member and advising on the services open to the family member and their immediate family. The WIBSS team conducted a benefit calculation and recommended that A initiate claims for New Style Employment and Support Allowance (NS ESA) and Personal Independence Payment (PIP).

A was supported with all claim forms and supported at assessments. A had never claimed any benefits previously and were shocked that they could claim anything. A had used all their savings over the past year and was genuinely concerned about paying bills and being able to live.

A could no longer work due to health issues. A has had a positive result from NS ESA, being placed in the support group allowing A to afford life's basics. A was however declined PIP the team have completed a Mandatory Reconsideration (MR) and will add A's recent NS ESA Health Care Assessment to the PIP MR as further evidence.

A is aware that the Welfare Rights team can support A with a PIP appeal should the MR be unsuccessful and if A would like to take this route.

Case Study B

B called the service for support with a Universal Credit (UC) Migration from B's Employment and Support Allowance (ESA), single person claim. ESA were querying Bs Compensation funds again, (compliance case). B was very anxious about the ESA compliance case and asked for the Welfare Rights team to take over both cases, the Migration, and the Compliance case.

The team gained the single and couples consent to consult with both DWP departments as UC migration could move them into a joint claim. The team conducted a benefit check for the couple and supported Bs partner to claim Attendance Allowance. The team then contacted ESA, provided a confirmation of payments letter.

ESA struggled to marry WIBSS funds with Bs bank statement funds. The team consulted with ESA compliance team and advised how to marry the funds. The welfare officer advised that WIBSS payments do not show up on bank statements as paid by WIBSS but another source, for confidentiality reasons. WIBSS confirmed how the payments would appear on the bank statements. ESA compliance team could then link the statements with the confirmation of payments letter and could close the compliance case. WIBSS asked ESA to provide all relevant information to UC to reduce workload and anxiety for B before the compliance case was closed.

The team supported the couple to migrate to UC joint claim and started a compliance case requiring B to provide all bank statements again. The team consulted with UC and provided evidence of compensation funds being exempt from benefit calculations. Unfortunately, the UC case worker did not understand that the compensation funds are exempt from benefit calculations and suspended the claim. The Welfare Rights team contacted A’s local partnership manager and asked them to get involved and requested that the UC claim was not closed until the issue was resolved, as a closure would mean that the couples Council Tax reduction claim would also be stopped.

Despite this UC closed the case. B was to remain on ESA, however the couples Council Tax claims was stopped when they were on a long holiday. The team supported B to reapply for Council Tax reduction and backdate the claim, explaining the issues B had experienced with a UC compliance case, and provided all the relevant information needed for Council Tax to be aware of the compensation exempt status, and to apply the reduction.

Despite the months of distress, B felt the outcome was good as the couple were now in receipt of full benefits they are entitled to claim. The Team advised that they had initiated communication with the DWP partnership manager to prevent further claimants going through the same thing. The partnership manager confirmed they had initiated training for UC claim handlers and the WIBSS team amended our confirmation of payments letters to state how WIBSS payments will show up as on beneficiary bank statements.

Psychology and Emotional Well-being Service



The psychology and wellbeing team continued to take on referrals both new and previous clients. It was a positive endorsement of the service that people want to re-engage and feel supported and that there were people making contact who had not previously received support.

The main issue raised by clients was the trauma of having to retell their story. Some felt there was a lack of understanding of what they had been through.

The service supported 45 clients – 27 infected and 18 affected. Of these, 25 were new referrals.

The Clinical Psychologist continued to build links with English Psychological Service and developed new links with services in Ireland and Scotland.

Discussions took place regarding onward referral for intervention based on locality.



Things We Will Do in 2026-27

The workplan for 2026-2027 will include the following –

- Continue to deliver a responsive WIBSS service to existing beneficiaries until the WIBSS closure date of 15th January 2027.
- Work with the Welsh Government, Cabinet Office and IBCA to inform decisions regarding the expanding up of the new body and to facilitate the operation of the compensation process and the smooth transition of WIBSS into IBCA.
- Continue to administer the Infected Blood Estate Interim Payments on behalf of the Infected Blood Compensation Authority (IBCA), and administer the additional payments, to the estates, announced by UK Government on 21 July 2025.
- A Transfer Project Group was set up in 2025-26 to manage the closure of the WIBSS. This was paused following the announcement the scheme would be extended for an additional year. This has now been reinstated and will manage the procedures to close the scheme on 15 January 2027.

Acknowledgements

This will be the final WIBSS Annual Report. It has been a privilege to administer the scheme, on behalf of the Welsh Government. The staff have striven to provide an exemplar service to all our beneficiaries.

During the eight years the scheme has been in operation, we have met and helped many inspirational people, formed bonds with many and have learned a lot.

We have also had 8 WIBSS babies during that time, with another one on the way.

I would like to take this opportunity to thank all the staff, who have worked for WIBSS and supported us, for all their hard work and dedication.

I wish them well in their future careers, because wherever, they end up, will be extremely lucky to have them!

Cynllun Cynorthwyo Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Thank you for reading our Annual Report. If you would like to find out more, please visit our website, our social media channels, or use the contact details provide below:

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This document was designed by the NWSSP Communications Team.
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TRUST BOARD		
ANNUAL ASSURANCE REPORT ON COMPLIANCE WITH THE NURSE STAFFING LEVELS (WALES) ACT 2016		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Rhian Wright, Lead Nurse Workforce, Education and Standards	
PRESENTED BY	Gillian Knight, Executive Director of Nursing, Allied Health Professionals & Health Science	
REPORT SPONSOR	I, **Gillian Knight, Interim Executive Director of Nursing, AHPs and Health Science**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	15/07/2026	Quality, Safety, Risk and Experience Board
	27/07/2026	Executive Management Board
	This paper was not reviewed at QSREB due to time constraints. However, it was subsequently reviewed and approved by the VCS Director of Nursing, AHPs and Health Science and the Heads of Nursing, with minor amendments made to the cover paper, not the report itself.	
ONWARD SCRUTINY ROUTE	NA	
PURPOSE OF THE REPORT	FOR APPROVAL	
	The Trust Board is asked to **Approve** the 2025/26 Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016 for onward approval by the Trust Board The Annual Report provides evidence and assurance that the Trust has met its statutory duty with regards to the Nurse Staffing Levels (Wales) 2016 Act during 2025/26, and that it is fully compliant with the Act. **Assurance Level: 4**	

EXECUTIVE SUMMARY	The 2025/26 Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016 provides assurance on the Trust's compliance with the Nurse Staffing Levels (Wales) Act 2016 in respect of the First Floor Ward for the period April 2025 to April 2026, and outlines the extent to which nurse staffing levels have been calculated, maintained and achieved The Annual Assurance Report provides reasonable assurance that nurse staffing levels on the First Floor Ward are sufficient to support the delivery of safe and effective care in line with the requirements of the Act. This is evidenced by: • A fully funded establishment aligned to the triangulated methodology • Improvement in planned roster compliance and data completeness (99.78%) • No reportable patient safety incidents or complaints meeting the reporting threshold during the period However, this assurance is moderated by emerging risks relating to staffing adequacy and variation in staff-reported assessments. Key findings/key risks identified: • No reportable incidents of harm or complaints were recorded during the period. While this provides positive assurance, reporting thresholds focus on moderate harm and above and may not fully capture emerging risks or lower-level impacts. • Increased perception of inadequate staffing, even when rosters are met • A rise in 'not appropriate' staffing shifts and red flags • Ongoing challenges in aligning staffing models with patient acuity and operational reality.
ACTION / DECISION	The Trust Board is asked to **Approve** the 2025/26 Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016.
ADDITIONAL RESOURCES	n/a

RELEVANT TRUST STRATEGIC GOALS
This report addresses the following goal(s) within the Trust's strategic plan:

- Outstanding for quality, safety, and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations

RELEVANT TRUST WELLBEING GOALS
This report addresses the following wellbeing goal(s):

- A Healthier Wales

QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
[Delete as appropriate and then remove this paragraph] • Safe • Efficient • Effective • Patient Centred
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

APPENDICES	Appendix no.	Appendix title
	Appendix 1	Key Considerations
	Appendix 1	The 2025/26 Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016

KEY CONSIDERATIONS

1. SITUATION

This paper is to provide the Trust Board with assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met.

Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016, the biannual nursing establishment reviews have taken place using a triangulated approach for the first floor ward, 25B area.

Although not a current mandated requirement the same process of biannual establishment reviews have been enacted for 25A areas during 2025.

2. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 places a statutory duty on NHS organisations to calculate, maintain and monitor nurse staffing levels in designated areas. Biannual establishment reviews have been undertaken using the nationally approved triangulated methodology for First Floor Ward, with assurance sought regarding the provision of safe and effective care.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

There is reasonable assurance that nurse staffing levels on the First Floor Ward are sufficient to support the delivery of safe and effective care in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016. This is evidenced by:

- A fully funded establishment aligned to the triangulated methodology
- An improvement in planned roster compliance and data completeness (99.78%)
- No reportable patient safety incidents or complaints meeting the reporting threshold of moderate or above harm.
- No reportable incidents of harm or complaints were recorded during the period. While this provides positive assurance, reporting thresholds focus on moderate harm and above and may not fully capture emerging risks or lower-level impacts.

However, the reviews noted:

- An increased perception amongst the staff of staffing levels being inadequate, even when the staffing numbers as per the rosters were met
- A rise in staff reporting ‘not appropriate’ staffing numbers on shift and staffing red flags
- Ongoing challenges in aligning staffing ratios and skill mix with patient acuity and operational demands which can vary significantly between shifts thereby demonstrating the need for a flexible and agile workforce model.

In view of the review findings, key actions were undertaken and are planned. These include:

Operational and Immediate Actions

- Redistribution of staff across the site, and the use of Bank staffing to maintain safe levels

Quality & Governance Actions

- Introduction of monthly roster KPI review meetings

Workforce & Sustainability Actions

- Increase in Health Care Support Worker establishment (fully funded)
- Development of workforce pipeline through preceptorship and education pathways that are multiprofessional and will transition to nVCC

Improvement Actions (Forward Focus)

- Strengthen triangulation by better linking acuity, occupancy, and staffing adequacy
- Review drivers behind ‘appropriate vs not appropriate’ assessments
- Improve data quality and staff understanding of reporting context
- Continue training on staffing data input and interpretation

In summary,

- There is reasonable assurance that the Trust has established and funded the required nurse staffing establishment, and that processes are in place to maintain and escalate staffing levels. However, assurance about the consistent adequacy of staffing at shift level is moderated by the proportion of shifts assessed as not appropriately staffed, increasing red flags and variation between the planned roster and real-time patient need.
- The nurse staffing establishment for First Floor Ward, inclusive of 26.9% headroom, is assessed as sufficient to deliver sensitive patient-centred care. The service is well-governed, with robust systems in place to respond effectively to staffing pressures and maintain patient safety.
- While no harm incidents and high compliance levels provide reassurance, emerging trends in staff perception and staffing adequacy highlight areas requiring continued scrutiny and model refinement.
- Overall, the ward demonstrates effective staffing governance and resilience, with clear actions underway to support future sustainability, service transformation, and improved alignment between staffing and patient need.

3.2 FINANCIAL IMPLICATIONS

There are no new financial implications associated with this report. The nursing establishment for the First Floor ward is fully funded, and the increase in Healthcare Support Worker establishment in October 2025 was accommodated within existing budgets.

3.3 LEGAL IMPLICATIONS

Compliance with the Nurse Staffing Levels (Wales) Act 2016 is a statutory requirement and remains subject to Welsh Government scrutiny and reporting obligations. The Annual Report provides assurance that the Trust was compliant with the Nurse Staffing Levels (Wales) Act 2016 during the period 2025/26.

3.4 PEOPLE IMPLICATIONS

A number of workforce initiatives have been implemented or strengthened during the reporting period to support safe staffing, workforce sustainability and resilience. These include enhancements to staffing establishments, strengthened workforce governance arrangements, flexible staffing approaches and continued investment in staff development and wellbeing.

3.5 WELSH LANGUAGE IMPLICATIONS

There are no Welsh language implications relating to this report

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

There are no risks on the risk register relating to nurse staffing levels on the First Floor ward

Risk Number	Risk title	Risk lead	Current score

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- **APPROVE** the 2025/26 Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016
- **NOTE** that there is reasonable assurance that nurse staffing levels are sufficient to support safe and effective care on the First Floor ward.
- **NOTE** the actions being undertaken to strengthen the staffing governance, workforce sustainability and data quality.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Velindre University NHS Trust		
Date annual assurance report is presented to Board	This report will be presented to the Trust Board in September 2026. *For noting:* ▪ *This annual report refers only to year 2025/2026, but it will form part of the 3 yearly assurance report which will be presented to Welsh Government in October 2027 to cover the reporting period April 2024- April 2027* ▪ *The staffing reviews conducted during April 6th 2025 – April 5th 2026 were undertaken under the oversight of the previous Executive Director of Nursing, AHPs & Health Scientists.* ▪ *This is a Welsh Government report template*		
	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	1		
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0		
The process and methodology used to	The triangulated methodology set out in the Welsh Levels of Care Toolkit has been used to inform the calculation of nurse staffing levels on First Floor Ward. This approach incorporates analysis of patient acuity, nurse staffing levels and key quality indicators, including patient falls, pressure damage, medication errors, and patient complaints, which collectively		

calculate the nurse staffing level.	support the determination of safe and appropriate nurse staffing levels. Establishment reviews are undertaken on a bi-annual basis with the senior nursing management team following completion of the bi-annual nurse staffing calculation. The First Floor Ward establishment includes the required 26.9% headroom to accommodate sickness absence, study leave, and annual leave. The Ward Manager is supernumerary to the planned ward roster; however, they do occasionally cover the Night Manager shift in response to staffing shortfalls. As part of the establishment review process, the designated person formally seeks assurance from each ward or unit manager regarding whether staffing levels are sufficient to support the delivery of dignified, sensitive, and appropriate patient care. The Annual Presentation of Nurse Staffing Levels Report (covering the period 1st October to 2024- 30th September 2025) was presented to the Trust Board on the 29th of January 2026. The ward's core function has remained unchanged throughout this period, and no staffing recalculations have been undertaken outside of the established bi-annual calculation cycle.
Informing patients	Bilingual All-Wales Informing Patients posters are displayed at the entrance to the ward, providing patients and relatives with information on the nurse staffing levels calculated for the specified period, along with the date the calculation was completed and formally signed off by the designated person. These posters are updated following each bi-annual nurse staffing re-calculation. A *"*Who Is Looking After Me Today*"* poster is prominently displayed, providing a shift-by-shift overview of the registered nurse and healthcare support worker staffing levels. Bilingual easy-read Frequently Asked Questions (FAQs) are displayed alongside the Informing Patients posters. In addition, bilingual copies of the All-Wales Nurse Staffing Levels FAQs are available on the ward for patients and visitors to view. The Nurse Staffing Programme Lead routinely monitors and updates the information displayed to ensure it remains accurate and current. Patients are also able to provide anonymous feedback via the digital feedback system, CIVICA. This enables patients to share real-time feedback and raise any concerns relating to their care in a timely and accessible manner. The annual and 3 yearly nurse staffing reports are shared with the public via the Trust's Quality, Safety and Performance Committee and at the Trust Board meetings, and are available for the public to access via the Trust's internet site.

