

Public Trust Board

Thu 26 March 2026, 10:00 - 13:00

Trust Headquarters, Nantgarw / Teams

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

Sara Moseley, Chair

1.1. Welcome and Apologies

Sara Moseley, Chair

1.2. In Attendance

Sara Moseley, Chair

1.3. Declarations of Interest

Sara Moseley, Chair

1.4. Minutes of the Public Trust Board meeting held on 29th January 2026

Sara Moseley, Chair

 1.4.0 DRAFT Public Trust Board minutes 29.01.2026 (v3SM).pdf (12 pages)

1.5. Public Action Log

Sara Moseley, Chair

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

1.6. Matters Arising

Sara Moseley, Chair

1.6.1. Fire Safety Training Compliance Improvement Plan

Lauren Fear, Director of Place, Portfolio and Partnerships

 1.6.1 Addendum Fire Safety Training - March Trust Board cover.pdf (5 pages)

 1.6.1a Matters Arising Fire Training addendum v.final.pdf (3 pages)

10:15 - 10:30
15 min

2. STAFF STORY

Alison Roberts, Senior Clinic Nurse, Wrexham

*To be shared on the day.

10:30 - 10:40
10 min

3. KEY REPORTS

3.1. Chair's Report

Sara Moseley, Chair

 3.1.0 Chair's update Trust Board 03.26 v1.pdf (8 pages)

3.2. Chief Executive's Update

Carl James, Chief Executive Officer (interim)

 3.2.0 CEO's Update Trust Board 260326 v1.pdf (6 pages)

10:40 - 11:20
40 min

4. QUALITY, SAFETY & PERFORMANCE

4.1. Performance Management Framework (January 2026)

Carl James, Chief Executive Officer (interim), Anne Carey, Chief Operating Officer, Sarah Jenkins, Executive Director OD & Workforce, Carl Taylor, Chief Digital Officer, Lauren Fear, Director of Place, Portfolio & Partnerships and Matthew Bunce, Executive Director of Finance

 4.1.0 Trust Board JAN PMF Data 2025 PowerPoint FINAL version 021.pdf (45 pages)

 41.0a Month 10 Finance Report Cover Paper - Trust Board 26.03.26.pdf (14 pages)

 4.1.0b Appendix 1 - M10 VELINDRE UNHS TRUST FINANCIAL POSITION TO JAN - Trust Board 26.03.26.pdf (36 pages)

 4.1.0c Appendix 2 - nVCC Project Finance Paper (Jan 26) FINAL.pdf (16 pages)

4.2. Trust Risk Register

Non Gwilym, Director of Corporate Governance (interim)

 4.2.0 Public TRR Cover Paper - TB - March 2026 - V02.pdf (9 pages)

 4.2.0a Public TRR Appendix - TB - MARCH 2026 - V02.pdf (6 pages)

4.3. Board Assurance Framework

Non Gwilym, Director of Corporate Governance (interim)

 BAF Cover Paper - TB- March -2026 V02.pdf (10 pages)

 BAF Overview March 2026 -TB -V02.pdf (7 pages)

 BAF 01 - SERVICE CAPACITY- V04.pdf (7 pages)

 BAF 02 - QUALITY -final.pdf (5 pages)

 BAF 03 - RDI -V03.pdf (7 pages)

 BAF 04 - UNIVERSITY STATUS.pdf (3 pages)

 BAF 05 - SUSTAINABILITY V04.pdf (4 pages)

 BAF 06 -CULTURE.pdf (5 pages)

 BAF 07 - DIGITAL.pdf (5 pages)

 BAF 08 - GOVERNANCE.pdf (5 pages)

 BAF 09 - FINANCE.pdf (15 pages)

 BAF 10 - PORTFOLIO.pdf (4 pages)

 BAF11 - WORKFORCE.pdf (7 pages)

11:20 - 11:30
10 min

COMFORT BREAK

11:30 - 12:25
55 min

5. ORGANISATIONAL DEVELOPMENT

5.1. Embedding the Donor & Patient Voice Across Velindre University NHS Trust Improvement

Chris Kelly, Deputy Head of Quality & Safety

 5.1.0 Trust Board Embedding the patient donor voice cover paper.pdf (4 pages)

 5.1.0a Appendix 1- Strengthening Donor Patient Carer Voice.pdf (9 pages)

5.2. Organisational Culture: Milestones

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

 5.2.0 2026 03 19 Organisational Culture Milestones report Board 26.3.26 (2).pdf (8 pages)

 5.2.0a 2026 03 30 Appendix 1 Culture Milestone Plan 26.3.26 (6) FINAL.pdf (29 pages)

- 📄 5.2.0b 2026 01 23 Trust Board - Culture Inclusion paper with cultural baseline.pdf (8 pages)
- 📄 5.2.0c 2026 01 06 Appendix 1 Culture Inclusion paper QSP.pdf (21 pages)
- 📄 5.2.0d Appendix 2 Culture & Inclusion Paper- Culture Baseline.pdf (17 pages)

5.3. Staff Survey 2025

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

- 📄 5.3.0 Trust Board NHS Staff Survey 2025 26.3.26.pdf (15 pages)
- 📄 5.3.0a Appendix 1 VUNHST Staff Survey Report 2025 25.2.26.pdf (36 pages)

5.4. Board Committee Structure

Non Gwilym, Director of Corporate Governance (interim)

- 📄 5.4.0 Board Committee Structure March 2026 v2.pdf (7 pages)

5.5. IMTP 2026/27 – 2028/29

Carl James, Chief Executive Officer (interim)

- 📄 5.5.0 Trust Board 26 03 2026 IMTP 2026 29 Cover Paper .pdf (5 pages)
- 📄 5.5.0a Trust Board 26 03 2026 IMTP Final Plan.pdf (212 pages)
- 📄 5.5.0b QIA IMTP 2026-2029 Beta 2.1 version.pdf (7 pages)

12:25 - 12:45
20 min

6. HOSTED SERVICES

6.1. Health Technology Wales (HTW) Strategic Plan

Susan Myles, Director, Health Technology Wales

- 📄 6.1.0 20260226-Strategic-Plan-2026-2030-v18.pdf (9 pages)

6.2. NHS Wales Shared Services Partnership – IMTP 2026-2029

Rebecca Nelson, Director of Planning, Performance & Informatics and Alison Ramsey, Director of Finance & Corporate Services (NWSSP)

- 📄 6.2.0 NWSSP Integrated Medium-Term Plan 2026-29 for Velindre Trust Board.pdf (15 pages)
- 📄 6.2.0a NWSSP Integrated Medium-Term Plan 2026 - 2029(V12).pdf (129 pages)

12:45 - 12:50
5 min

7. COMMITTEE HIGHLIGHTS FOR DISCUSSION

7.1. Public Charitable Funds Committee Highlight Report (10/03/2026)

Sara Moseley, Chair and Chair of the Charitable Funds Committee

- 📄 7.1.0 Highlight Report PUBLIC CFC 10 March.pdf (4 pages)