Section 25E (2a) Extent to which the nurse staffing level has been maintained As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report				
Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2024 following January audit Second cycle: autumn 2024: following June audit		**Period Covered April 25 – Oct 26……**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**1**	**28.42**	**14.21**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**1**	**28.42**	**14.21**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**1**	**31.26**	**17.06**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	**1**	**31.26**	**17.06**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**		
	During the October 2025 staffing review, an adjustment to the staffing establishment was approved, resulting in an increase in the Healthcare Support Worker (HCSW) establishment from 14.21 WTE to 17.06 WTE. This change reflected an increased requirement for HCSW provision on day shifts due to rising patient acuity and increased patient numbers (during March – August 2025). Full funding for the increased establishment was agreed, as this was already within the existing budget. We will continue to review the WTE requirement via the bi-annual staffing reviews. In contrast to previous years, the Band 6 Coordinator role has been included within the WTE figures – this has been as a result of benchmarking that was undertaken with other organisations. Therefore, the WTE figure appears to be increased in			

comparison with previous reporting, but this is not the case. The role was previously presented within the narrative of the reports, but not in the WTE figure.

The nursing establishment for First Floor Ward is appropriately funded and supports delivery of the planned roster. There are no financial concerns relating to the staffing of First Floor Ward.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>

	Total number of shifts	**Shifts where planned roster met & appropriate**	**Shifts where planned roster met but not appropriate**	**Shifts where planned roster not met but appropriate**	**Shifts where planned roster not met and not appropriate**	**Data completeness**
TOTAL 2026	900 Includes early, late and night shifts April to Aug then switched to Long Day and Night for remainder of the year.	545 shifts 60.56%	66 shifts 7.33%	160 shifts 17.78%	118 shifts 13.11%	99.78%
TOTAL 2025	1095 365 nights +365 early shifts and 365 late shifts	353 shifts 32.24%	31 shifts 2.83%	520 shifts 47.49%	124 shifts 11.32%	93.88 %

	Over the past year, data compliance has increased from 93.88% to 99.78%. The percentage of shifts that have been reported as met and appropriate, have increased from 32.24% to 60.56%. Overall shifts that are deemed appropriately staffed total 78.34% which is a slight decrease on last year's shifts which totaled 79.73% The total number of shifts where the roster was met but staffing was deemed not appropriate has risen from 2.83% to 7.33% this year. Shifts where the roster was not met and were deemed not appropriate have also increased from 11.32% to 13.11%. 90 staffing red flags were raised during the reporting period. There is a clear process that the staff follow if staffing is deemed to be short, and staff are redeployed from other areas of the Cancer Centre to provide cover. Training has been implemented for ward staff regarding completion of the dataset. This has been necessary as staffing levels are frequently reported as insufficient without full consideration of the wider context. For example, on occasions where there are unoccupied beds, staffing may still be recorded as inadequate based on the assumption of full occupancy. For instance, where five registered nurses are required for full capacity, the presence of unoccupied beds (e.g. 10 empty beds) may not always be appropriately reflected in staffing assessments. Increasing staff perception of inappropriate staffing (despite roster being met) may indicate: • mismatch between establishment and real-time demand • limitations in current acuity/reflection model • potential future impact on quality, staff experience, and sustainability While there has been a significant improvement in shifts meeting the planned roster (60.56% vs 32.24%), this has not translated into a corresponding improvement in perceived staffing adequacy. This reflects: • increased patient acuity • improved reporting accuracy

	• ongoing challenges in aligning staffing models with operational reality
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	During the reporting period from 6th April 2025 to 5th April 2026, First Floor Ward has recorded acuity twice a day solely utilising the SafeCare system. *NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency. Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards.*
Process for maintaining the Nurse staffing level	Risk escalation processes are in place to enable real time monitoring and escalation of nurse staffing concerns. Any issues regarding nurse staffing levels in Velindre Cancer Centre are escalated to the nurse in charge via a bleep system. In addition, staff can submit red flags using the SafeCare system to highlight any staffing concerns, the raising of a red flag triggers an email notification to the ward manager and senior nursing team. Operational teams take "all reasonable steps" to maintain the nurse staffing levels required based on acuity and bed occupancy. If nurse staffing levels are deemed insufficient, reasonable steps such as redeployment of staff from other areas as well as the use of bank and agency are fully explored. Operational steps to maintain the nurse staffing level include: • Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care. • Appropriate utilisation of bank, overtime and agency – for example, to provide cover for enhanced 1:1 supervision, maternity cover, sickness.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards				
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period . (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	0	0
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	0
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	0	0

There were no reportable incidents or complaints during the current reporting period. Similarly, in the previous reporting period, there were no incidents of patient harm relating to quality indicators that met the criteria for reporting.

The absence of reported harm incidents provides positive assurance, however:

- thresholds for reporting are high (moderate harm and above)
- therefore, absence of harm does not wholly mitigate risk signalled in staffing variability

Two complaints relating to nursing care were managed through the *Putting Things Right* process in the previous year's report; however, in both cases no breach of duty was identified.

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult wards measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA.

Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.

It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

The quality indicators for the adults in-patient wards will be as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)).*

The data to be reported for each of the above will be:

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

In late 2024, it became apparent that there is significant variation in the types of complaints that are being reported within each organisation's nurse staffing report due to local interpretation of the Operational Guidance. As a result, the Reporting Group presented an SBAR that outlined a proposed criteria for standardised complaint reporting to the DDoN Forum in February 2025. This criteria was agreed by the DDoN Forum on the basis that reports are reviewed later in 2025 to establish if the criteria is adequately sensitive and produces the right level of practically useful context as a quality indicator.

The agreed criteria is as follows:

Complaints received by 25B areas that:

- *Have been closed within this reporting period;*
- *Are being managed through PTR;*
- *Have identified a breach in the duty of care;*
- *Are relevant to nursing care (using the guidance document to support).*

Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	Where nurse staffing levels have not been maintained, there is clear evidence that operational teams have taken all reasonable steps to mitigate the impact. These actions include the use of temporary staffing and the application of a risk-based approach to staff redeployment from other units. Where staffing is assessed as insufficient, the ward manager or ward coordinator can also provide direct support by undertaking clinical duties to ensure patient safety is maintained. Staff are also able to escalate concerns regarding staffing levels by raising red flags through SafeCare, and senior nursing support is readily accessible. In addition: • All incidents relating to inpatient falls and pressure damage are reviewed through monthly learning panels, with nurse staffing levels considered as a potential contributory factor where relevant. • The Medication Safety Group meets monthly to review all medication-related incidents, share best practice, and identify and deliver relevant learning. • Regular Trust-wide complaints meetings are held to review complaints and concerns and to monitor compliance with the Putting Things Right process.
	Section 25A: Duty to have regard to provide sufficient nurses

Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Establishment reviews in 25A areas follow the same format as 25B establishment reviews and are conducted biannually. In each review a triangulated assessment is carried out to determine if nurses have enough time to care for patients sensitively. In 2024, recruitment of newly qualified nurses commenced through the student streamlining process, further strengthening the nursing workforce. This process has subsequently been paused as the service is currently over-established in relation to qualified nursing staff. Newly qualified nurses participate in a 12-month, coordinated preceptorship programme, which includes planned study days and rotations across a range of units within the Cancer Centre. In addition, Velindre Cancer Services continues to support several Healthcare Support Workers to undertake the Certificate in Higher Education (CertHE) programme, enabling progression into registered nursing roles. No new CertHE places have been commissioned this year, as a number of staff are already undertaking the programme and are expected to qualify in due course. Historically, staffing and rostering for the First Floor Ward included staff working across multiple clinical areas. To improve the accuracy of rostering analysis and enhance operational efficiency, the separation of the nursing workforce for First Floor Ward from the Ambulatory and Assessment Units took place during August 2025. This change has enabled improved scrutiny, assurance, and effective management of staffing arrangements. This supports longer-term workforce sustainability through: • internal pipeline development • skill mix evolution • alignment with Cancer Centre transformation and workforce modernisation
	Conclusion & Recommendations
	Conclusion: Overall, there is assurance that nurse staffing levels on First Floor Ward are sufficient to deliver safe and effective care, in line with the Nurse Staffing Levels (Wales) Act. This assurance is supported by: • fully funded establishment • improved roster compliance

	• absence of reportable harm incidents However, this assurance is moderated by variability in perceived staffing adequacy and increasing 'not appropriate' shifts. • There were no reportable incidents or complaints on the ward that met the threshold for reporting during the reporting period • There has been an increase in the establishment of Health Care Support Workers during the last 12 months, this increase is fully funded • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016 • First Floor establishment includes the required 26.9% headroom • There are no financial concerns in the funding of the establishment for first floor ward • 78.34% of shifts were deemed to be appropriately staffed with a data compliance rate of 99.78%. As previously discussed, further training has been provided to the ward staff regarding the completion of this dataset, as there is often little consideration of the wider context e.g. staffing numbers versus the bed occupancy when inputting the data. • Establishment reviews in 25A areas follow the same format as 25B establishment reviews and are conducted bi-annually • Monthly roster analysis meetings have been introduced by the Head of Nursing to assess Roster Key Performance Indicators and to discuss any staffing trends and red flags • Utilising the triangulated methodology the ward establishment is considered sufficient to provide sensitive and appropriate care to patients Recommendations: • Strengthen the triangulated methodology by incorporating a more explicit linkage between acuity, occupancy and staffing adequacy scoring • Undertake a focused review of 'appropriate vs not appropriate' assessments to understand drivers of variation • Develop a more MDT-informed workforce model for 25A areas to support service transformation • Continue to improve data quality and consistency, particularly in relation to staff reporting behaviours • Report back to Committee on trends in staffing adequacy and associated risk

	• Further training to be provided to staff regarding the staffing levels data input (as described above) • Consider the most effective approach to the undertaking of the staffing reviews of the 25A areas during 25/26, as a deep dive review with a more MDT lens, combined with workforce planning may be the most effective method to support the Cancer Centre in its transformation and workforce modernisation agenda. • For this report to be considered for approved at the VCS Divisional Quality & Safety meeting, at the Executive Management Board meeting, at the Trust's Quality, Safety and Performance Committee and the Trust Board • To expect for the data within this report to be included in the Trust's 3 yearly safe staffing report which will be finalised in 2027, to reflect the period (April 2024 – April 2027).

TRUST BOARD		
TRUST SEAL REPORT: 24 JULY 2026 – 17 SEPTEMBER 2026		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Kyle Page, Business Support Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	N/A
	DD/MM/YYYY	
	N/A	
ONWARD SCRUTINY ROUTE	N/A – For Trust Board only	
PURPOSE OF THE REPORT	**FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)**	
	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).	
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer / Acting Chief Executive Officer at every seal request **(24th July 2026 – 17th September 2026).**	
ACTION / DECISION	The Trust Board is requested to **NOTE for ASSURANCE** the contents of the Trust Board Seal Register included below.	
ADDITIONAL RESOURCES	N/A	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		

• N/A
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):
• N/A
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
• N/A
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Trust Seal Register

KEY CONSIDERATIONS

1. SITUATION

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer / Acting Chief Executive Officer at every seal request **(24th July 2026 – 17th September 2026).**

2. BACKGROUND

2.1 Board members are asked to view the content of the report. Further information or queries should be directed to the interim Director of Corporate Governance.

3. MATTERS FOR CONSIDERATION

3.1 **ASSESSMENT** - Please refer to the Seal Register at Appendix 1.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None.

3.3 LEGAL IMPLICATIONS

3.3.1 None.

3.4 PEOPLE IMPLICATIONS

3.4.1 None.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

None.

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is requested to **DISCUSS** and **NOTE** the contents of the Trust Board Seal Register included below.

APPENDIX 1 – TRUST SEAL REGISTER

Date	Document Details	Signed
05/08/2026	Deed of Collateral Warranty of the Design & Build of the Medical Gases package in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) Velindre University NHS Trust and (2) M&M Medical Ltd.	Sara Moseley (Chair) / Carl James (CEO)
05/08/2026	Deed of Collateral Warranty of the Electrical Package (zone 2), in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) Velindre University NHS Trust and (2) Highadmit Projects Ltd.	Sara Moseley (Chair) / Carl James (CEO)
05/08/2026	Deed of Collateral Warranty of the Design & Build of the Photo Voltaic System Package, in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1) Velindre University NHS Trust and (2) Bounty Energy Solutions and Technologies Ltd.	Sara Moseley (Chair) / Carl James (CEO)
05/08/2026	Deed of Collateral Warranty of the Design & Build of the Gas Suppression Systems Package in respect of the nVCC in Whitchurch, Cardiff, Wales, between (1)	Sara Moseley (Chair) / Carl James (CEO)

Date	Document Details	Signed
	Velindre University NHS Trust and (2) Protec Fire Detection Public Limited Company.	

TRUST BOARD		
TRUST WIDE POLICIES APPROVED UPDATE		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Kay Barrow, Corporate Governance Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	24/08/2026	Executive Management Board
	15/09/2026	Quality, Safety and Experience Committee
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
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 other written control documents and to advise of those that have been approved during the period **August 2026 to September 2026.**	
ACTION / DECISION	The Trust Board is asked to **NOTE for ASSURANCE** the Trust wide policies and other written control documents that have been approved during the period August 2026 to September 2026.	
ADDITIONAL RESOURCES	**N/A**	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
• Outstanding for quality, safety, and experience		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
• A More Equal Wales		
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:		

- Safe
- Timely
- Equitable
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)
A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Yes - please outline what, if any, actions were taken as a result
Each policy will be individually assessed to ensure compliance with EIA requirements.

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Key Considerations
	Appendix 2	GC11 Procedure for Accessing Legal Advice
	Appendix 3	QS25 Preceptorship Policy for Registered Nurses, Allied Health Professionals and Healthcare Scientists

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

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 an update on any approved Trust wide policies and/or other written control documents.

2. BACKGROUND

2.1 The purpose of this report is for the Trust Board to note for assurance the trust wide policies and other written control documents that have been through the Trust governance process and approved during the period August 2026 to September 2026.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 Since the last report, the following Trust wide policies and other written control documents have been **APPROVED**, which has been uploaded to the Trust Intranet and/or Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
2	GC11 Procedure for Accessing Legal Advice	Interim Director of Corporate Governance	Executive Management Board	24/08/2026
3	QS25 Preceptorship Policy for Registered Nurses, Allied Health Professionals and Healthcare Scientists	Executive Director of Nursing, AHPs and Health Sciences	Quality, Safety and Experience Committee	15/09/2026

3.2 FINANCIAL IMPLICATIONS

3.2.1 Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

3.3 LEGAL IMPLICATIONS

3.3.1 Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal.

3.3.2 Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

3.4 PEOPLE IMPLICATIONS

3.4.1 There are no people implications because of the activity outlined in this report.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 All trust wide policies that are published on the Trust's website will be translated into Welsh to comply with the Welsh Language Standards.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

08 - Governance

3.6.2 **Operational Risks**

There are no associated operational or reputational risks because of the activity outlined in this report.

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE for ASSURANCE** the Trust wide policies and other written control documents that have been approved during the period **August 2026 to September 2026.**

Ref: GC 11

PROCEDURE FOR ACCESSING LEGAL ADVICE

Executive Sponsor & Function	Director of Corporate Governance Governance Function
Document Author:	Head of Corporate Governance
Approved by:	Executive Management Board
Approval Date:	24 August 2026
Date of Equality Impact Assessment:	October 2025
Equality Impact Assessment Outcome:	No negative impact identified
Review Date:	August 2029
Version:	Version 5

Contents

		Page
1	Background	3
2	Scope of the Procedure	3
3	Aims and Objectives of the Procedure	3
4	Legal Providers within the Framework	3
5	Accessing the Framework	4
6	Nominated Authorised Officer(s)	4
7	Initiating the Advice	4
8	Detailed Procedural Steps	4
9	Out of Hours Legal Advice	5
10	Billing and Payment Arrangements	5
11	Arrangements for Hosted Organisations and Programmes	6
12	Equality Impact Assessment	6
13	Training	7
14	Resources	7
15	Implementation and Monitoring	7
16	Procedure Compliance / Non-Conformance	7
17	Distribution	7
18	Review	7
19	Legislation and Reference Information	8
20	Further Information	8
Appendix 1	Authorised Personnel for Accessing / Initiating Legal Advice	9
Appendix 2	Proforma for Accessing/Initiating Legal Advice	10

1. Background

1.1 To support Health Boards and Trusts in achieving value for money when obtaining legal services in support of their activities, NHS Wales Shared Services Partnership (NWSSP) provides legal services via NWSSP Legal and Risk Services. In addition, legal services are available via the Collaborative Procurement Framework

2. Scope of the Procedure

2.1 This procedure is applicable across the whole of the Trust in all locations. It applies to all employees. The term "employees" includes all those who have a contract of employment or honorary contract with the Trust and who may need to access legal advice or services for the purposes of the Trust.

2.2 Any reference in this Procedure to the Trust should also be applied to any services or programmes that the Trust hosts such as the NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and Advanced Therapies Wales (ATW).

2.3 Handling clinical negligence claims remains the responsibility of NWSSP Legal and Risk Team.

2.4 This procedure covers all categories of legal activity, however, there may be personal or professional matters which should be directed to the appropriate professional body for legal advice i.e. General Medical Council (GMC).

2.5 Furthermore, staff can access legal advice from the Employee Assistance Programme (EAP), further information is available on the Trust intranet site.

3. Aims and Objectives

3.1 The purpose of this procedure is to ensure the Trust complies with the NHS Wales Legal Services Framework ('the framework') and accesses advice through the most appropriate and effective route.

3.2 The procedure will support Standing Orders, the Scheme of Reservation & Delegation and Standing Financial Instructions

4. Legal Providers in the "Framework"

4.1 <u>NWSSP – Legal & Risk Services:</u>

NWSSP Legal and Risk Services was established by Welsh Government for the purpose of providing specific legal services as one cohesive group legal service for the whole of NWSSP, including all of those bodies under the Shared Services Partnership umbrella.

It is hosted by Velindre University NHS Trust ('the Trust') and are effectively "in house" legal providers to the whole of NHS Wales providing a comprehensive, in-house, specialist legal service to Health Service bodies in Wales.

4.2 Wales Collaborative Procurement Hub

The Wales Collaborative Procurement Hub is a new approach to collaborative procurement in Wales. It brings together organisations across the public sector in Wales, identifying national, regional and local collaborative agreements.

Building upon collaboration work between Welsh Local Government and the Welsh Government's Commercial Procurement Delivery team (formerly the National Procurement Service), the hub provides access to frameworks designed to meet the needs of customers, deliver value for money, and embrace the Well-being of Future Generations Act.

There are a number of collaborative procurement frameworks for a range of goods, services and works agreements.

5. Accessing the Framework

5.1 If an NHS Wales Organisation wishes to use legal services then it should instruct Legal and Risk Services in the first instance via its Authorised Officer. Alternatively it may access an appropriate Collaborative Procurement Framework where Legal and Risk Services are not able to act or in the case of conflict of interests. Access to the Collaborative Procurement Framework will be managed by the Authorised Officer and the nominated contact in Legal & Risk Services.

6. Nominated "Authorised Officer" within the Trust

6.1 The Trust has appointed an Authorised Officer, the Head of Corporate Governance, who has responsibility for authorising all requests for legal services that are sent to the contractors (Legal & Risk Services and/or the Collaborative Procurement Framework under this arrangement. Where a request for legal services has been sent direct to the contractor by a person who is not the Authorised Officer, a duty has been imposed upon the contractor to notify the Authorised Officer as quickly as reasonably practicable.

7. Initiating the Legal Advice

7.1 In the first instance, the Head of Corporate Governance is the individual authorised to request legal advice, or the Director of Corporate Governance in their absence. This allows for monitoring of any legal activity and associated costs.

7.2 The Head of Corporate Governance will need to have received approval from the appropriate individual outlined in Appendix 1, prior to initiating the advice.

8. Detailed Procedure Steps

8.1 Where it becomes apparent that legal services are required, any member of staff can discuss the need for the provision of legal advice with their Line Manager and then Divisional Director.

8.2 Following discussion and approval (Appendix 1) from the Executive / Divisional Director (as appropriate) any staff member can submit an electronic 'request for legal advice' proforma (See Appendix 2) to the Head of Corporate Governance by emailing VUNHST.CorporateGovernance@wales.nhs.uk

8.3 Assuming appropriate approval is in place (see Appendix 1), the Head of Corporate Governance will forward the request to the Legal and Risk Services contact for advice. Legal and Risk Services will accept the instructions or will access the Collaborate Procurement Framework on behalf of the Trust advising on the appropriate contractor for the subject matter e.g. employment legal advice, commercial legal advice.

8.4 The Head of Corporate Governance reviews the case and proceeds to access the recommended advisor. They will also provide contact details of the individual seeking advice to the Legal Provider to enable them to liaise directly.

8.5 The Head of Corporate Governance will retain a register of all legal advice accessed through the process outlined in this procedure.

9. Out of Hours Legal Advice

9.1 Legal and Risk Services no longer provide legal advice outside of normal working hours (i.e. beyond 9am-5pm). In instances where legal advice outside of normal working hours is required the approach should be to use the established Executive 'on call' rota arrangements in the first instance.

10. Billing / Payment Arrangements

10.1 As NHS Wales Shared Services Partnership is a hosted organisation of the Trust (for which Legal & Risk Services is a part), Legal & Risk Services billing arrangements will be managed via Shared Services financial procedures and arrangements as set with the Trust.

10.2 If advice is being sought from a Legal Provider via the Collaborative Procurment Framework then an official purchase order number must be raised in accordance with NHS Wales 'No Purchase Order No Pay Policy', which is available on the Trust website via the following link: https://velindre.nhs.wales/policies/governance-and-communication/gc18-no-purchase-order-no-pay/

10.3 Where applicable all invoices sent from the Legal Providers will be received by the Head of Corporate Governance for payment in line with their delegated limits. Any invoices above the Head of Corporate Governances delegation will be submitted to the appropriate Executive/Divisional Director for authorisation for payment.

11. Arrangements for Hosted Organisations and Programmes

11.1 Hosted Organisations or Programmes will adhere to the procedural arrangements outlined in this document, except for the exceptions outlined below:

11.2 NHS Wales Shared Services Partnership (NWSSP)

Due to the nature and size of the NWSSP the management and access to legal advice requests will remain the responsibility of the NWSSP and they will access advice directly through their agreed internal processes.

Authorised officers will be appointed to manage this function and provide central co- ordination and monitoring of advice requests.

12. Equality Impact Assessment

12.1 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.

12.2 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.

12.3 The assessment found that there was no impact 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

13. Training

13.1 Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the procedure provisions and that they are adhered to at all times.

14. Resources

14.1 The implementation and management arrangements associated with this procedure do not present any significant resource implications to the Trust.

15. Implementation & Monitoring

15.1 This procedure will be implemented and maintained by the Head of Corporate Governance.

15.2 NHS Wales Shared Services Partnership - Legal and Risk Services, have the responsibility of monitoring the provision of legal services to NHS Wales.

15.3 Legal & Risk Services will provide performance reports and matter analyses to the Trust on a quarterly basis.

16. Procedure Conformance / Non-Compliance

16.1 If any Trust employee fails to comply with this procedure, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

17. Distribution

17.1 The procedure will be available via the Trust Intranet Site and from the Head of Corporate Governance. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy.

18. Review

18.1 There will be a review of the operation of the procedure as necessary and at least every three years.

19. Legislation/References

19.1 NHS Wales Shared Services Partnership Legal & Risk Services – Arrangements for the Provision of Legal Services to NHS Wales from 1st February 2016.

19.2 National Procurement Service (NPS) Legal Services by Solicitors Framework Guidance

20. Further Information

20.1 For more information, please contact VUNHST.CorporateGovernance@wales.nhs.uk

Appendix 1

Authorised Personnel for Approving Legal Advice and Associated Expenditure within their Division / Function

The Head of Corporate Governance will need to have received approval from the appropriate individual outlined below, prior to instructing advice requests

Velindre University NHS Trust

Executive Team:

- Chief Executive
- Executive Director of Workforce and Organisational Development
- Executive Director of Finance
- Executive Director of Nursing, AHP's & Healthcare Sciences
- Executive Medical Director/ Deputy Chief Executive
- Director of Strategy, Planning and Performance
- Director of Place, Portfolio and Partnerships
- Director of Corporate Governance
- Chief Operating Officer
- Chief Digital Officer
- Divisional Directors

In the absence of the Executive Director or Divisional Director where formal cover rules apply e.g. annual leave cover etc., the Assistant / Associate Director or Deputy Director can authorise access to legal advice.

In exceptional circumstances where time may not allow it may be necessary for a member of the Executive Team to contact the Legal Provider directly, in which case the above listed individuals are authorised to request legal advice. Arrangements must be made to ensure that the Head of Corporate Governance is notified of the advice request in order for it to be captured in central monitoring arrangements.

Hosted Organisations and Programmes

NHS Wales Shared Services Partnership (NWSSP):	Director (see Section 10 above)
Health Technology Wales (HTW):	Director
Advanced Therapies Wales (ATW):	Head of Programmes

Appendix 2

Proforma for the access to Legal Advice

This form should be completed and sent to the Head of Corporate Governance at VUNHST.CorporateGovernance@wales.nhs.uk prior to accessing legal advice.

PART A – TO BE COMPLETED BY INDIVIDUAL SEEKING LEGAL ADVICE	
Date issue raised:	
Name of the person raising the issue:	
Responsible Executive/Divisional Director:	
Has approval been received from Executive/Divisional Director? *Yes – (enter date and format received i.e. via email) No – (this is required before advice can be initiated)*	
Description of Issue:	
Deadline for Response:	
Contact details for any queries:	
Director Authorisation to proceed to request legal advice:	
PART B – COMPLETED BY LEGAL SERVICES & GOVERNANCE MANAGER	
Internal Reference Number:	
Date Legal Provider Contacted:	
Name of the Legal Provider contact:	
Legal Provider Reference Number:	
Milestone Figure:	£
Purchase Order Number Raised:	
Date entered on Advice Register:	
Date Legal & Risk Service response received:	
Summary of Legal & Risk Service advice received:	
What was the cost of the advice:	
Details of Invoices Received:	
Which area of law and which external contractor was contacted:	

Ref: QS 25

PRECEPTORSHIP POLICY FOR REGISTERED NURSES, ALLIED HEALTH PROFESSIONALS AND HEALTHCARE SCIENTISTS

Executive Sponsor & Function:	Executive Director for Nursing, Allied Health Professionals and Healthcare Science
Document Author:	Lead Nurse for Workforce, Education and Standards. Education, Development and Recruitment Lead Nurse (VCS)
Approved by:	Quality, Safety and Experience Committee
Approval Date:	15 September 2026
Date of Equality Impact Assessment:	16/5/2025
Equality Impact Assessment Outcome:	Complete
Review Date:	September 2029
Version:	5

Contents

1. Introduction....3
2. Purpose....3
3. Aims and Objectives....3
4. Scope....3
5. Definitions/Glossary of Terms....4
6. Preceptorship Programme Duration and Design....5
7. Role Responsibilities....5
7.1 Preceptee Role....5
7.2 Preceptor Role....6
7.3 Preceptorship Champion Role....7
7.4 Departmental Programme Facilitators/Education Leads....8
7.5 Line Manager....8
7.6 Trust Preceptorship Lead....9
8. Restorative Clinical Supervision....10
9. Equality....10
10. Evaluation....10
11. Review....10
12. References....11
Appendix 1: Skills Matrix....12
Appendix 2: Standards of preceptorship (NMC, HCPC and All-Wales Preceptorship Standards)....13

1. Introduction

Velindre University NHS Trust is dedicated to supporting the preceptorship of new registrants, ensuring a positive transition to confident and competent registered professionals, enabling delivery of high-quality, safe, and effective care to service users while exemplifying the Trust's values and behaviours in their practice.

The transition from pre-registration student to autonomous practitioner can be a stressful and challenging experience for many newly registered nurses, healthcare scientists (HCSs) and allied health professionals (AHPs). Although new registrants (preceptees) are competent and knowledgeable at the point of registration, they require structured support and guidance from experienced professionals to assist them to integrate into their new roles and teams. Preceptorship enables a period of structured transition that provides the foundations for professional development and prepares preceptees to be safe, confident and competent practitioners.