12:50 - 12:55
5 min

8. CONSENT ITEMS FOR APPROVAL

Sara Moseley, Chair

8.1. Trust Policies for Approval

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

- All Wales Reserve Forces Training and Mobilisation Policy

- 📄 8.1.0 Trust Board Cover Paper_All Wales Reserve Forces Training and Mobilisation Policy_26.03.26.pdf (6 pages)
- 📄 8.1.0a 11_2025 NHS Wales Reserve Forces Training and Mobilisation Policy.pdf (11 pages)

8.2. Microsoft Enterprise Agreement – Strategic Case

Carl James, CEO (interim)

 8.2.0 20260317 Microsoft Enterprise Agreement PUBLIC Trust Board v3.0 Update_STRATEGIC CASE.pdf (7 pages)

8.3. Chair's Urgent Actions

Non Gwilym, Director of Corporate Governance (interim)

 8.3.0 PUBLIC Chairs Urgent Action Report MAR 2026 v1.pdf (4 pages)

8.4. NWSSP Commitments of Expenditure

Led by Alison Ramsey, Director of Finance and Corporate Services

- All Wales e-Rostering Solution
- NHS Resolution Service Level Agreement provided by the NHS Litigation Authority
- General Medical Services (GMS) Payments System

 8.4.0a Velindre Trust Board M&D e-Rostering CP March 2026.pdf (8 pages)

 8.4.0b Appendix 1 - Commitment of Expenditure - MD e-Rostering March 2026.pdf (9 pages)

 8.4.0c Appendix 2 - Quality Impact Assessment M&D e-Rostering March 2026.pdf (7 pages)

 8.4.0d NHS Resolution SLA CP March 2026.pdf (7 pages)

 8.4.0e - Commitment of Expenditure Form.pdf (7 pages)

 8.4.0f - Quality Impact Assessment NHS Resolution SLA.pdf (5 pages)

 8.4.0g (GMS) Payments System CP March 2026.pdf (8 pages)

 8.4.0h Commitment of Expenditure Form.pdf (8 pages)

 8.4.0i Quality Impact Assessment.pdf (5 pages)

8.5. Amendment to NWSSP Standing Orders

James Quance, Assistant Director of Corporate Services, NWSSP

 8.5.0a Annexe 5 revisions March 2026 Final.pdf (4 pages)

 8.5.0 Velindre Trust Board Amendment to SSPC Standing Orders March 2026.pdf (8 pages)

12:55 - 13:00

5 min

9. CONSENT FOR NOTING

Sara Moseley, Chair

9.1. Trust Seal Report

Non Gwilym, Director of Corporate Governance (Interim)

 9.1.0 Trust Seal Report 24.01.2026-20.03.2026.pdf (4 pages)

9.2. Public Quality, Safety & Performance Committee Highlight Report (12/03/2026) – including Q3 Integrated Quality and Safety Report

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

 9.2.0 Public QSP Highlight Report 12th March 2026 (NW)(VM).pdf (10 pages)

 9.2.0a Appendix 1 - QUARTER 3 2025-26 Integrated Q&S Report QSP.pdf (67 pages)

9.3. Public nVCC Project Scrutiny Sub-Committee Highlight Report (22/01/2026)

Hilary Jones, Independent Member and Chair of the nVCC Project Sub-Committee

 9.3.0 Trust Board PUBLIC nVCC PROJECT SCRUTINY SUB-COMMITTEE HIGHLIGHT REPORT Jan.2026.pdf (4 pages)

9.4. Public Strategic Development Committee Highlight Report (04/11/2025)

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

 9.4.0 TRUST BOARD PUBLIC SDC HIGHLIGHT REPORT 04.11.2025 v1.pdf (9 pages)

9.5. Public Audit Committee Highlight Report (03/03/2026)

📄 9.5.0 Highlight Report Public Audit Committee 3 March 2026 final.pdf (4 pages)

9.6. Trust-wide policy approvals update

Non Gwilym, Director of Corporate Governance (interim)

- 📄 9.6.0 TRUST WIDE POLICIES APPROVED UPDATE MAR 2026.pdf (4 pages)
- 📄 9.6.0a APPENDIX 1 IG15 VUNHST Bring Your Own Device (BYOD) Policy v1_MAR 26.pdf (8 pages)
- 📄 9.6.0b APPENDIX 2 IG16 Artificial Intelligence (AI) Policy v1 MAR 26.pdf (14 pages)
- 📄 9.6.0c APPENDIX 3 IPC03 ANTT Policy-Procedure V1.pdf (32 pages)
- 📄 9.6.0d APPENDIX 4 PP04 Asbestos Policy_v3_MAR 25.pdf (6 pages)
- 📄 9.6.0e APPENDIX 5 PP09 Water Safety Policy and Appendices_v3_MAR 26.pdf (16 pages)
- 📄 9.6.0f APPENDIX 6 QS02 Safety Alerts and Important Notification Procedure v5_MAR 26.pdf (10 pages)
- 📄 9.6.0g APPENDIX 7 QS18 Health Safety and Welfare Policy v9_MAR 26.pdf (11 pages)

9.7. Shared Services Partnership Committee Assurance Report (22/01/2026)

Non Gwilym, Director of Corporate Governance (interim)

- 📄 9.7.0 Shared Services Partnership Committee (SSPC) Assurance Report of 22 January 2026.pdf (10 pages)

9.8. NHS Wales Shared Services Audit Committee Highlight Report (10/02/2026)

Non Gwilym, Director of Corporate Governance (interim)

- 📄 9.8.0 NWSSP Audit Committee Highlight Report 10 February 2026.pdf (8 pages)

9.9. Joint Commissioning Committee Highlight Report (27/01/2026)

Non Gwilym, Director of Corporate Governance (interim)

- 📄 9.9.0 JC Highlight Report - 27 Jan 2026.pdf (5 pages)

9.10. Strategic Partnership Update

Lauren Fear, Director of Place, Portfolio and Partnerships

- 📄 9.10.0 Strategic Partnerships Update - Trust Board - March 26.pdf (6 pages)

9.11. Anti-Racist Wales Action Plan Progress Report

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

- 📄 9.11.0 Trust Board Anti-racist Action Plan report 26.3.26.pdf (9 pages)
- 📄 9.11.0a Appendix 1 Anti racist progress 13.3.26.pdf (10 pages)
- 📄 9.11.0b Appendix 2 VUNHST WRES Report June 2025.pdf (15 pages)

13:00 - 13:00 10. ANY OTHER BUSINESS

0 min

Sara Moseley, Chair

*Prior approval required by Chair

13:00 - 13:00 11. DATE OF NEXT MEETING

0 min

The next meeting will be held on 21st May 2026 @ 10:00

13:00 - 13:00 12. CLOSE

0 min

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

13. ITEMS FOR DISCUSSION IN PART B

- Minutes of the previous meeting
- Action log
- NHS Wales Microsoft Enterprise Agreement – Full business Case
- Readiness Master Plan
- Private Trust Risk Register
- Lineofsight Board Development Programme
- NWSSP update
- Scheme of Delegation – nVCC
- nVCC Construction Programme
- IRS Change in Machine Configuration to be installed at nVCC
- Chairs Urgent Actions
- Commitments of Expenditure Exceeding CEO Limit
- NWSSP items for approval
- Private Committee Highlight Reports

**MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
29th January 2026 – 11:30am-2:30pm**

PRESENT Sara Moseley Gareth Jones Prof. Andrew Westwell Vicky Morris Hilary Jones John Union Carl James Matthew Bunce Dr Jacinta Abraham Sarah Jenkins ATTENDEES Anne Carey Lauren Fear Non Gwilym Carl Taylor Kyle Page	Chair Independent Member Independent Member Independent Member Independent Member (remotely) Independent Member Chief Executive Officer (interim) Executive Director of Finance Executive Medical Director / Deputy Chief Executive Executive Director of People and Organisational Development (interim) Chief Operating Officer Director of Place, Portfolio and Partnerships Director of Corporate Governance (interim) Chief Digital Officer 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: • Lindsay Foyster, Vice Chair • Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science • Ceri Doyle, Independent Member • Katrina Febry, Audit Lead, Audit Wales **Gareth Jones joined the meeting at 11:45am due to travel issues.	
1.2.0	In Attendance: The Chair extended a warm welcome to the following additional attendees: • Bethan Davis, Simultaneous Welsh Translation • Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience (deputising for Nicola Williams) • David Cogan, Chair of Patient and Carer Partnership Board • Ben Leijokari-Olosunde, Aspiring Board Members Programme Member • Alison Ramsey, Director of Finance and Corporate Services, NWSSP, (for item 6.2.0 if required)	
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 27th November 2025 The Trust Board was content that the minutes of the meeting held on the 27 th November 2025 were an accurate reflection of proceedings.	
1.5.0	Action Log The Board was content to close the six actions marked as 'propose to close'. Non Gwilym advised the following in relation to the remaining open action (Revisions to Schedule 2 of Trust Standing Orders (item 7.1.4 – 23.05.2024)) : This has been incorporated into a wider piece of work which is already underway, suggesting that it may be appropriate to close the action at this point. The related Terms of Reference are currently being reviewed. While progress has been made, the work is not yet fully complete and a revised version will return to Board. The Trust Board was content to close the action on this basis and Non Gwilym agreed to update the note in the log.	NG
1.6.0	Matters Arising Led by Sara Moseley, Chair	
	There were no matters arising for discussion at today's meeting.	
2.0.0	REFLECTIONS	
2.1.0	David Cogan, Chair of Patient & Carer Partnership Board David Cogan reflected on the work and development of the Patient and Carer Partnership Board, focusing on what had gone well, what had not gone so well, and the opportunities ahead. The following key points were raised: What had gone well • The Patient and Carer Partnership Board has been operating for approximately 18 months. Membership confidence has grown, and the Board now has a waiting list, indicating increased awareness and credibility across the Trust. • The Board is becoming embedded earlier in service development, an example being robust engagement with the Pharmacy team on their five-year strategy. • Progress has been made on initiatives such as listening posts within Velindre to hear directly from current patients. • Partnership Board members are increasingly involved in Trust activities, including attendance at Trust Board and Charitable Funds meetings. What had not gone so well • The Board has not yet reached its target membership (7 members rather than 12), and diversity remains limited. • Patient representatives do not yet have a seat at all key decision-making tables, which limits their influence. • Structural changes and leadership turnover within the organisation have slowed progress and created uncertainty. • Patient involvement is sometimes treated as a "tick-box exercise", with engagement occurring too late in decision-making.	

	- There is no clear organisational "home", strategy, or accountability lead for patient engagement, making escalation and coordination difficult. Opportunities and asks of the Trust Board: - David proposed using a Trust Board Development Day to hold a strategic discussion on patient engagement and involvement. - Clarification regarding (1) who "the patient" is (current, former, future), (2) how patient voice should influence decisions and (3) where accountability for patient engagement sits. - A requirement for better infrastructure and support, including administrative support and emotional support for patient representatives. - The importance of embedding patient representation in recruitment panels, key committees, and prioritisation of change programmes. The Partnership Board should be patient-led, as opposed to adapting to existing organisational structures. Board members considered the following issues: - The need for a single point of accountability for patient and carer engagement, to enable escalation and coordinated progress. - Resources required to support the Patient and Carer Partnership Board - The location of the Board which is currently outside the Trust's formal structures - How the Trust ensures appropriate support and wellbeing arrangements are in place for members of the Patient and Carer Partnership Board, particularly when undertaking listening and engagement activities that may be emotionally challenging. The Trust Board NOTED the update.	
3.0.0	KEY REPORTS	
3.1.0	Chair's Report Sara Moseley, Chair The Chair took her report as read and added the following updates: - The Chair's annual appraisal with the Cabinet Secretary had been scheduled for the 2nd March 2026, and details of what is expected would be shared once the documentation had been received. Finalising Independent Members' objectives would follow. - NWSSP governance and accountability work was progressing with the establishment by Welsh Government of a group to oversee implementation of the recommendations arising from its review. Colleagues from Velindre and the Shared Services Partnership are working together to prioritise recommendations, and distinguishing what sits primarily with Velindre, with the Shared Services Partnership, and with Welsh Government. - The recent Performance Accountability meeting had been an intense but constructive process. The Trust had presented strongly as a team, demonstrating a clear understanding of risks, strengths and ambitions. The Trust Board NOTED the content of the Chair's update.	
3.2.0	Chief Executive's Report Carl James, Chief Executive Officer (interim)	

	Carl James indicated a busy, enjoyable period for the Trust, highlighting the following: • The signing of the Blood Establishment Computer System (BECS) contract, which is significant in terms of supporting a reliable blood supply across Wales and enabling future service transformation. • A positive Performance Accountability Meeting. • Emerging strategic themes from recent activity, such as the Trust's future ambition and direction, the importance of effective leadership and culture and the need for agility and governance to support delivery. The 'Readiness Board' had been established to bring together building commissioning, clinical readiness and service transformation, ensuring the move into the new Cancer Centre. Lauren Fear explained that the Readiness Board is being supported by work to clarify reporting lines and governance arrangements, ensuring clear Board-level assurance. "Readiness" includes support services such as estates and commercial arrangements, and she highlighted the importance of Board oversight and training in relation to future service payments for the new Cancer Centre. It was agreed that a Readiness master plan setting out key milestones, risks, impacts and outcomes would be brought to the March meeting of the Trust Board. It was also agreed to keep the Board sighted on any strategic or operational sticking points that may require Board-level focus or intervention. The Trust Board NOTED the Chief Executive's update.	LF
4.0.0	QUALITY, SAFETY & PERFORMANCE	
4.1.0	Performance Management Framework (PMF) (November 2025) Carl James, Chief Executive Officer (interim), Anne Carey, Chief Operating Officer, Sarah Jenkins, Interim Executive Director of People & Organisational Development, Carl Taylor, Chief Digital Officer, Lauren Fear, Director of Place, Portfolio and Partnerships and Matthew Bunce, Executive Director of Finance The report provided the Board with a detailed analysis of all Performance Management Framework Key Performance Indicators (KPIs) and key issues for the attention of the Board for the month of November 2025. The following was highlighted: • The PMF has continued to evolve, with changes made over recent months to better reflect service complexity and national changes. • Cancer clinical standards have been revised nationally, including greater categorisation of patient groups, and the PMF is being adapted accordingly. • Velindre treats around 200 SCP (Single Cancer Pathway) patients per month where it provides the first definitive treatment. Work is underway to separate SCP patients from other treatment cohorts in reporting, to improve visibility and accountability. Board members raised the following: • The requirement for clearer articulation of actions being taken where performance is below target, particularly in Radiotherapy, symptom control and areas affected by workforce shortages. It was highlighted that some challenges relate to capacity and booking processes, with mitigation actions including process review, automation, and workforce planning.	