2. Purpose

The purpose of this policy is to provide the clinical governance framework for the delivery and evaluation of high-quality preceptorship programmes for professionals registered with the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC). The policy aligns with the Welsh Government Preceptorship Position Statement (WHC 2024) and the standards of the relevant professional regulators, as outlined in Appendix 2.

3. Aims and Objectives

This policy aims to provide preceptorship guidance for newly qualified, return to practice, internationally educated nurses, healthcare scientists and allied health professionals within Velindre University NHS Trust. This policy will:

- Identify robust structured processes for preceptorship for registered nurses, HCSs and AHPs working in Velindre Cancer Service and the Welsh Blood Service.
- Ensure a consistent and equitable approach for the provision of preceptorship programs.
- Support preceptees to develop skills, knowledge, competence, behaviours and experiences that will enhance their professional development and support high quality patient and donor care.

4. Scope

This policy relates to all preceptorship activity that supports non-medical professionals registered with the NMC or the HCPC, who are transitioning from newly qualified practitioners to confident registered practitioners. Additionally, this policy can be used to support those who are internationally educated or returning to practice.
This policy serves as an overarching framework, under which specific preceptorship procedures for AHPs, Nursing, and Healthcare Scientists will be implemented.

5. Definitions/Glossary of Terms

Definitions, in the context of this policy, are outlined below: -

Preceptorship	A period of structured transitional support, guidance and development for newly registered practitioners to build confidence and further develop competence as they transition to an autonomous professional.
Preceptee	A newly registered practitioner who is entering employment in Velindre University NHS Trust for the first time following professional registration with the Nursing and Midwifery Council, Health and Care Professionals Council or other appropriate professional bodies.
Preceptor	A qualified practitioner with at least 12 months of experience, who is a practice assessor or has relevant training and experience in mentoring new staff and demonstrates a willingness to develop. Preceptors provide support and guidance to the preceptee throughout the preceptorship period.
Preceptorship Champion	A registered practitioner who promotes the value and benefit of preceptorship for their division and supports implementation within their area.
Departmental Programme Facilitator	A person who organises and manages the implementation of preceptorship programmes and associated activities for newly registered nurses, HCSs or AHPs.
Line Manager	Direct line manager of preceptors, preceptees and preceptorship champions.
Trust Preceptorship Lead	A central point of contact and lead for preceptorship within Velindre University NHS Trust.
Preceptorship period	Designated period of support and guidance for those requiring preceptorship, typically 12 months.
Preceptorship Activity	Any activity that supports the preceptorship process, this can include but is not limited to preceptorship meetings, training, reflection writing, and completing of relevant reflection or preceptorship paperwork.
Preceptorship Community of Practice	A collaborative group or preceptors, preceptee's and champions that engage to share knowledge, experiences, good practice, development opportunities, and support of preceptorship activity.
Supernumerary	A period of time when the preceptee is not included in the establishment numbers allowing the preceptee to work alongside their preceptor.
Clinical Supervision	A formal process of support, reflection, learning and development that is of benefit to both newly registered professionals and experienced health care professionals. Clinical supervision can be delivered on an individual or group basis.

6. Preceptorship Programme Duration and Design

The standard preceptorship period is 12 months. A longer period can be negotiated locally depending on the needs of the preceptee. The duration may be shorter for Allied Health Professionals undertaking a rotation within the Velindre Centre Service.

The preceptorship programme will include opportunities to apply underpinning knowledge, assess competencies and engage in training focused on leadership and professional issues. A blended compassionately led learning approach will underpin the preceptorship programme to maximise effective use of preceptors' and preceptees' time to enhance development of skills and knowledge. Departmental Programme Facilitators will coordinate teaching and learning activities to support the development of knowledge, confidence and competence. A detailed timetable will be provided, outlining the training sessions designated as core components of the preceptee's development. Methods may include:

- Formal classroom sessions/study days
- 1:1 tutorials/support from peers
- Group discussions
- Reflections
- Work based learning
- Action learning sets
- Self-directed learning
- Shadowing
- Portfolio development
- Restorative Clinical Supervision

Preceptorship must be adaptable and tailored to the needs of the individual preceptee, allowing for some variation across departments.

7. Role Responsibilities

7.1 Preceptee Role

In accordance with NMC and HCPC regulations, upon registration, practitioners are autonomous and accountable for their acts and omissions. During preceptorship preceptees will further develop their confidence and competence to practice. Therefore, active participation in and successful completion of preceptorship programmes are instrumental in supporting their professional development.

Responsibilities:

- Actively participate in the preceptorship programme including all organised learning opportunities.
- Abide by the Trust values and behaviours.
- Work with preceptor and mentor to identify, plan and achieve all learning objectives.
- Work at least 40% of their shifts alongside their mentor/preceptor whilst completing preceptorship competencies.
- Engage fully in the preceptorship programme and respond appropriately to constructive feedback.

- Take responsibility for individual learning and development and commit to learning by completing preceptorship programmes within the agreed timeframe, engaging in various learning activities, such as attending study days, e-learning and reflective practice.
- Ensure all mandatory and statutory training relevant to the role is completed in a timely manner.
- Prepare for and attend regular agreed meetings with preceptor to support the achievement of learning objectives.
- Notify Preceptor and Line Manager/Professional Lead if any difficulties are experienced in accessing or completing any part of the programme.
- Use this time to develop CPD portfolio which can be used to support revalidation or audit as applicable.
- Maintain responsibility for documentation of preceptorship processes and learning resources e.g. assessment workbooks, certificates and written reflections.
- Remain accountable for own practice within the context and limitations of their knowledge as set out in their professional codes of practice, escalating concerns regarding competency and abilities.

Time associated with role	
First 6 months	7.5 hours per month
6 – 12 months	3 hours per month

7.2 Preceptor Role

A named person supporting the preceptee though professional transition to a confident and competent practitioner. A qualified practitioner with a minimum of 12 months experience and has undergone preceptorship training as highlighted in the skills matrix Appendix 1. Preceptors can nominate themselves, by speaking with their manager or the Departmental Programme Facilitator.

A named preceptor will support each registrant throughout the preceptorship programme. If the preceptor is unavailable, for example due to sickness, then an alternative preceptor will be allocated. This will be arranged locally between registrant and line managers. Preceptors have a responsibility to support new registrants with their transition from student to registered practitioner.

Responsibilities:

- Meet with the preceptee within the first week of employment. Promote a positive culture by welcoming the preceptee and helping them to integrate into the team.
- Work with the preceptee to identify areas for development, supporting transition into role, facilitating the achievement of competencies through a range of preceptorship activities.
- Give timely and appropriate feedback to preceptees on a regular basis. This is to include facilitating reflection of the preceptee's experiences. Identify and discuss concerns, identifying areas for development in a constructive and compassionate manner, and agreeing future plans.
- Give positive feedback and encouragement to preceptee on those aspects of performance that are being done well.
- Use reflection and coaching skills to enable preceptees to develop confidence in both their professional scope of practice and in the context of their organisational roles.

- Share individual knowledge and experience with the preceptee.
- Maintain responsibility for documentation of preceptorship processes, such as learning contract and meeting records.
- Recognise and respect cultural and individual diversity.
- Engage in regular scheduled meetings with the preceptee to discuss individual practice and provide regular and constructive feedback.
- Engage in regular communication with preceptee's line manager to ensure that PADR process holds 'no surprises'.
- Raise any concerns about wellbeing, progress or competence of the preceptee with the line manager and departmental programme facilitator to implement a plan to remedy and support transition.
- Have insight, compassion and empathy with the preceptee.
- Facilitate the development of the preceptee through reflective learning.
- Act as an exemplary role model for best practice, embodying the Trusts values and behaviours in supporting preceptees and preceptors.
- Continuously develop skills to uphold best practices, including completing any training or updates related to preceptorship and maintaining own clinical skills and practice.
- Ensure that all Statutory and Mandatory training relevant to the role is up to date.
- Facilitate protected time to undertake preceptorship activities such as meetings between preceptor, mentor and preceptee.
- Collaborate with preceptors, preceptorship champions and programme facilitators within the Preceptorship Community of Practice, to share experiences, evaluation data, and good practices.

Time associated with role	
Initial training	2 hours
Ongoing commitment	1.5 hours per month

7.3 Preceptorship Champion Role

The preceptorship champion is a registered practitioner who promotes the value and benefit of preceptorship and supports implementation within their area and Trust. A qualified practitioner with a minimum of 12 months experience and has undergone preceptorship training as highlighted in the skills matrix Appendix 1.

Responsibilities:

- Attend organised training attaining the appropriate knowledge, skills, and capabilities to develop and support preceptorship.
- Raise the profile, value, and benefits of preceptorship within their own department, organisation, and across professional networks.
- Act as a role model for best practice, embodying the Trusts values and behaviours in supporting preceptees and preceptors.
- Support and supervise department preceptors and preceptees.
- Advocating uni and multi-professional preceptorship activities.
- Help to inform the evolution of the Trusts strategic direction, based on local experiences.
- Collaborate with preceptorship champions, preceptors and programme facilitators within the Preceptorship Community of Practice, to share experiences, evaluation data, and promote good practices.

Time associated with role	
Initial training	15 hours
Ongoing commitment	2 hours per month

7.4 Departmental Programme Facilitators/Education Leads

Responsibility for the planning, coordination and management of preceptorship programmes within their division, including the development and maintenance of a robust departmental infrastructure to support the effective delivery, sustainability, and ongoing evaluation of preceptorship.

Responsibilities:

- Plan and manage preceptorship programmes, where applicable liaising with a range of clinical professionals to ensure the programme reflects current practice. Learning opportunities may range from blended learning, taught sessions/study days and reflective activities.
- Ensure that any learning opportunities are current and are tailored to the needs of newly recruited registrants and the organisation.
- Maintain an up-to-date list of preceptors.
- Allocate preceptees to preceptors, monitoring the success of the relationship throughout the preceptorship period.
- Programme facilitators will be responsible for annual evaluation of preceptorship programmes.
- Evaluate the preceptorship programme on a regular basis, make changes as required, notifying key stakeholders e.g. service leads/team leaders/speakers/professional leads of key findings.
- Maintain copies of documentation of preceptorship processes, such as learning contracts, meeting records and personal reflections along with related learning resources e.g. training certificates.
- Record and maintain databases and registers of preceptorship programme attendance, ensuring that line managers and preceptors are notified of any nonattendance of preceptees.
- Provide planned and ad hoc opportunities for preceptees and preceptors to explore any concerns they may have about their preceptorship experience.
- Collaborate with programme facilitators, preceptorship champions and preceptors within the Preceptorship Community of Practice, to share experiences, evaluation data, and good practices.

Time associated with Role

Departmental Programme Facilitators are typically clinical educators, or training leads within their department. For programme facilitators without designated time for education or training, this role is expected to require a minimum of 2 hours per month. The exact time needed will depend on the size of the team and the number of preceptees and preceptors.

7.5 Line Manager

Responsibilities:

- Liaise with Programme Facilitator to allocate preceptor to new preceptee prior to commencement of role. If the Preceptor works part-time a second co-preceptor should be allocated to ensure maximum support is provided.
- Ensure that preceptors have protected time to meet their obligations.
- Ensure the implementation of the Preceptorship Policy and profession specific Procedure within the department.
- Ensure the preceptee and preceptor have protected time for agreed meetings.
- To work with the programme facilitator to ensure that there are sufficient trained preceptors in the area.
- Ensure the preceptee is allocated the appropriate supernumerary period.
- Ensure the preceptee and preceptor have the opportunity to work alongside each other on a regular basis (at least 40% of the time).
- Supporting the preceptee to attend organised study days and training opportunities.
- If the preceptor is unavailable for instance on sick leave to identify an alternative trained preceptor.
- Work collaboratively with the Preceptee and Preceptor to identify and address any concerns relating to the Preceptee's competence, performance, or progression. Where issues are identified, develop and implement a structured and supportive development plan with clearly defined objectives, review points, and agreed actions to facilitate successful achievement of the required competencies.

7.6 Trust Preceptorship Lead

A Central point of contact and lead for preceptorship within Velindre University NHS Trust. Responsible for the implementation, governance, resourcing, and evaluation of preceptorship throughout the Trust. The preceptorship programme will be managed and facilitated by the departmental programme facilitator in each area in partnership with educational leads and preceptorship lead for the Trust.

Responsibilities:

- Develop and update the Preceptorship Policy to align with national preceptorship frameworks set by the NMC and HCPC. Reviewing the Preceptorship Policy every 3 years with departmental programme facilitators.
- Responsible for the implementation, governance, resourcing, and evaluation of all preceptorship programmes provided within the Trust.
- Identify and monitor relevant training and support for preceptorship.
- Work across local, regional, and national systems to provide assurance of the Trust Preceptorship Policy, including a formal annual evaluation and review.
- Evaluate the impact and effectiveness of preceptorship programmes linking to staff retention data and preceptee and preceptor feedback.
- Ensure the Preceptorship Community of Practice is established and maintained.
- Schedule annual meetings with Departmental Programme Facilitators, champions, key stakeholders, including preceptee representation, to evaluate the effectiveness of preceptorship. Facilitating the opportunity for good practice and the creation of improvements based on statistical analysis and feedback.

Time associated with Role

The Preceptorship Lead for the Trust is expected to have dedicated time allocated within their substantive post to fulfil these requirements.

8. Restorative Clinical Supervision

A formal process of support, reflection, learning and development that is of benefit to both newly registered professionals and experienced health care professionals. Clinical Supervision creates a safe space for healthcare professionals (across all specialities) and other practitioners to reflect on their practice with the intention of learning, developing and improving knowledge, competence and confidence in their role.

Registered Nurses will be offered clinical supervision on an individual or group basis during their preceptorship period in line with the All Wales Clinical Supervision Principles (WG, 2024). Velindre University NHS Trust is committed to ensuring that preceptorship and restorative clinical supervision is embedded within the Trust, fostering a culture that supports reflection, continued learning and improvement and promotes a positive work environment.

9. Equality

All preceptorship programmes will be inclusive with the integration of a range of teaching and learning methods to cater for individual preceptee's needs e.g. disabilities, dyslexia. The Trust realises that some staff may require additional support due to specific needs, as such the Trust will aim to meet reasonable adjustments and take account of protected characteristics in accordance with the Equality Act 2010.

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.

10. Evaluation

Monitoring of the following aspects of effectiveness will be collected annually:

- Percentage of new registrants successfully completing the preceptorship process
- Preceptee evaluation forms
- Feedback from facilitators at taught study days
- Feedback from preceptors and line managers

The outcomes of ongoing monitoring will inform a formal annual review of the preceptorship programme. As part of this process, the Preceptorship Lead will meet with Preceptorship Champions, Education Leads, and Programme Facilitators to evaluate the findings, share examples of good practice, identify areas for improvement, and agree on any necessary changes to the programme. Based on the evaluation results and feedback, the content of programmes will be updated and amended, as required. Evaluation results and programme amendments will be shared with staff who contribute to teaching and learning activities.

11. Review

The Policy will initially be reviewed after 12 months, subsequently review of the policy will be instigated by the preceptorship lead on a 3 yearly basis.

12. References

Health Education England (2023) AHP preceptorship standards and framework. www.hee.nhs.uk/sites/default/files/NHSE%20AHP%20Preceptroship%20standards%20and%20Framework.pdf

Health Care Professions Council (2024) Standards of conduct, performance and ethics.

Health and Care Professions Council (2023) Principles for preceptorship. https://www.hcpc-uk.org/resources/information/principles-forpreceptorship/

Health and Care Professions Council (2023) Standards of proficiency. https://www.hcpc-uk.org/standards/standards-of-proficiency/

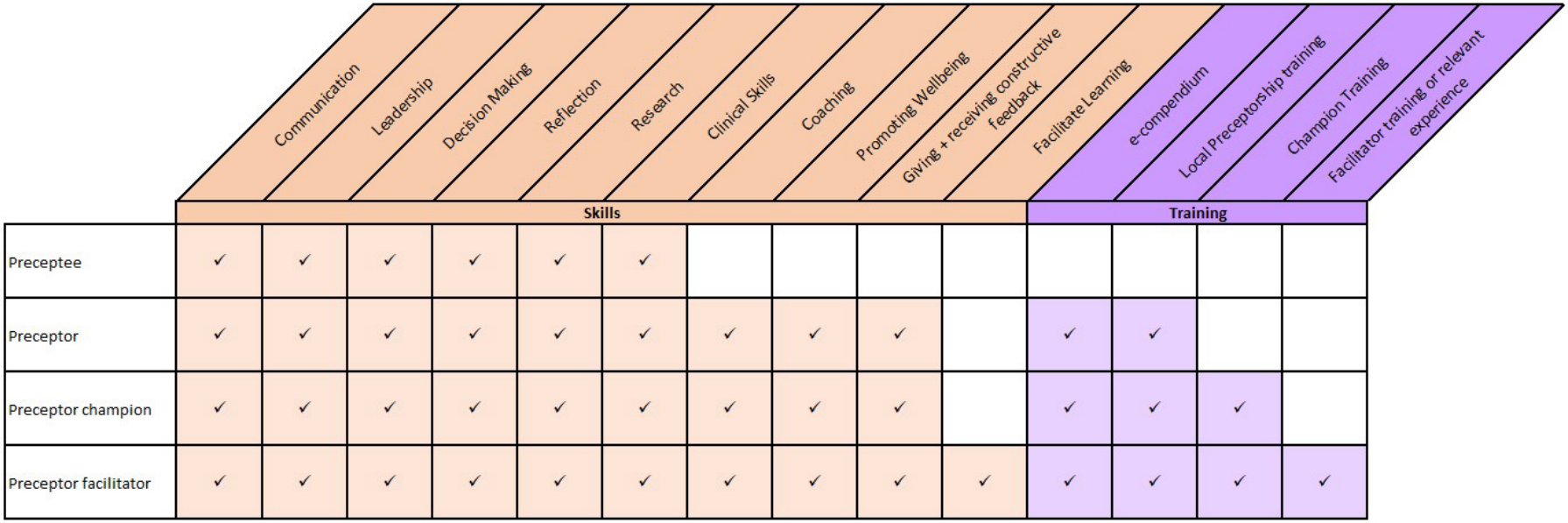
Nursing and Midwifery Council (2020) Principles for Preceptorship.

Nursing and Midwifery Council (2025) The Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates

Welsh Government (2024) An All-Wales Career Spanning Approach to Preceptorship and Clinical Supervision in Nursing https://www.gov.wales/sites/default/files/publications/2024-03/nursing-preceptorship-and-restorative-clinical-supervision-position-statement.pdf

Welsh Government (2024) Welsh Health Circular – Nursing Preceptorship & Restorative Clinical Supervision – A National Position Statement https://www.gov.wales/sites/default/files/publications/2024-03/nursing-preceptorship-and-restorative-clinical-supervision-position-statement.pdf

Appendix 1: Skills Matrix



	Communication	Leadership	Decision Making	Reflection	Research	Clinical Skills	Coaching	Promoting Wellbeing	Giving + receiving constructive feedback	Facilitate Learning	e-compendium	Local Preceptorship training	Champion Training	Facilitator training or relevant experience
	Skills										Training			
Preceptee	✓	✓	✓	✓	✓	✓								
Preceptor	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Preceptor champion	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	
Preceptor facilitator	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix 2: Standards of preceptorship (NMC, HCPC and All-Wales Preceptorship Standards)

Organisational Culture and Preceptorship		
NMC	**HCPC**	**VUNHST**
	a) embed in the organisation's workforce and organisational systems to enable preceptee access and engagement;	This policy highlights the process for identifying staff requiring preceptorship and provides resources for preceptorship
1.1 It is kind, fair, impartial, transparent, collaborative and fosters good interprofessional and multi-agency relationships	b) comply with equality legislation and take account of national and local equality, diversity and inclusion policies;	This policy complies with all local equality legislation, and is fair, impartial, transparent and collaborative.
1.2 There is an understanding of the importance of having systems and processes in place to support and build confidence of newly registered nurses, midwives and nursing associates		This policy highlights the benefits of preceptorship and gives guidance on implementation of preceptorship process, as well as the activities that can support this such as education and reflection.
	c) provide opportunities for preceptees to develop confidence and to support their future career;	This policy outlines preceptorship activities that can be completed to support a preceptee's development.
1.3 There is an approach to preceptorship that prioritises individual mental and physical health and wellbeing	d) prioritise preceptee and preceptor health and wellbeing;	This policy outlines that preceptor champions, mentors and preceptors receive training that highlights the importance of wellbeing, additionally, preceptorship is tailored to the individual.
-and promotes accountability, self-reflection and safe practice in accordance with the Code	e) promote a culture of learning, self-reflection and safe practice.	This policy highlights a process and resources to encourage preceptee, mentor and preceptor reflection throughout the preceptorship period.

2.1 There are processes in place to identify those who require preceptorship		All recruiting managers will gauge the appropriateness of preceptorship for successful applicants.

Quality and oversight of preceptorship		
NMC	**HCPC**	**VUNHST**
2.2 There is sufficient preceptor capacity to support all of those who require preceptorship		Line managers and departmental programme facilitator will identify numbers of preceptor's and mentors needed to support preceptee's.
2.3 The employer, preceptees and preceptors understand and comply with national and local policies, and the relevant governance requirements required by the four countries of the UK	g) understanding of, and compliance with, national and local policies, and the relevant governance requirements required by the four countries of the UK.	This policy is written in line with national and local policies.
2.4 Preceptorship activities should complement the preceptees' induction and orientation into the local workplace	c) integration with induction to professional role where appropriate;	This Policy outlines preceptorship activities that will align with and build upon the preceptee's induction and orientation programs. Multiprofessional working and learning are embedded throughout preceptorship programmes, promoting collaboration, shared learning, and effective teamworking across professional groups.
	b) processes in place to support an appropriate mix of profession-specific, multi-profession and uni-profession learning and development within organisations or with wider system and professional networks;	
2.5 There is recognition of the impact of system challenges on effective preceptorship and how to mitigate these	d) recognition of the impact of system challenges and how to mitigate these;	Evaluation of preceptorship will assess the impact of system challenges and inform strategies for their mitigation.

2.6 Processes are in place to monitor, evaluate and review preceptorship programmes	e) systems in place to monitor, evaluate and review preceptorship programmes;	Monitoring processes are in place to evaluate and review preceptorship within the Trust.
2.7 There is a governance framework around preceptorship which allows the process to be audited and reported.	f) professional and organisational governance frameworks which allow the process to be audited and reported;	Preceptorship Policy will be audited every 3 years.
	a) processes to ensure registrants can access preceptorship and which meets their individual needs;	The preceptorship process can be tailored to meet the preceptee's learning and professional needs.

Preceptee empowerment		
NMC	**HCPC**	**VUNHST**
	a) access to a preceptorship programme which instils the importance of continuing professional development;	Preceptorship programs will offer preceptees opportunities to engage in diverse CPD activities that support their individual development, promote reflective practice, and generate a CPD record suitable for revalidation purposes.
3.1 Preceptees are provided with the appropriate resources to enable them to develop confidence as newly registered nurses, midwives and nursing associates	b) appropriate resources and guidance to develop confidence and support continuing professional development;	
3.2 Are supported according to their individual learning needs	c) a tailored programme of support and learning reflecting individual needs;	
3.4 Have opportunities for reflection and feedback to support their approach to preparing for revalidation		
3.3 Are supported by a nominated preceptor	d) an identified preceptor for the duration of their preceptorship	Preceptee's will be allocated a preceptor at the start of their employment.

3.5 Are empowered to work in partnership with preceptors and can influence the content and length of their preceptorship programme to meet both individual and organisational needs	e) autonomy to influence the duration and content of their preceptorship in partnership with their preceptor, others in their organisation and wider professional networks.	Preceptors and preceptees should complete learning contracts within the first week of preceptorship, The preceptee can determine the frequency of meetings as long as the minimum standard set within each discipline's procedure is achieved.
4.1 Preceptors act as professional role models	a) act as a professional role model and be supportive, constructive and compassionate in their approach;	This policy outlines the expected skills, knowledge and training that preceptors should hold before conducting their duties in order to support effective, multi-professional preceptorship that benefits both the preceptee, the preceptor and the organisation.
	b) help to facilitate multi-professional aspects of preceptorship where appropriate;	
	d) support preceptees to engage with their wider profession, and help build networks	
	locally or through external professional networks;	Best practices will be shared and celebrated, with outcomes from ongoing evaluations communicated to preceptors. The community of practice will encourage the sharing of effective practice as well as signposting to resources for preceptorship. Preceptees are provided with regular opportunities to give feedback on the support they receive throughout their preceptorship programme.
4.2 Receive ongoing support and actively engage in professional development	f) be encouraged to see the personal and professional benefit of taking on the role of preceptor;	
4.3 Are supportive and constructive in their approach to the preceptee	c) support preceptees to reflect on their development and signpost to relevant support and development opportunities;	
4.4 Share effective practice and learn from others	e) share effective practice and learn from each other;	
4.5 Seek and are given feedback on the quality of all aspects of their preceptorship role.	g) have access to feedback on the quality and impacts of all aspects of their work as preceptors.	

	b) be flexible to support various types of transition in a timely way;	Registrants can request coaching or mentoring if they feel they require support in a new role.
5.1 Be timely and align with the start of a new employment role		
5.2 Recognise the knowledge, skills, attributes and competence nurses, midwives and nursing associates have at the point of registration		This policy highlights the need to provide a variety of preceptorship activities, especially ones that match the preceptee's personal and professional needs, recognising that these activities should not re-teach entry level skills, but support them to work as a confident autonomous practitioner within their specific role, understanding the Trusts values and behaviours. The Policy highlights the fact that preceptorship can be tailored to suit individual needs
5.3 Seek to ensure that activities within the programme are agreed with the individual preceptee		
5.4 Vary in length and content according to the needs of the individual nurse, midwife and nursing associate and the organisation. Individual countries, regions or organisations may set minimum or maximum lengths for preceptorship	e) vary in length and content according to the needs of the individual preceptee and the organisation. Individual countries, regions or organisations may set minimum or maximum lengths for preceptorship.	
5.5 Include activities designed to welcome and integrate the preceptee into the team and place of work		The policy highlights the requirement for preceptees to be welcomed into the team, supporting their integration into the workplace and enhancing their early professional experience.
5.6 Be designed to ensure that it is possible for the preceptee to meet the aims and outcomes of the	a) be tailored to take account of the environment the individual preceptee is working in;	
preceptorship programme within the agreed timeframe		

	c) have flexibility to deliver common themes of preceptorship in a multiprofessional way while ensuring profession specific elements are provided where necessary;	Comments above
	d) have a structured design which describes how the programme delivers success for preceptees;	
	f) have awareness of, and align with, other profession specific and workforce development programmes.	

Alignment with All-Wales Preceptorship Standards 2024 (Nursing)

	All Wales Preceptorship Standards	VUNHST Standards
1	Preceptorship is mandated across NHS Wales and organisations must be preceptee ready.	A 12-month preceptorship programme exists in the Velindre Cancer Service (for nursing), including 4-week local induction. All preceptees are allocated a designated mentor in their specific clinical area and an overall preceptor in the Trust. Preceptorship programme evaluation is sought after the 4-week induction.
2	Preceptorship programmes will be delivered in a healthy, compassionate culture of learning and wellbeing.	Compassionate leadership is actively supported and encouraged in VUNHST. Compassionate leadership training is being offered to nurses including preceptees across the Trust facilitated by People and Organisation Development Department. Preceptees attend bi-monthly study days for 12 months. RCS is also offered to preceptees on a regular basis during their preceptorship programme.
3	Preceptees will be welcomed and integrated into the workplace and will receive effective, timely support enabling growth into accountable, independent, knowledgeable, skilled practitioners. They will be supernumerary for the first month of employment and their programme of preceptorship will last up to 18 months.	Preceptees are supernumerary for the first 4 weeks of employment. Preceptorship duration is 12 months; however, this can be negotiated locally if more support is required.
4	Preceptors will have the necessary skills, knowledge, and allocated time to support preceptees for the duration of the preceptorship period, to include paid time off for training.	Preceptors complete practice assessor and supervisor training in working time. It is estimated that monthly preceptorship duties for meetings, paperwork etc. amounts to 1.5 hours in work time.

Alignment with All Wales Clinical Supervision Principles (Nursing)

It is important to highlight principle 2 from the All-Wales Clinical Supervision Principles, as this principle is directly applicable to Nurse Preceptorship

	All Wales Clinical Supervision Principle	VUNHST
2	Organisations must provide protected time for staff to access and provide Restorative Clinical Supervision, in all settings, with its inclusion in structured Preceptorship programmes.	Restorative Clinical Supervision sessions are offered to nurses on the preceptorship programme up to four times a year.