	• The importance of clarity and consistency in assurance ratings, noting that changes in assurance status should clearly indicate whether movement is recent or historic. • That the PMF was recognised as improving, but members emphasised the need for clearer links between performance, risk and action and continued refinement to ensure greater clarity of narrative and continued refinement to ensure the Framework remains accessible and meaningful at Board level. • In relation to the SACT performance position, they asked which workforce roles were contributing to the pressure, what actions were in place to address this, and where the organisation was with recruitment and mitigation. Anne Carey advised that the main issue affecting SACT performance relates to booking capacity and that a process review is underway to understand and address bottlenecks, removing non-specialist tasks from the booking team to allow them to focus on their expertise. Workforce planning is also supporting to stabilise and strengthen the team. • Whether Radiotherapy performance data includes both Velindre and the satellite service at Nevill Hall, and whether there was value in separating the performance to understand differences. Anne Carey advised that Radiotherapy performance data presented to the Board includes both Velindre and the satellite service as a single service review. However, the data is separated and reviewed locally to understand differences between sites. • In terms of closure of incidents within the Welsh Blood Service, that the report referenced improved performance linked to the recruitment of a lead nurse. It was queried why the incident review (and closure) had been dependent on recruiting a Lead Nurse, given the number of experienced clinical professionals already working within WBS and whether opportunities had existed for existing clinical staff to step into a leadership or oversight role for incident management in the interim. It was advised that WBS incidents are already managed through the quality team and that the Lead Nurse role was intended to provide additional senior leadership to align with quality and safety governance, rather than being the sole driver for incident closure. • That the reported percentage of patients rating their experience as positive is 96%. It was queried how many patient responses this figure was based on. Tina Jenkins advised that while exact response numbers were not readily available, these could be provided in the Quality report going forward. • The recurring nature of sickness absence within the PMF, which remains consistently high beyond winter pressures. It was queried what actions are in place to drive improvement. Sarah Jenkins advised that sickness absence is being addressed through a proactive and targeted approach, including improved access to data, coaching and support for managers and targeted action in areas with persistently higher sickness levels. DIGITAL: Carl Taylor reported that performance against major digital incidents has improved, with the Trust meeting the target for the first time through six consecutive reporting periods. He noted that while the number of incidents remains too high, the trend is positive and reflects improved partnership working and sustained focus on digital resilience. The Chair asked that work to prepare the organisation for the nVCC be brought back to the Trust Board with clear visibility of milestones, risks and any strategic sticking points, and that the Board be assured on how readiness will be actively overseen as the programme progresses. FRESH: Lauren Fear indicated that performance across the FRESH (Facilities, Risk, Estates, Safety and Health) portfolio remains solid, with good performance reported against the KPIs. Lauren highlighted the closure of a Health and Safety issue escalated to the HSE and confirmed that this had been addressed and would	CT

	be included in the next report. It was also advised that Audit Wales is undertaking a review of estates functions across NHS organisations and it was confirmed that the audit brief has been signed off and that findings are expected to be reported to the Board in May/June. The low compliance with fire safety and evacuation procedures was acknowledged and Lauren confirmed that a detailed 2026/27 improvement plan will be brought to the March Quality, Safety & Performance Committee. FINANCE: Matthew Bunce advised that financial performance remained on track to deliver all key targets for the year. It was noted that the full finance report had not been appended to the PMF item and confirmed that it would be circulated to Board members following the meeting. There were no new financial concerns noted at this stage. The Chair queried the level of confidence in delivering the savings plan, given the risks associated with non-delivery, and sought assurance on the robustness of the position. Matthew advised that there was confidence in delivering the current year savings plan, noting that while some savings are non-recurrent and will increase the challenge in future years, the in-year position remains on track and pressures are reflected in the forward financial plan, with mitigation in development. The Chair queried the impact of cost pressures and whether these could affect delivery of the savings plan. Matthew confirmed that known pressures, including Welsh Risk Pool costs, are built into the financial plan and are being actively managed. He acknowledged increased challenge in future years due to non-recurrent pressures but confirmed that the in-year position remains on track, with mitigation reflected in forward planning. The Trust Board: • NOTED the Performance Management Framework for assurance purposes. • CONCURRED with the levels of assurance noted in the report.	LF
4.2.0	VUNHST Risk Register Non Gwilym, Interim Director of Corporate Governance Non Gwilym presented the Risk Register, confirming it had been reviewed through QSP and reflected the Trust's current key risks. Board members raised the following: • That a number of risks had remained at the same score for a significant period. Non Gwilym responded that where risk scores have remained unchanged, this reflects that the underlying risks continue to exist and have not yet been sufficiently mitigated to justify de-escalation. Non emphasised that risk scoring must be evidence-based and that maintaining a stable score provides appropriate transparency until assurance demonstrates a material reduction in risk. The Trust Board NOTED: • the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. • the update on the Datix risk system replacement.	

	the assurance level 3.	
4.3.0	Board Assurance Framework (BAF) Non Gwilym, Interim Director of Corporate Governance Non Gwilym introduced the paper. Non advised that the Framework brings together the Trust's main strategic risks, linking them to controls, assurances and gaps, in addition to building on work already reviewed via Trust Committees. Board members commented on the following: - Some emerging priorities, particularly readiness for the New Velindre Cancer Centre (nVCC), were not yet sufficiently explicit within the Framework. - The importance of Patient Reported Outcome Measures (PROMs) data in evidencing patient outcomes and experience, noting the need to establish a clear baseline and to use the data to demonstrate improvement over time as the dataset matures. Members were advised that there are currently only a small number of months' worth of data, meaning it is too early to draw trends or conclusions. The intention is to build a robust dataset, to inform service improvement and assurance and that this data will be integrated into the routine Performance Management Framework (PMF) once sufficiently mature. The Trust Board: NOTED the current status of the Board Assurance Framework, which has a current assurance rating of 2.	
4.4.0	Culture and Inclusion Report Sarah Jenkins, Executive Director of People and Organisational Development (Interim) Sarah Jenkins advised that the report brought together learning from discovery work, staff engagement and the recent neutral assessment, which provided a clearer understanding of organisational culture. She said that overall culture is positive, but identified two key areas requiring focused improvement: - Speaking up safely; - How change is managed across the organisation. Sarah Jenkins emphasised that building trust through leadership visibility and behaviour is central to addressing both issues, and that this is equally important for patients and staff; the organisation must move beyond initiatives to ensure actions have measurable impact, and that future work will focus on listening more effectively, co-creating solutions with staff, and embedding learning rather than adding new layers of activity. The Board was asked to support a wider, connected programme of work linking culture, leadership and governance, noting that this would be a priority over the coming year and would align closely with workforce and nVCC readiness work. The Board raised the following: - Lack of clarity on timescales and milestones. Sarah Jenkins advised that while a number of immediate actions are underway, the next phase of work requires	

	focus on listening to staff and co-creating solutions, as opposed to imposing a pre-determined action plan, therefore ensuring meaningful and sustainable change. • That culture and inclusion should be managed through existing leadership, workforce and governance arrangements, rather than as a standalone initiative, with a focus on listening to staff and refining current plans rather than adding new programmes. • That patients experience organisational culture on a daily basis, often more intensely than staff, as they observe how staff interact, communicate and behave throughout providing care. It was noted that patients can act as an important independent lens on culture. • That only around a third of staff complete the staff survey, therefore limiting how representative the results are. It was agreed that the survey should be combined with other data, such as patient and donor feedback, walkabouts and direct conversations with staff and learning from incidents and speaking up routes. The Board TOOK ASSURANCE on the details provided and discussed in detail at QSP and SDC and AGREED the further work required on Governance, Culture and Leadership.	
4.5.0	Embedding the Donor & Patient Voice Across Velindre University NHS Trust Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience Tina Jenkins advised that the paper was intended to prompt early discussion on embedding the donor and patient voice, highlighting the need to reduce silo working, triangulate feedback, and clearly evidence how patient and donor views inform improvement, with a tangible plan to be brought back to the Board. The Chair cautioned against over-engineering this work, emphasising the need to maintain a simple approach focusing on meaningful engagement rather than additional paperwork. Tina Jenkins advised that this work would be taken forward through Executive Management Board, Quality Safety & Performance Committee and with both divisions, and that a revised paper with an agreed plan would be brought to the March meeting of the Trust Board for consideration and approval. The Trust Board NOTED the discussion.	TJ
5.0.0	COMMITTEE HIGHLIGHTS FOR DISCUSSION	
5.1.0	Public Audit Committee Highlight Report (02/12/2025) Gareth Jones, Independent Member and Chair of the Audit Committee Gareth Jones highlighted the Digital Health and Care Record (DHCR) audit and explained that Phase 2 delivery is subject to national prioritisation following a move to a product-based delivery model. Carl James advised that while Phase 2 funding for the Digital Health and Care Record (DHCR) exists, delivery is now dependent on national prioritisation and capacity, rather than a dedicated project team. The Trust's requirements have been fed into the national product roadmap and are being actively discussed. It was also suggested that a future Board Development session would provide better	

	understanding of this work, key risks and dependencies and how digital enablement underpins future service delivery. It was noted that Velindre had identified 11 priorities (two completed and nine outstanding). A particular priority highlighted for the Trust was hospital-initiated referrals, which is a critical enabler for patient safety and pathway efficiency. It was confirmed that this DHCW had been asked to prioritise delivery of this. The Trust Board NOTED the content of the report.	
6.0.0	CONSENT ITEMS FOR APPROVAL	
6.1.0	Trust Policies for Approval Sarah Jenkins, Interim Executive Director of People and Organisational Development The Board received four policies and one procedure for approval. The Trust Board: • APPROVED the All Wales Anti-Sexual Harassment Policy • APPROVED the All Wales Short Term Protection of Earnings Guidance • APPROVED the All Wales Medical Appraisal Policy • APPROVED the Flexible Working Policy The Board APPROVED the policies presented and NOTED the updated Exit Interview Procedure (as this did not require Board approval), with members emphasising the importance of clear, accessible guidance for managers. It was agreed to develop a summary guide for manager to support consistent and effective use of the Exit Interview Procedure.	SJ
6.2.0	NWSSP Commitments of Expenditure for CEO Approval Alison Ramsey, Director of Finance and Corporate Services, NWSSP The Board had received the following documents for approval: • Influenza vaccinations purchase This item related to the procurement of Influenza vaccinations for the forthcoming vaccinations programme, which is a routine annual purchase. Assurance was provided that the purchase is completely funded by Welsh Government, with no financial risk to the Trust. Alison Ramsey agreed to forward Welsh Government's written confirmation of this. The Quality Impact Assessment (QIA) had been completed, with final sign off pending. • E-expenses contract extension & Trac recruitment contract extension It was confirmed that the above were contract extensions, both linked to the transition away from ESR. It was noted that a contract renewal was required to ensure continuity while the future workforce solution is implemented and that the proposal had been considered and approved by the Shared Services Partnership Committee.	AR

	• Health Courier Services Fleet Insurance annual premium It was noted that this formed year three of an existing all-Wales contract. The Board acknowledged historic approval arrangements and were assured that future approvals will be better aligned to contract timelines. • Forensic & Statement Reconciliation Software The Board noted the importance of the Forensic & Statement Reconciliation Software contracts in terms of supporting financial assurance, fraud prevention and error detection. It was acknowledged that it would have been beneficial for conversations to have taken place earlier given the complexity, and the need for clearer completion of the Quality Impact Assessment was also reiterated. • Remote Advice and Guidance System contract renewal The Board had previously approved a 12-month extension to the Remote Advice and Guidance system contract, noting that the original contract had been approved in 2022 and that Welsh Government funding for the extension had now been confirmed. The Trust Board APPROVED: • the expenditure for required volumes of Influenza vaccine product and AUTHORISED the subsequent signing of the Purchase Orders by the Chief Executive. • renewal of the e-expenses contract for an initial period of two years from 05 August 2026 to 04 August 2028, with an additional option for a further two (2) years in 12-month increments, and in doing so also authorised the Chief Executive to approve the purchase order. • renewal of the contract for the TRAC recruitment system for two years from 01 August 2026 to 31 July 2028, with the option to extend for a further two years (1+1) from 01 August 2028 to 31 July 2030, and in doing so also authorised the Chief Executive to approve the purchase order; • and AUTHORISED the Chief Executive to sign the purchase order for Health Courier Services Fleet Insurance for the period 1 December 2025 to 30 November 2026. • the Forensic & Statement Reconciliation Software contract for £497,146.01 excluding VAT (£596,575.21 including VAT) and in doing so also AUTHORISED the Chief Executive to approve the purchase order. • the 12-month Remote Advice contract extension from 01/04/2026 – 31/03/2027 with a value of £761,935 (excluding VAT) and in doing so also AUTHORISED the Chief Executive to approve the purchase order.	
6.3.0	Summary of Chair's Urgent Actions since November 2025 Non Gwilym, Interim Director of Corporate Governance There were two (2) urgent items of business for the Trust Board that were considered via Chair's Urgent Action during this period: • Procurement Dashboard – Benchmarking and Analytics Business Justification Case and Commitment of Expenditure • GP Locum Hub Wales Contract	