TRUST BOARD		
ASSURANCE REPORT FROM THE SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC) MEETING HELD ON 16 JULY 2026		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Roxann Davies, NWSSP Corporate Services Manager	
PRESENTED BY	Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services	
REPORT SPONSOR	I, Linsay Payne, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	09/09/2026	Shared Services Partnership Committee (SSPC) Committee Members (by email)
ONWARD SCRUTINY ROUTE	This Assurance Report has been sent to all SSPC Members for cascading to their respective organisations' Board, for noting and assurance purposes.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	To provide the Trust Board with assurance that key controls are in place.	
EXECUTIVE SUMMARY	This paper has been prepared to provide the Trust Board with details of the key issues considered by the Shared Services Partnership Committee, at its meeting on 16 July 2026.	
ACTION / DECISION	The Trust Board is asked to **NOTE** the contents of the Assurance Report.	
ADDITIONAL RESOURCES	Not Applicable.	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:		

There are no quality and safety implications identified from the activities outlined in this highlight report.		
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.		
Status: QIA not required - not a strategic decision		
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Shared Services Partnership Committee (SSPC) Assurance Report 16 July 2026

1. SITUATION

1.1 To provide the Trust Board with details of the key issues considered by the Shared Services Partnership Committee, at its meeting on 16 July 2026, for **NOTING**.

2. BACKGROUND

2.1 A summary of the business matters discussed at the last Shared Services Partnership Committee meeting, is outlined in Appendix 1.

3. MATTERS FOR CONSIDERATION

3.1 FINANCIAL IMPLICATIONS

3.1.1 Not applicable.

3.2 LEGAL IMPLICATIONS

3.2.1 Not applicable

3.3 PEOPLE IMPLICATIONS

3.3.1 Not applicable

3.4 WELSH LANGUAGE IMPLICATIONS

3.4.1 Not applicable

3.5 RISKS / REPUTATIONAL IMPLICATIONS

3.5.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE** contents of the Shared Services Partnership Committee Assurance Report for 16 July 2026.

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee (SSPC)**
Chaired by	Dr Susan Barnes, Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager
Date of Meeting	16 July 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Managing Director's Update Report – The Managing Director presented an update on key NWSSP developments since the previous meeting to complement the overarching report, with particular focus on two strategic programmes: Transforming Access to Medicines Service (TrAMS) and the Future Workforce Solution (FWS).

The TrAMS South East Hub Full Business Case has been completed and was progressing through the formal approval routes within individual organisations. Construction of the South East Radiopharmacy facility had been completed, with commissioning, validation and operational readiness activities continuing. Programme momentum remained positive across all hub developments, with continued oversight required in relation to commissioning timelines, workforce capacity, funding dependencies and service continuity during transition.

In relation to FWS, the Committee noted that the Managing Director had written to the NHS Business Services Authority (NHSBSA) in June raising concerns regarding programme clarity, scope, timelines and implementation expectations. Members were advised that the go-live date remained under review by NHSBSA and Infosys through the contract review process, with further formal communication anticipated and assurances received on improved communication and benefits realisation. Members discussed the implications of a revised timeline for early adopters, later implementation waves and funding arrangements, noting that year zero and year one funding had been approved under the previous administration, with further remapping required once the revised plan was agreed. Given the scale, complexity and multi-organisational impact of FWS, Members emphasised the need for appropriate programme assurance, including Internal Audit involvement at key staging and readiness points, subject to receipt of the revised plan. A further update would be brought to the September 2026 meeting.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Update Report.

Deep Dive Presentation

Foundational Economy - The Committee received a detailed presentation on the Foundational Economy programme and its contribution to wider procurement priorities, including decarbonisation, value for money, supply chain resilience, waiting list support and compliance with an increasingly complex legislative framework. Procurement activity

continued to be underpinned by a focus on patient outcomes and value.

Enhanced analytical capabilities, including new Power BI and contract pipeline reporting tools, were highlighted, providing improved visibility of supplier spend, location and future procurement opportunities. Welsh-headquartered suppliers continued to account for 42.93% of NHS Wales expenditure, with spend increasing from just over £1bn in 2019/20 to more than £2.3bn in the latest year. Members noted that around £1.1bn of contracts were due for renewal during the year, presenting opportunities to further support foundational economy objectives where market conditions allowed.

Members welcomed the improved intelligence and discussed NWSSP's role in supporting delivery of the Social Partnership and Public Procurement (Wales) Act 2023 through a collaborative all-Wales approach. Discussion focused on the need to refine measures of economic impact beyond supplier headquarters location, alongside continued supplier engagement, support for SMEs and micro-businesses, and consideration of wider economic and employment benefits. The Committee recognised NWSSP's strategic procurement role and potential to further contribute to economic growth through innovative commercial approaches and partnership models.

The Committee **NOTED** the update provided in relation to Foundational Economy.

Items for Approval

Scan for Safety Wales Programme – The Committee considered the three-year extension of the Scan for Safety Programme, noting forthcoming regulatory requirements for enhanced traceability of implantable medical devices and Wales' comparatively advanced position. The programme will support compliance requirements and further development of inventory management capabilities, including exploration of artificial intelligence to optimise stock management across NHS Wales. The Committee **APPROVED** the extension of the Scan for Safety Programme and its supporting Inventory Management Contract with Omnicell by utilising the 36 months available as per the original Full Business Case and current contract terms.

Student Awards Bursary System – The Committee considered the proposed three-year contract extension for the Student Awards Bursary System, recognising the need to maintain continuity of support for students whilst Welsh Government continues to review bursary arrangements. The Committee **APPROVED** the Student Bursary Award System contract extension for three (3) years with effect from 1 April 2027 to 31 March 2030 with a total cost of £382,515.

Material Handling Equipment Lease, Hire and Maintenance – The Committee considered proposals to award a five-year contract for material handling equipment and received assurance regarding procurement, supplier due diligence and risk mitigations, including consideration of the single tender response received. The Committee **APPROVED** the award of the contract to Toyota Material Handling UK Limited, up to a maximum estimated value of £1.04m excluding VAT over the full five-year term, and **NOTED** the demand-led nature of the agreement, the associated risks and mitigations, and that progression remained subject to all required approvals and procurement requirements being completed.

NWSSP Annual Review 2025-26 – The Committee received the Annual Review 2025-26, which reflected NWSSP's 15-year anniversary on 1 April 2026 and provided an overview of organisational achievements, governance arrangements, performance and future priorities. The Committee **APPROVED** the Annual Review.

Digital Strategy – The Committee considered the refreshed Digital Strategy, designed to support organisational priorities through strengthened digital foundations, workforce capability, data maturity, cyber resilience and innovation. Discussion highlighted alignment with national digital priorities, workforce readiness and future investment requirements. The Committee **APPROVED** the refreshed Digital Strategy.

Opportunities Pipeline – The Committee received an update on the Opportunities Pipeline, setting out existing, emerging and longer-term opportunities through which NWSSP could further support NHS Wales in response to financial and service challenges. Members endorsed the strategic direction, emphasising the importance of partnership working, governance and stakeholder sponsorship. Some members of the Committee were keen to explore NWSSP's ability to take forward initiatives on a local and regional basis and not be constrained by consensus on all-Wales approaches every time. The Committee **NOTED** the update on the NWSSP Opportunities Pipeline, including initiatives already in hand for 2026/27, and **APPROVED** the proposed approach to undertaking discovery work on medium to longer-term opportunities before any final decision on development and implementation.

NHS Wales Preparedness, Resilience and Response Annual Report 2025-26 – The Committee received assurance regarding the maturity of NWSSP's emergency preparedness, resilience and response arrangements and the organisation's contribution to wider NHS Wales planning and collaboration. AR commented that NWSSP would be working with the Welsh Government in response to the recently published COVID Inquiry Module 5 report on PPE Procurement. The Committee **APPROVED** the Annual Report for submission to NHS Performance and Improvement.

Items for Noting

Welsh Risk Pool Assurance Programme – The Committee received an update on the Welsh Risk Pool Assurance Programme, including work to strengthen forecasting, financial mitigation and learning from clinical negligence claims. Members noted ongoing engagement with NHS Wales organisations and external partners to support continuous improvement and future risk reduction. The Committee **NOTED** the update.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee received the Finance Report as at 31 May 2026, noting a year-to-date surplus of £813k, delivery of Cost Improvement Programme savings, continued vacancy controls and no agency expenditure reported in the year to date. Key risks related to digital programme funding, Future Workforce Solution implementation, Radiopharmacy transition costs and energy price volatility. The Committee also noted capital programme progress, Welsh Risk Pool expenditure monitoring and the ongoing grip and control improvement programme.

People and Organisational Development Report – The Committee received an update on workforce performance, noting improved staff turnover, stable sickness absence and continued targeted interventions in areas of higher absence. Strong mandatory training compliance, ongoing workforce planning activity and a positive Internal Audit review of attraction and retention were highlighted. Members also noted NWSSP's achievement of silver status under the Armed Forces Employer Recognition Scheme.

Performance Information Report – The Committee received the latest performance report, noting continued delivery of professional influence benefits of £57m and generally

positive organisational performance. A small number of targets remained below target relating to procurement savings delivery and timely responses to audit recommendations, with corrective actions underway. Improvements in recruitment performance were also noted.

Outcome Measures Report – The Committee received an update on performance against NWSSP's strategic outcomes, noting positive performance across key measures including employee satisfaction, customer satisfaction, professional influence benefits, decarbonisation and foundational economy objectives.

Transformation Management Office (TMO) Update Report – The Committee received an update on the transformation portfolio, comprising 21 programmes, projects and initiatives across NHS Wales and NWSSP. Progress was reported across a number of schemes, including projects reaching completion and continued strengthening of reporting, assurance and benefits realisation arrangements.

Integrated Medium-Term Plan (IMTP) Quarter 4 Report 2025-26 – The Committee received the year-end IMTP performance report, prior to its submission to Welsh Government, noting that the majority of objectives had either been completed or remained on track. Areas of slippage and external dependency were being managed through the 2026-27 planning cycle.

NWSSP Annual Governance Statement (AGS) 2025-26 – The Committee received the final Annual Governance Statement, noting its prior consideration and approval through the Audit Committee and inclusion within the annual accounts process.

NWSSP Corporate Risk Register – The Committee received the Corporate Risk Register, noting the current risk profile, of which there were eight red and ten amber risks for action. No new risks had been escalated, although key programme risks had been refined to improve oversight. Ongoing review of risk targets and organisational risk appetite was also noted.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Items for Information

The Committee received several items for information, covering items 7.1 to 7.4 of Part A and items 1.1 to 1.9 of Part A2. These comprised the Finance Monitoring Returns for Months 1 and 2 of 2026-27, the Personal Protective Equipment (PPE) Report, the NWSSP Audit Committee Assurance Report from 28 April 2026, and the SSPC Forward Plan 2026-27, together with a suite of annual reports covering Audit Committee, Local Counter Fraud Services, Concerns and Complaints, Declarations of Interest and Gifts, Hospitality and Sponsorship, Health and Safety, Welsh Language, Duty of Quality, Medical Examiners Service and Surgical Materials Testing Laboratory.

Part B – Private

Transforming Access to Medicines Service (TrAMS) South East Hub Full Business Case – The Committee considered the Full Business Case for the South East TrAMS Hub, which forms part of the national programme to modernise aseptic medicines manufacturing services across Wales. Members noted the case for change, including infrastructure, regulatory and workforce challenges, and that the proposal sought £21.7m capital investment to develop a regional hub at Imperial Park (IP5). The Committee acknowledged extensive stakeholder engagement and the strategic importance of the

programme in delivering a sustainable all-Wales service model. The Committee **APPROVED** the Full Business Case, subject to remaining organisational approvals and submission to Welsh Government.

Transforming Access to Medicines Service (TrAMS) Clean Room Design and Build Contract Change Approval – The Committee considered proposed contract changes associated with the South East TrAMS Hub development, noting that progression remained contingent upon approval of the Full Business Case, Welsh Government approval and confirmation of capital funding. Assurance was provided regarding cost validation, governance oversight, risk management and lessons learned arrangements. The Committee **APPROVED** the clean room design and build contract changes. Trust Board approval consideration to follow on 30 July 2026.

Aseptic Isolators for the South East Transforming Access to Medicines Service (TrAMS) Project – The Committee considered the procurement of 15 aseptic isolators required to support operations within the proposed South East Hub. Members noted that the purchase formed an essential component of the overall TrAMS infrastructure programme and remained subject to Full Business Case approval, Welsh Government approval and confirmation of capital funding. The Committee **APPROVED** the purchase of the isolators. Trust Board approval consideration to follow on 30 July 2026.

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	Tuesday 15 September 2026, 10.00am to 12.00pm

TRUST BOARD		
HIGHLIGHT REPORT FROM THE CHAIR OF THE VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTERSHIP (NWSSP AUDIT COMMITTEE) – MEETING HELD ON 7 JULY 2026		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Carly Wilce, NWSSP Corporate Services Manager	
PRESENTED BY	Gareth Jones, Chair of NWSSP Audit Committee	
REPORT SPONSOR	I, Gareth Jones, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	15/09/2026	Shared Services Partnership Committee (SSPC)
	24/09/2026	Formal Senior Leadership Group (FSLG)
ONWARD SCRUTINY ROUTE	Submitted to the Trust Board for noting and assurance.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	To provide the Trust Board with assurance that key controls are in place.	
EXECUTIVE SUMMARY	This paper provides the Trust Board with a summary of the key issues considered by the NWSSP Audit Committee at its meeting held on 7 July 2026.	
ACTION / DECISION	The Trust Board is asked to **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 7 July 2026.	
ADDITIONAL RESOURCES	Not Applicable.	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		

QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
There are no quality and safety implications identified from the activities outlined in this highlight report.
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

APPENDICES	Appendix no.	Appendix title
	Appendix 1	Key Considerations

APPENDIX 1 – KEY CONSIDERATIONS

NWSSP AUDIT COMMITTEE HIGHLIGHT REPORT – 7 JULY 2026

1. SITUATION

1.1 To provide the Trust Board with details of the key issues considered in Part A by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) at its meeting held on 7 July 2026, for noting.

2. BACKGROUND

2.1 The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) provides assurance to the Shared Services Partnership Committee (SSPC) on matters delegated to it through the Trust's and NWSSP's Standing Orders. A summary of the business considered at the meeting held on 7 July 2026 is set out below.

3. MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for **alert/escalation** to the Board.
ADVISE	There were no matters for **advice/escalation** to the Board.
ASSURE	**Managing Director's Update** The Managing Director provided a comprehensive update on developments across NWSSP. Key updates include: • A new Chair of the Shared Services Partnership Committee (SSPC) had been appointed following a robust recruitment process. The successful candidate is Dr Sue Barnes, Chief Executive of the Wales Air Ambulance Charity.