	No objections to approval were received in respect of the item of business considered, although one matter was raised and was detailed in the report. The Trust Board RATIFIED the Chairs Urgent Action taken between the 21/11/2025 and 22/01/2026.	
6.4.0	Nurse Staffing Levels Act Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience Tina Jenkins noted an increase in acuity and bed occupancy but confirming that the organisation remains compliant with the Act, including the required 25% uplift; staffing levels continue to be reviewed and adjusted to reflect patient need. The increase in acuity was the result of patients generally presenting with more complex needs and requiring greater levels of care, and that changes to skill mix and deployment of healthcare support workers had been made in response. Additionally, increased vigour in ward review processes and reporting may be contributing to better capture of acuity data. The importance of clarity in how harm is reported within the context of the Nurse Staffing Levels Act was noted, highlighting that while the report states no harm attributable to staffing levels, harm such as pressure ulcers has occurred and is being reviewed through quality processes. The need for careful wording and clear distinction between harm attributable to staffing compliance under the Act and harm arising from wider clinical factors was emphasised. The Trust Board APPROVED the report in line with the Nurse Staffing Levels (Wales) Act 2016, prior to the report being submitted to Welsh Government.	
7.0.0	CONSENT FOR NOTING	
7.1.0	Trust Seal Report Non Gwilym, Director of Corporate Governance (Interim) The Trust Board NOTED the content of the report.	
7.2.0	Public Quality, Safety & Performance Committee Highlight Report (13/01/2026) Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee The Trust Board NOTED the content of the report.	
7.3.0	Public nVCC Project Scrutiny Sub-Committee Highlight Reports (21/10/2025 & 20/11/2025) Hilary Jones, Independent Member and Chair of the nVCC Project Sub-Committee The Trust Board NOTED the content of the reports.	
7.4.0	Public Strategic Development Committee Highlight Report (04/11/2025) Lindsay Foyster, Vice Chair and Chair of the Strategic Development Committee The Trust Board NOTED the content of the report.	
7.5.0	Public Charitable Funds Committee Highlight Report (09/12/2025)	

	Sara Moseley, Chair and Chair of the Charitable Funds Committee The Trust Board NOTED the content of the report.	
7.6.0	NHS Wales Shared Services Partnership Assurance Report (14/11/2025) James Quance, Assistant Director of Corporate Services It was noted that the report did not sufficiently reflect emerging issues relating to the TrAMs programme, in particular, slippage in the timetable due to delays in progress from Outline Business Case to Full Business Case ahead of the pre-election period. It was acknowledged that this could result in a delay of approximately 5 months and may have material implications for some partner organisations. Anne Carey agreed to escalate this through Shared Services governance to ensure this is reflected more explicitly in the report. The Trust Board NOTED the content of the report.	AC
7.7.0	NHS Wales Shared Services Partnership Audit Committee Highlight Report (07/11/2025) Gareth Jones, Independent Member and Chair of the NWSSP Audit Committee The Trust Board NOTED the content of the report.	
7.8.0	Trust-wide policy approvals update Non Gwilym, Interim Director of Corporate Governance The Trust Board NOTED the content of the report.	
7.9.0	Charitable Funds (Trustee) Annual Report & Annual Accounts Led by Anne Carey, Chief Operating Officer and Matthew Bunce, Executive Director of Finance The Trust Board NOTED the content of the report.	
7.10.0	Health Technology Wales (HTW) Strategic Plan Susan Myles, Director, Health Technology Wales Non Gwilym indicated that the Health Technology Wales Strategic Plan was subject to public consultation until 23 January. Further meetings with HTW management team would take place ahead of the final plan being brought back to the March Board for approval. The Trust Board NOTED the content of the report.	
8.0.0	ANY OTHER BUSINESS	
	Sara Moseley, Chair The Chair had not received prior notice of any other business.	
9.0.0	DATE OF NEXT MEETING	
	The next public meeting will take place on Thursday, 26 th March 2026.	
10.0.0	CLOSE	

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	STATUS
29.01.2026			CHIEF EXECUTIVE'S REPORT				
	3.2.0	59	A Readiness master plan setting out key milestones, risks, impacts and outcomes to be brought to the March meeting of the Trust Board.	Director of Place, Portfolio and Partnerships	26/03/2026	March update - Paper to be shared with the Trust Board following nVCC Scrutiny Sub-Committee discussion on 19th March	PROPOSE TO CLOSE
29.01.2026			PERFORMANCE MANAGEMENT FRAMEWORK				
	4.1.0	60	Work to prepare the organisation for the nVCC in relation to Digital to be brought back to Board with clear visibility of milestones, risks and any strategic sticking points.	Chief Digital Officer	26/03/2026	March update - digital workstream, including progress on milestones, to governed through nVCC project board and nVCC readiness board. Work on milestones to conclude as part of overall detailed plan by end of April, reporting into nVCC Scrutiny Committee and onward to Board via highlight report.	PROPOSE TO CLOSE
29.01.2026			PERFORMANCE MANAGEMENT FRAMEWORK				
	4.1.0	61	Detailed 2026/27 improvement plan for compliance with fire safety training to be brought to the March meeting of the Board.	Director of Place, Portfolio and Partnerships	26/03/2026	To be addressed under matters arising at March Board.	PROPOSE TO CLOSE
29.01.2026			EMBEDDING THE DONOR & PATIENT VOICE ACROSS VUNHST				
	4.5.0	62	Revised paper with an agreed plan to be brought to the March meeting of the Board for consideration and approval.	Interim Deputy Director of Nursing, Quality & Patient Experience	26/03/2026	To be addressed as an item on March Board agenda.	PROPOSE TO CLOSE
29.01.2026			TRUST POLICIES FOR APPROVAL				
	6.1.0	63	Develop a summary guide for Managers, to support consistent and effective use of the Exit Interview Procedure.	Interim Executive Director of People & Organisational Development	26/03/2026	March update - One page summary produced and will be sent to Comms. Flowchart included in the procedure. January update - Policy Group will work on a summarised guide for managers on 1 page with accessibility to the details on the intranet.	PROPOSE TO CLOSE
29.01.2026			NWSSP COMMITMENTS OF EXPENDITURE FOR APPROVAL				
	6.2.0	64	NWSSP to forward Welsh Government's written confirmation of funding for the purchase of Influenza vaccinations for the forthcoming vaccinations programme.	Director of Finance & Corporate Services, NWSSP	26/03/2026	March update - WG written confirmation received from NWSSP following January's Board.	PROPOSE TO CLOSE
29.01.2026			NWSSP ASSURANCE REPORT (14/11/2025)				
	7.6.0	65	As the report did not sufficiently reflect emerging issues relating to the TrAMs programme in particular, slippage in timetable, this is to be escalated through Shared Services Govenance to ensure more explicit reflection in the report.	Chief Operating Officer	26/03/2026	16/03/26 - COO attended the TrAMs Programme Board and requested an update on the timeline for the FBC and clarity regarding the delay to the opening of the south-east hub. An update from the TrAMs Programme Director was received by the CEO 16/03/2026.	PROPOSE TO CLOSE