	• At Month 2, NWSSP was reporting a stable financial position, with a surplus of £0.813m. Opportunities to identify further recurring savings continued to be explored and were scheduled for discussion at the July SSPC meeting. • No further queries had been received from Welsh Government regarding the purchase of Sandringham Park for the South West TrAMS Hub following the feedback provided by NWSSP. • The launch of the Future Workforce Solution (FWS) system has been delayed by approximately eight months. Concerns had been escalated to the Chief Executive Officer of the NHS Business Services Authority regarding programme definitions, scope, funding arrangements and financial assumptions. • Progress continued on the implementation of the new Resident Doctor contract in NHS Wales, although challenges remained in relation to funding and rota arrangements. NWSSP's contribution remained on track to support the planned go-live dates. • Despite the recent red weather health alert, measures implemented within Laundry Services had effectively supported staff wellbeing while maintaining service delivery.
ASSURE	**Audit Wales Update** Audit Wales presented an update confirming the completion of its assurance work for NWSSP. A positive outcome was reported, with no concerns raised. The management letter will be submitted to the NWSSP Audit Committee in October 2026.
ASSURE	**Internal Audit Progress Update** The Head of Internal Audit and Assurance Services presented the progress report, providing an update on delivery of the 2026-27 Internal Audit Plan and other activity undertaken since the previous meeting. One internal audit report was on the agenda for the Audit Committee's consideration.
ASSURE	**Internal Audit Reports** The Audit Committee received the Internal Audit report for Medical Examiner Services, which was awarded a Reasonable Assurance rating. The review assessed compliance with key system controls and the effectiveness of risk management and governance arrangements within the service. Three medium-priority recommendations were identified, one of which was already implemented with progress against agreed actions to be monitored through the NWSSP Agreed Management Action Tracker.
ASSURE	**Counter Fraud Annual Report 2025-26** The NWSSP Counter Fraud Manager presented the Counter Fraud Annual Report 2025-26, which included the Counter Fraud Functional Standard Return. The return was assessed as Green, with two areas receiving an Amber rating, and has been submitted to the NHS Counter Fraud Authority. It was also noted that a Service Level Agreement had been established with Swansea Bay University Health Board to support fraud risk assessments. As a result, it is anticipated that the return will achieve a fully Green rating next year. The NWSSP Audit Committee **APPROVED** the Draft Counter Fraud Annual Plan 2026–27.
ASSURE	**Counter Fraud Progress Update Q1** The NWSSP Counter Fraud Manager presented the Counter Fraud Update for Q1. Key points to highlight include:

	• A divisional review of compliance with Fraud Awareness e-learning identified several gaps, which were being actively targeted. • No notices had been received from the Counter Fraud Authority during the period. The next National Fraud Initiative (NFI) data-matching exercise was due to commence shortly. • A Counter Fraud coffee morning and bespoke training sessions had been conducted and would be reflected in future performance reports.
ASSURE	**Grip and Control Arrangements** The Director of Finance and Corporate Services presented the findings of the 2026 Grip and Control Assessment, undertaken in accordance with the NHS Grip and Control Framework. The assessment will be submitted to NHS Performance and Improvement. Key areas identified for further attention included workforce planning, vacancy management, VAT recovery arrangements, write-off procedures, and the documentation of service cessation processes. The importance of ensuring effective benefits realisation from both revenue and capital investments was also highlighted. An update on progress against the associated action plan will be provided at future meetings.
ASSURE	**Annual Declarations of Interest, and Gifts, Hospitality and Sponsorship 2025-26** The Assistant Director of Corporate Services presented the Annual Declarations of Interest and Gifts, Hospitality and Sponsorship Report 2025-26. The report was positive and advised that all NWSSP staff are required to submit a declaration via ESR, including a nil return where no interests exist. Compliance rates were low in some service areas, and a targeted approach to improving completion rates was underway. Members noted that a further update on compliance levels within the underperforming areas would be provided at the next meeting.
ASSURE	**Governance Matters** The Director of Finance and Corporate Services presented the Governance Matters report, which detailed contracting activity for the last quarter. There were two occasions where a contract award was not progressed in accordance with Standing Orders and the Scheme of Delegation. There were **21** contracts let by NWSSP and **14** further contracts let on an All-Wales basis for NHS Wales. **Eight** declarations had been made in relation to gifts, hospitality or sponsorship since the last meeting, and **one** internal audit report concluded as Limited Assurance and had been reported to Welsh Government. Of the **132** audit recommendations, **118** had been implemented, **13** were not yet due, and **one** was overdue. The overdue recommendation was reliant on a third-party organisation for full implementation and was therefore outside NWSSP's direct control. The Audit Committee approved an extension to the target date. The NWSSP Corporate Risk Register contains **8** red risks and **10** amber risks for action. Following engagement with the Director of Corporate Governance at Velindre University NHS Trust to ensure alignment with existing arrangements, the revised NWSSP Risk Management Protocol was considered and approved. The Committee received assurance that robust governance, control and risk management arrangements are operating effectively across NWSSP.

	The NWSSP Audit Committee **APPROVED** the revised NWSSP Risk Management Protocol.
ASSURE	**NWSSP Audit Committee Annual Report 2025-26** The Assistant Director of Corporate Services presented the Audit Committee Annual Report 2025-26, prepared in accordance with the Audit Committee's Terms of Reference. The report provided a summary of the Committee's work during 2025-26 and the assurance it provides to the Shared Services Partnership Committee (SSPC) and the Accountable Officer in support of the Annual Governance Statement. The report was progressed to the SSPC meeting on 16 July 2026.
INFORM	**The following item was received for information:** NWSSP Welsh Language Annual Report 2025-26.
APPENDICES	Not applicable

3.1 FINANCIAL IMPLICATIONS

3.1.1 Not applicable

3.2 LEGAL IMPLICATIONS

3.2.1 Not applicable

3.3 PEOPLE IMPLICATIONS

3.3.1 Not applicable

3.4 WELSH LANGUAGE IMPLICATIONS

3.4.1 Not applicable

3.5 RISKS / REPUTATIONAL IMPLICATIONS

3.5.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

3.5.2 Not applicable

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 7 July 2026.

TRUST BOARD		
HIGHLIGHT REPORT FROM THE CHAIR OF THE VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTERSHIP (NWSSP AUDIT COMMITTEE) – PART A MEETING HELD ON 15 JUNE 2026		
DATE OF MEETING	24 September 2026	
STATUS	Public	
REPORT AUTHOR	Carly Wilce, NWSSP Corporate Services Manager	
PRESENTED BY	Gareth Jones, Chair of NWSSP Audit Committee	
REPORT SPONSOR	I, **Gareth Jones**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	15/09/2026	Shared Services Partnership Committee (SSPC)
	24/09/2026	Formal Senior Leadership Group (FSLG)
ONWARD SCRUTINY ROUTE	Submitted to the Trust Board for noting and assurance.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	To provide the Trust Board with assurance that key controls are in place.	
EXECUTIVE SUMMARY	This paper provides the Trust Board with a summary of the key issues considered by the NWSSP Audit Committee at its Part A meeting held on 15 June 2026.	
ACTION / DECISION	The Trust Board is asked to **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 15 June 2026 (Part A).	
ADDITIONAL RESOURCES	Not Applicable.	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		

QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:		
There are no quality and safety implications identified from the activities outlined in this highlight report.		
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.		
Status: QIA not required - not a strategic decision		
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Key Considerations

APPENDIX 1 – KEY CONSIDERATIONS

NWSSP AUDIT COMMITTEE HIGHLIGHT REPORT – 15 JUNE 2026, PART A

1. SITUATION

1.1 To provide the Trust Board with details of the key issues considered in Part A by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) at its meeting held on 15 June 2026, for noting.

2. BACKGROUND

2.1 The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) provides assurance to the Shared Services Partnership Committee (SSPC) on matters delegated to it through the Trust's and NWSSP's Standing Orders. A summary of the business considered in Part A at the meeting held on 15 June 2026 is set out below.

3. MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for **alert/escalation** to the Board.
ADVISE	There were no matters for **advice/escalation** to the Board.
ASSURE	**Internal Audit Progress Report** The Head of Internal Audit presented an update on delivery of the 2025–26 Internal Audit Plan. The Committee received assurance that delivery of the Plan was progressing appropriately, with six audit reports finalised during the reporting period and presented for Committee consideration. The Audit Committee further noted that the only remaining report from the 2025–26 Internal Audit Plan was in progress and was expected to be finalised for presentation at the next Audit Committee meeting on 7 July 2026.

ASSURE	**Internal Audit Reports** The Committee received assurance from the Internal Audit reports that the key systems and controls reviewed were generally operating effectively, with all reviews reported to the meeting receiving either Substantial or Reasonable Assurance. Where findings were identified, agreed management actions had been established and will continue to be monitored through the NWSSP Agreed Management Action Tracker. • **Procurement Services - Single Tender Actions and Declarations of Interest:** The audit provided Reasonable Assurance on the adequacy and effectiveness of the control arrangements, with four key findings identified for management action. • **Health Courier Services - Vehicle Management:** The audit provided Reasonable Assurance on fleet compliance and the arrangements in place for vehicle maintenance and incident management, with five key findings identified for management action. • **Recruitment and Retention:** The audit provided Substantial Assurance on the adequacy of recruitment and retention arrangements within NWSSP, with no findings identified. • **Capital – Radiopharmacy Phase 2:** The audit provided Reasonable Assurance on progress against plans to deliver the South-East Wales Radiopharmacy Unit, in line with the Audit Plan and approved Business Case. Four medium priority findings were identified for management action. • **Budget Setting:** The audit provided Substantial Assurance on compliance with the NHS Finances (Wales) Act 2014 and the extent to which the NWSSP Integrated Medium Term Plan supports delivery of the financial break-even duty over a three-year period. One key finding was identified for management action. • **Cyber Security Governance Arrangements:** This item was considered during the Part B private session and is therefore not detailed within the public highlight report.
ASSURE	**NWSSP Head of Internal Audit Opinion & Annual Report 2025-26** The Head of Internal Audit presented the 2025–26 Audit Opinion and Annual Report. The report provides assurance that NWSSP has maintained a sound system of internal control and supports the assurances provided to the Managing Director, as Accountable Officer. The opinion is based on the programme of work delivered in accordance with the risk-based Internal Audit Plan, which was presented to and approved by the NWSSP Audit Committee. The overall opinion for 2025–26 was that Reasonable Assurance could be provided.
ASSURE	**Draft 2025-26 NWSSP Annual Governance Statement (AGS)** The Assistant Director of Corporate Services presented the Annual Governance Statement (AGS) for the Audit Committee's consideration and approval. The AGS set out NWSSP's arrangements for governance, risk management and internal control, providing assurance to the Welsh Government, the Shared Services Partnership Committee, Velindre University NHS Trust as the host organisation, and Audit Wales that NWSSP had operated in accordance with established governance and accountability frameworks. The AGS concluded that NWSSP had operated effectively within its governance and accountability arrangements during the reporting period. A significant feature of the statement was its reference to the Welsh Government's Independent Governance and Accountability Review of NWSSP, which concluded that governance arrangements were fundamentally sound while identifying a number of areas for further enhancement. Work to implement the review's recommendations was ongoing through the Working Group established by Welsh Government.

	The Chief Executive Officer of Velindre University NHS Trust advised that he had not yet had the opportunity to review the document and wished to do so to ensure that its wording was clear, concise and accurate, and that any potential ambiguity was avoided. Consequently, it was agreed that approval of the AGS would be progressed by Chair's Action outside the meeting, subject to any agreed amendments being incorporated. The revised AGS was circulated to members on 18 June 2026 and was subsequently approved by Chair's Urgent Action.
INFORM	No items were received for information.
APPENDICES	Not applicable

3.1 FINANCIAL IMPLICATIONS

3.1.1 Not applicable.

3.2 LEGAL IMPLICATIONS

3.2.1 Not applicable

3.3 PEOPLE IMPLICATIONS

3.3.1 Not applicable

3.4 WELSH LANGUAGE IMPLICATIONS

3.4.1 Not applicable

3.5 RISKS / REPUTATIONAL IMPLICATIONS

3.5.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

3.5.2 Not applicable

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 15 June 2026 (Part A).

TRUST BOARD		
Emergency Preparedness, Resilience and Response – Winter Preparedness 2026/27 - Stress Testing		
DATE OF MEETING	24/09/2026	
STATUS	Public	
REPORT AUTHOR	Kate Hannam, Divisional Director of VCS Peter Richardson, Head of Quality, WBS	
PRESENTED BY	Chief Operating Officer	
REPORT SPONSOR	I, **Anne Carey, Chief Operating Officer**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	24/08/2026	Executive Management Board
	The underlying Winter Preparedness Plans have been considered through Executive Management Board. Due to the national timetable, the divisional stress-testing outcomes are presented directly to Trust Board for assurance ahead of submission.	
ONWARD SCRUTINY ROUTE	Board-assured winter planning information will inform the final submission to NHS Wales Performance and Improvement on 25 September 2026. Actions and residual risks will continue through Trust Emergency Preparedness, Resilience and Response governance.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)	
	Reasonable assurance is provided that both divisions have tested key winter resilience scenarios and identified practical mitigations, learning, further actions and residual risks. Further Trust-wide work is required to strengthen escalation, workforce resilience, operational coordination and assurance during 2026/27.	
EXECUTIVE SUMMARY	The accompanying presentation summarises the outcomes of recent stress-testing exercises undertaken by Velindre Cancer Services and Welsh Blood Service following development of their Winter Preparedness Plans. The exercises considered likely demand and extreme-pressure conditions and were undertaken to guide the Trust approach to Emergency Preparedness, Resilience and Response (EPRR) during 2026/27. The testing demonstrated that established response arrangements supported service continuity, while identifying opportunities to strengthen command and escalation, workforce resilience, patient flow, mutual aid, adverse-	

	weather logistics, infection prevention and consistent Trust-wide oversight.
ACTION / DECISION	Receive and note the divisional stress-testing outcomes, actions and residual risks set out in Appendix 1. • Take reasonable assurance on divisional preparedness for likely demand and extreme-pressure scenarios. • Support the proposed Trust-wide priorities for EPRR development and winter resilience during 2026/27. • Note that the Board-assured information will support the national submission due on 25 September 2026.
ADDITIONAL RESOURCES	None – slides for each divisions' stress testing exercises are included as appendices.

RELEVANT TRUST STRATEGIC GOALS
This report addresses the following goal(s) within the Trust's strategic plan:

- Outstanding for quality, safety, and experience
- A sustainable organisation that plays its part in creating a better future for people across the globe

RELEVANT TRUST WELLBEING GOALS
This report addresses the following wellbeing goal(s):

- A Resilient Wales
- A Healthier Wales
- A globally responsible Wales

QUALITY AND SAFETY IMPLICATIONS
This report impacts one or more of the following Six Domains of Quality:

[Delete as appropriate and then remove this paragraph]

- Safe
- Timely
- Efficient
- Effective
- Patient Centred

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision

EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)

Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	WBS - EPRR Winter Preparation and Testing
	Appendix 2	VCS - EPRR Winter Preparation and Testing

APPENDIX 1 – KEY CONSIDERATIONS

1. **SITUATION**

1.1 NHS Wales requested organisations to undertake local stress testing against a likely demand scenario and an extreme-pressure scenario. This paper presents the outcomes from both Trust divisions for Board assurance and describes how the learning will guide the Trust approach to EPRR in 2026/27.

2. **BACKGROUND**

2.1 Velindre Cancer Services (VCS) and Welsh Blood Service (WBS) developed Winter Preparedness Plans for anticipated pressures and demand fluctuations. Local exercises and recent operational incidents were used to test core resilience and recovery arrangements, identify learning and improvements, and summarise actions and residual risks. The accompanying presentation brings the divisional outcomes together for Board oversight.

3. **MATTERS FOR CONSIDERATION**

The Board is invited to consider the strength of current divisional arrangements, the learning identified through testing, the residual risks that require continued oversight, and the proposed areas for Trust-wide development.

3.1 ASSESSMENT

3.1.1 VCS tested demand exceeding acute oncology inpatient capacity and workforce constraints affecting safe staffing. Mitigations included enhanced senior triage, safety huddles, consultant-led reviews, alternative pathways, active patient-flow management, temporary staffing, redeployment, workload prioritisation and skill-mix review. The workforce scenario indicated that mitigating actions maintained clinical activity and patient outcomes. Learning identified the need for clearer Trust-wide command, routine site coordination, improved bank and agency arrangements, a Trust-wide OPEL framework, and a patient-flow and full-capacity protocol.

WBS used recent business continuity incidents affecting the blood supply chain and red cell immuno-haematology service to test resilience. Blood stocks recovered following operational controls and active oversight, and red cell testing remained within target times during significant staff shortages. Residual risks relate to workforce resilience, temperature-controlled collection venues and the availability of mutual aid during national pressure.

Across both divisions, priority themes are consistent escalation and command arrangements, workforce resilience, operational readiness, adverse-weather logistics, infection prevention and control, joint exercising, and continued governance of actions and residual risks.

3.2 FINANCIAL IMPLICATIONS

3.2.1 No additional funding is requested through this paper. Some improvement actions or resilience options may require separate assessment and approval through established planning and business-case processes.

3.3 LEGAL IMPLICATIONS

3.3.1 No specific legal implications have been identified from this assurance report. The work supports the Trust's responsibilities for emergency preparedness, resilience, business continuity and safe service delivery.

3.4 PEOPLE IMPLICATIONS

3.4.1 The exercises highlighted workforce availability, specialist skill resilience, bank and agency arrangements, redeployment, overtime, vaccination and cross-organisational support as key considerations. Any changes to workforce arrangements will be progressed through the appropriate governance and engagement routes.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 No specific Welsh language implications have been identified from this assurance report. Communications and service arrangements arising from EPRR actions should continue to comply with the Trust's Welsh language duties.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

Residual operational risks include workforce capacity and specialist skills, acute oncology demand and patient flow, temperature control at collection venues, adverse-weather access, limited mutual-aid capacity during national pressure, and the need for consistent Trust-wide escalation and situational oversight. Failure to address identified learning could affect service continuity, patient safety, stakeholder confidence and the Trust's ability to demonstrate assurance.

3.6.1 **Relevant Strategic Risk - Board Assurance Framework (BAF)**

Not Applicable

Operational Risks

The presentation identifies residual operational risks and mitigations. Specific risks will continue to be managed and reported through divisional and Trust risk processes.

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to receive and note the stress-testing outcomes; take reasonable assurance on divisional preparedness; support the Trust-wide priorities identified for 2026/27; and note the onward national submission timetable.

VCS Business Continuity Stress Testing / Winter Preparation September 2026

Mark David, Head of Operations, EPRR lead
Emma Mitchell, Head of Nursing, Acute, IP & Palliative
Kate Hannam, Divisional Director of Velindre Cancer Services

Winter Planning – VCS

- VCS has been the subject of Business Continuity (stress testing) during August 2026. This has tested our core resilience and recovery arrangements, has identified learning and improvements and helps provide assurance that our services remain resilient.
- Business Continuity plans are in place to deal with anticipated winter pressures and fluctuations in demand. These plans have been recently reviewed as part of an external review of the EPRR arrangements within the service by NWSSP
- Business Impact Assessments have been completed by all departments, and additional supporting plans have been developed which include:
  - Hire of 4x4 vehicles to support the fleet in adverse weather
  - Active promotion of Flu vaccinations – especially for all staff
- The Trust has plans in place to respond to adverse weather which are in addition to local service based plans – estates, digital, workforce etc.

Stress Test – Winter Preparedness

Two scenarios have been stress tested locally for VCS as part of winter preparedness. These scenarios have focused on our acute oncology service – this service includes the following provision : telephone helpline; SDEC; Ambulatory Care/Day Unit; Assessment Unit and IP ward.

Scenario 1 – demand exceeds capacity for our acute oncology IP service

Scenario 2 – workforce constraints on our IP service due to unforeseen adverse situations (flu, adverse weather etc)

Scenario 1 –

Demand exceeding the capacity available within the acute oncology setting at VCS

Context *- Capacity within the acute oncology ward is balanced during business as usual, with an average occupancy which provides headroom to manage fluctuations in demand sufficiently.*

Scenario 1 *tested the acute service response if demand did exceed the available capacity during the winter period with the following actions to manage this demand through the use of the: treatment helpline; the AMOU and Patient flow management on the IP ward as highlighted below:*

Clinical management of patients within Treatment Helpline

- Enhanced senior decision making on the telephone helpline to support triage and risk-based treatment plans supporting patients to be managed at home with wrap around support from local teams and utilisation of community/virtual pathways where clinically safe to do so
- Review of planned day case activity and opportunities for this to be delivered elsewhere or delayed- possibility of increasing weekend activity to support any backlog this creates.
- Sign post patients to alternative support where clinically appropriate – primary care; community response teams etc
- Enhance consultant connect and SOS treatment helplines direct with HB to support patient management within local healthcare setting.

Clinical management of patients within AMOU

- Additional safety huddle to co-ordinate response led by Head of Nursing and Clinical Director
- Consultant led review of all patients currently within the Unit requiring admission, and whether these can be managed on an alternative pathway.
- Review opportunity of additional hot clinics/virtual ward capacity to allow admission avoidance or early discharge.
- Escalate delays impacting on discharge or patient pathways – diagnostics, repatriations etc
- Admission threshold into the service, where possible consider the use of virtual assessments/hot clinics/SDEC services/primary care.

Optimal Patient Flow on the ward

- Additional safety huddles to co-ordinate response led by Head of Nursing and Clinical Director – full MDT in attendance
- Consultant led review of all patients on the ward with escalation to the wider MDT about capacity constraints and the requirement to review discharge threshold, utilising primary care services/hot clinics/planned OPA to follow up patients.
- Escalation of any delays to discharge to the directorate senior leadership team – diagnostics, pharmacy, repatriations, SST decision making, transport etc
- Review of SACT delivery on the ward and to risk assess if required as inpatient or can be delivered within the SACT units.
- Review planned care such as PRRT and brachytherapy
- Identify surge capacity within the service, if all opportunities to release capacity is not sufficient.
- Risk based decisions on any closed capacity for IPC reasons.

Scenario 2 –

Workforce constraints – unsafe staffing levels

A scenario was tested over the summer utilising the adverse weather SOP – the issue tested concerned the risk to being able to staff the acute setting safely due to a reduction in nurse staff levels by 30% over the week causing increase demands on acute oncology service.

Processes Affected:

- Providing care to patients requiring services from the Acute Medical Oncology Unit. This includes the acutely unwell patient requiring SDEC/Assessment and urgent care within the ambulatory Unit.
- Providing inpatient care to up to 30 patients within the first-floor ward.

The lessons from this have been used to inform the winter preparedness assurance associated with workforce constraints

Risk	Mitigations stress tested
Staff absence rates remain higher than normal and are expected to remain for the next couple of weeks.	Utilisation of temporary workforce through bank, agency or requesting staff to work overtime where appropriate actioned.
	Full review of staffing levels across the site, risk-based decisions made on the redeployment of staff from other areas to balance the risk across the service.
	Ensured that all staff management days / time, study leave, personal development time, and non-clinical duties are considered and where possible paused.
	Risk based decisions made on delaying elements of the workload/tasks, as an example weekly patient assessments.
	Skill mix review completed, and utilisation of other staff groups to support, such as pharmacy completing medication routine checks instead of nursing team.
	Assessed whether assistance is required from corporate nursing colleagues.
	MDT's made aware, and through board round and ward round ensuring patients are reviewed with a discharge home approach when clinically safe to do so, to support the reduction of inpatients within the ward.

Outcome

- As a result of the mitigating actions taken staff reductions didn't impact on clinical activities or patient outcomes.
- VCS established a Silver incident group – formal meetings in place, actions logged and escalated to Division and Trust through sit reps and lessons learned undertaken

Learning

- The requirement for Trust wide leadership during periods of escalation.
- The requirement of a business-as-usual site wide 'safe to start' style meeting to be introduced to strengthen and coordinate local ownership, governance and comms
- Review of bank process required and the governance process around utilising agency for registered and unregistered workforce.
- Resilience in the nurse bank being just a Velindre nurse bank and therefore restricted the ability to cover shifts, exploration of an All-Wales Bank system

Recommendations

- **Review of current escalation process and required leadership at bronze, silver, gold meetings.**
- **Review of bank/agency systems and processes – locally and Nationally.**
- **Development and implementation of Trust wide OPEL system** - The Trust currently does not have a framework such as OPEL to oversee the operational and clinical activities across the Trust. This is a recognised gap, and the COO has instigated discussions to develop the framework for Velindre.
- VCS are currently developing a **local Patient Flow SOP,** which will enable a Trust wide OPEL framework to be built on – due for completion in December 2026.
- **Implementation of safety huddles/site meetings at VCS** – these are included as part of the Patient Flow SOP and are due to be tested in October within the acute oncology directorate before full roll out across the Divisional Services – due for completion November 2026.
- **Full capacity protocol** – to be included within the Patient Flow SOP – risk assessed additional capacity for surges in demand:
  - There is no capacity within first floor ward for additional patients to be placed due to the environment constraints.
  - Surge capacity would need to be held within the AMOU, this may include remaining open overnight. This could be up to 6 inpatients and would require an additional workforce to support these patients.

    Nursing workforce: By day managed within the current assessment unit staffing and by night would require 2 RN's (breaks covered by ffw)

    Medical workforce: Process in place to ensure they have been post-taked and have a medical plan, with a consultant review the following morning. Current resident medical teams from the ward and assessment unit would be able to manage the additional patients.

Welsh Blood Service Business Continuity Stress Testing - Winter Preparation 2026/27

Peter Richardson, Head of Quality & Safety, WBS

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

Core transfusion services

The Welsh Blood Service provides two core services to support blood transfusion across Wales:

Collection and supply

Donated blood components

Specialist services

Red cell immuno-haematology services

RESILIENCE ASSURANCE

Both services experienced Business Continuity incidents during July and August 2026. These incidents stress-tested core resilience and recovery arrangements, identified learning and improvements, and provided assurance that services remain resilient across Wales.

Blood supply chain

Business Continuity response triggered on 13 July 2026

Exceptionally hot weather, high staff sickness and higher-than-forecast red cell demand led to a sustained drop in blood stock levels.

Actions taken

- Brought forward labelling and release of in-process blood.
- Issued a pre-amber alert requesting hospitals temporarily reduce stock levels by 10%.
- Reviewed donation session locations for temperature-control risk and moved sessions to lower-risk venues.
- Prioritised venues with capacity for more donation chairs.
- Planned additional weekend donation sessions.
- Issued donor communications explaining the difficulties and encouraging re-booking.

Blood supply chain

Outcome and recovery

Stocks recovered

Blood stocks rose consistently over the following two weeks.

Active oversight

The WBS BC/EP group met regularly to monitor the situation.

Response stood down

BC/EP measures were stood down and the national blood shortage plan Pre-Amber alert was removed on 30 July 2026.

WINTER READINESS

Blood stock levels continued to grow through August and September, as planned in preparation for the Christmas period.

Red cell immuno-haematology (RCI)

Significant staff shortage reported on 26 August 2026

Seven Biomedical Scientists were absent due to sickness, including two senior staff. This substantially reduced the number of fully trained and competent staff available for the full range of RCI testing. The illness appeared linked to a possible Influenza A outbreak within the department.

Actions taken

- Identified staff in other WBS departments who could support RCI.
- Alerted Hospital Transfusion Laboratories and sought support to prioritise tests by clinical need.
- Alerted NHSBT to the situation and potential need for laboratory support under mutual aid arrangements.
- Sought further IPC advice on limiting the spread of infection.

Red cell immuno-haematology (RCI)

Outcome

2 days

Staff shortages continued

100%

Testing completed within target times

1 Sept

Return to service as usual communicated

- One staff member returned on 28 August; the remaining staff returned the following week.
- NHSBT confirmed support was available for high-priority urgent testing, although capacity would be limited.
- Hospital Transfusion Laboratories were informed of a return to service as usual on 1 September 2026.

Residual risks and mitigations

Workforce resilience

Absence rates remain higher than normal and were expected to remain so throughout September. Overtime clinics were identified as an option, and a task and finish group was established to consider further interventions and ascertain the root cause of high sickness rates.

Temperature control

Each collection venue is risk-assessed for suitability during exceptionally hot or cold weather. More suitable venues are being sought, and investment in a fixed collection clinic in North Wales would provide additional resilience.

Mutual aid capacity

Other UK services may have limited ability to provide mutual aid during periods of national stress. Early engagement with UK blood services is therefore essential.

Winter planning

Established arrangements for anticipated pressures and demand fluctuations

Daily resilience

Review blood supply operations and monitor demand fluctuations.

Clinic continuity

Backup clinic plans for access or temperature-control issues.

Adverse weather

Hire of 4x4 vehicles to support the fleet.

Workforce health

Active promotion of flu vaccination, especially for donor-facing staff.

Shortage response

Nationally agreed blood and platelet shortage plan available for invocation.

Mutual aid

Formal arrangements across UK blood services in times of crisis.