TRUST BOARD	
Fire Safety Training – Addendum	
DATE OF MEETING	26 th March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
PREPARED BY	Robin Weaver, Trust Fire Safety Manager
PRESENTED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
APPROVED BY	Lauren Fear, Director of Place, Portfolio and Partnerships
EXECUTIVE SUMMARY	The update attached responds to the January Trust Board action for a more detailed update on Fire Training.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE this report.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Quality, Safety and Performance Committee	Circulated following the March Committee meeting
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS There was a summary of the position and progress made in the compliance with Fire Safety training as part of the FiRe, Estates, Sustainability and Health and safety (FRESH) Highlight report. However the Trust Board action specifically asked for a detailed update – and given paper timings, this was then circulated to the Quality, Safety and Performance Committee after the meeting.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	3 (Aligned to agreed assurance rating for Fire, of which training is a significant component)

QSPC report [February 2026] – Addendum

Training Compliance – Fire Safety

1 Background - Role(s) & Responsibilities for fire training

- 1.1 Under Article 21 of the *Regulatory Reform (Fire Safety) Order 2005* and Firecode (WHTM 05), the Trust must ensure that all staff—including bank, temporary, and volunteer personnel—understand the fire risks they may face and know how to respond in an emergency. This requirement applies to all staff, regardless of role or seniority.
- 1.2 The Authorised Person (Fire) is responsible for ensuring the effectiveness of fire safety training by:
- ensuring an appropriate fire safety training programme is in place and, with the Authorised Person (Fire Training) and the training department, developing a Training Needs Analysis (TNA). The TNA should include suitable drills and exercises—live, simulated, or desktop—and consider opportunities to integrate training for major incidents with emergency preparedness, resilience, and response (EPRR) requirements
 - ensuring suitable arrangements are in place for the delivery of fire safety training
 - regularly assessing the effectiveness of staff training
 - advising the Trust on compliance with legal requirements
 - periodically reviewing the technical content of fire safety training programmes and materials
- 1.3 Local managers, including senior nurses and ward or department leads, must ensure that:
- sufficient appropriately trained staff are always available to implement the local emergency action plan and evacuation procedures, and all new staff receive basic workplace familiarisation on their first day
 - staff complete the required fire safety training and any specialist training relevant to their roles, as set out in the TNA matrix
 - an adequate number of trained Evacuation Wardens (named persons) and/or Evacuation Coordinators (nominated persons) are in place
 - staff can recognise changes in their environment that present an immediate risk and know how to access appropriate professional support
 - evacuation drills, live or desktop exercises, and walkthroughs are carried out regularly in line with the TNA

2 Current compliance [to end of February 2026] – Refer to Appendix A

2.1 Level 1 [Essential fire awareness]

- Since April 2025, overall compliance has been sustained above the WG benchmark [85%], which historically has been a challenge, but there are fluctuations with divisional compliance.
- Compliance currently sits at **87.7%**

2.2 Level 2 [Clinical fire awareness]

- Medical and Clinical staff have responsibility for the safety patients, donors and visitors in the event of fire and require an enhanced level of training.
- Overall compliance has not achieved the WG benchmark of 85% in the last 15 months; compliance for WBS Blood Donation staff is generally above the benchmark but VCS has rarely exceeded 65% over this period.
- Compliance currently sits at **70.1%**

2.3 Several factors such as the availability of rooms to deliver training and timings of sessions contribute to the continued lack of compliance, with the primary issue being service pressures and the difficulty of releasing staff for training. While patient care is rightly a priority, local management still has a clear responsibility to ensure that enough appropriately trained staff are available to implement the local emergency action plan and evacuation procedures which directly supports the safety of patients, visitors, and staff.

3 Current Actions

3.1 The following actions have been taken to improve compliance:

- a. Based on the Training Needs Analysis, a prospectus of 'open-house' training available for staff to book onto training available through ESR:
 - 3 sessions per month for clinical fire awareness [2 classroom and 1 over TEAMS]
 - 2 Evacuation Coordinator sessions per month [1 classroom and 1 over TEAMS]
- b. The Authorised Person (Fire) works with departments to deliver fire training on a 'local' arrangement at a time and place to suit staff need ;departments which have local arrangements in place include Integrated Care [FF wards] and Main OPD.
- c. VCS have appointed General Managers who have been identified as the points of contact for fire safety matters including development of local training plans to improve compliance.
- d. Month record of number of 'seats' available, number of 'seats' booked and number of attendees are recorded to further improve training offerings for 2026/27 and beyond.

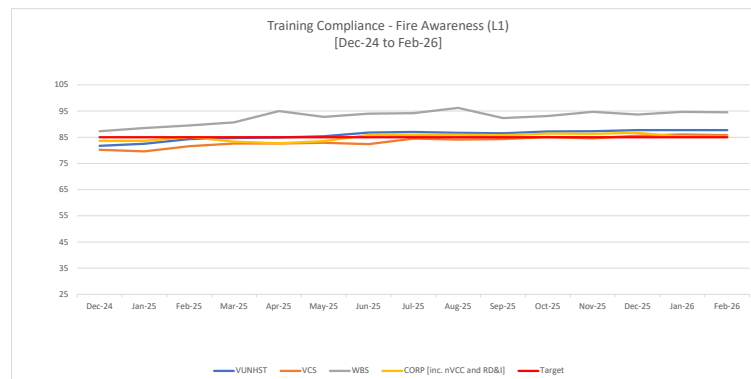
4 Future Actions

4.1 The following actions are being implemented to further improve compliance for fire safety training and also provide opportunity to enhance staff understanding an skillsets regarding keeping themselves and others safe in the event of emergencies:

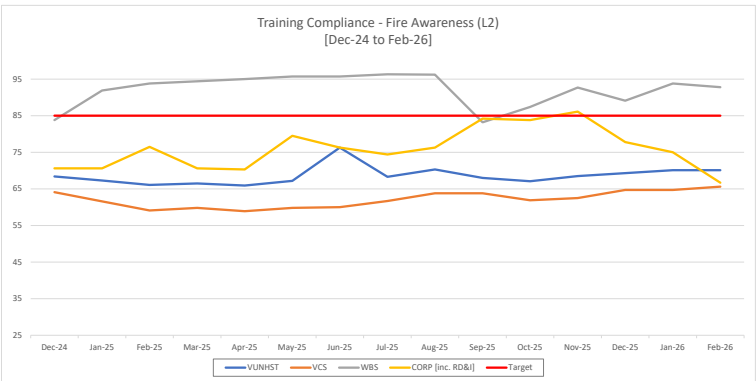
1. The Authorised Person (Fire) to liaise with relevant subject matter experts and develop coordinated training to support safety and appropriate emergency response in the workplace [fire, security, ACT, major incident response] based on a 4-year training cycle - **Q1 (2026/27) [June 2026]**:
 - Year 1 – Full statutory & mandatory training and participation in drill or exercise.
 - Year 2 & 3 - 'Principles of Emergency Response' training which provides the key messages and essential information necessary to implement local emergency plans and procedures year coupled with participation in annual drill or exercise.
 - Year 4 – as Year 1
2. Based on the analysis discussed under d above, the Authorised Person (Fire) to review and refresh of the current TNA for fire safety to reflect current trends regarding compliance and attendance – **Q2 (2026/27) [August 2026]**.
3. VCS Operational Management Board to gain assurance through the VCS Cynefin that robust annual training plans for individual departments are developed, in place and implemented - **Q3 (2026/27) [October 2026]**.

APPENDIX A – Fire safety training compliance [February 2026]

Training Compliance - Fire Awareness (L1) [Dec-24 to Feb-26]																
MONTH	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	
VUNHST	81.7	82.5	84.3	84.7	84.9	85.4	86.8	87.0	86.7	86.5	87.2	87.3	87.7	87.7	87.7	
VCS	80.2	79.6	81.6	82.6	82.6	82.9	82.4	84.5	84.1	84.3	85.1	84.6	85.6	86.1	85.8	
WBS	87.3	88.5	89.5	90.7	95	92.8	94.0	94.2	96.2	92.3	93.1	94.7	93.7	94.7	94.5	
CORP [inc. nVCC and RD&I]	83.6	83.6	85.1	83.3	82.7	83.5	85.9	85.9	86.0	85.8	86.4	86.3	86.7	85.2	85.3	
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	



Training Compliance - Fire Awareness (L2) [Dec-24 to Feb-26]															
MONTH	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
VUNHST	68.4	67.3	66.1	66.5	65.9	67.2	76.3	68.3	70.3	68.0	67.1	68.5	69.3	70.1	70.1
VCS	64.1	61.6	59.1	59.8	58.9	59.8	60	61.7	63.8	63.8	61.9	62.5	64.7	64.7	65.6
WBS	83.8	91.9	93.8	94.4	95	95.7	95.7	96.3	96.2	83.2	87.4	92.7	89.1	93.8	92.8
CORP (inc. RD&I)	70.6	70.6	76.5	70.6	70.3	79.5	76.3	74.4	76.3	84.2	83.8	86.1	77.8	75.0	66.7
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



QSP report [February 2026] – Addendum

Training Compliance – Fire Safety

1 Background - Role(s) & Responsibilities for fire training

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2 Current compliance [to end of February 2026] – Refer to Appendix A

- 2.1 Level 1 [Essential fire awareness]
- Since April 2025, overall compliance has been sustained above the WG benchmark [85%], which historically has been a challenge, but there are fluctuations with divisional compliance.
 - Compliance currently sits at **87.7%**
- 2.2 Level 2 [Clinical fire awareness]
- Medical and Clinical staff have responsibility for the safety patients, donors and visitors in the event of fire and require an enhanced level of training.
 - Overall compliance has not achieved the WG benchmark of 85% in the last 15 months; compliance for WBS Blood Donation staff is generally above the benchmark but VCS has rarely exceeded **65%** over this period.

- Compliance currently sits at **70.1%**

2.3 Several factors such as the availability of rooms to deliver training and timings of sessions contribute to the continued lack of compliance, with the primary issue being service pressures and the difficulty of releasing staff for training. While patient care is rightly a priority, local management still has a clear responsibility to ensure that enough appropriately trained staff are available to implement the local emergency action plan and evacuation procedures which directly supports the safety of patients, visitors, and staff.

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- c. VCS have appointed General Managers who have been identified as the points of contact for fire safety matters including development of local training plans to improve compliance.
- d. Month record of number of 'seats' available, number of 'seats' booked and number of attendees are recorded to further improve training offerings for 2026/27 and beyond.

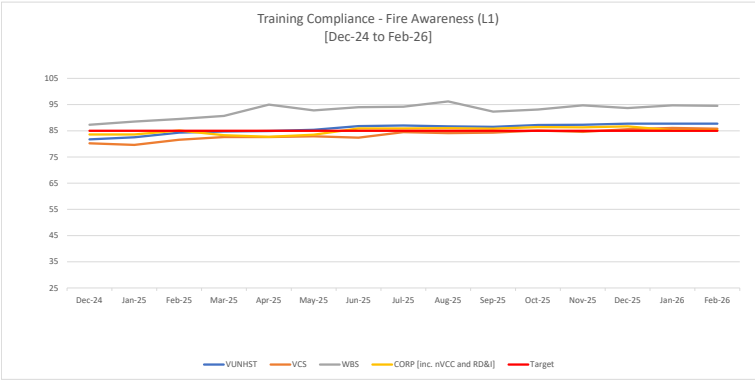
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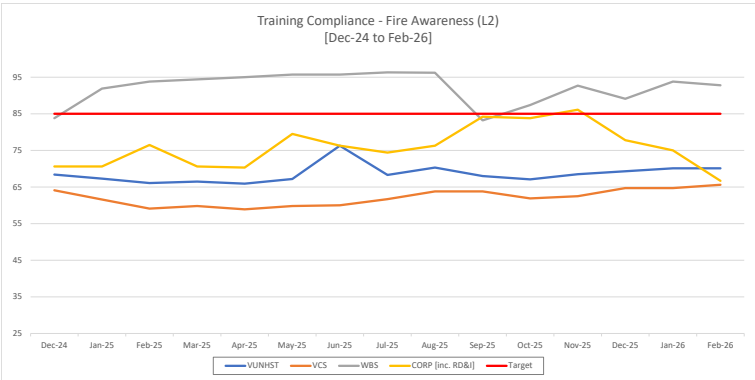
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 - Year 4 – as Year 1
2. Based on the analysis discussed under d above, the Authorised Person (Fire) to review and refresh of the current TNA for fire safety to reflect current trends regarding compliance and attendance – **Q2 (2026/27) [August 2026]**.
3. VCS Operational Management Board to gain assurance through the VCS Cynefin that robust annual training plans for individual departments are developed, in place and implemented - **Q3 (2026/27) [October 2026]**.

APPENDIX A – Fire safety training compliance [February 2026]

Training Compliance - Fire Awareness (L1) [Dec-24 to Feb-26]															
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VCS	80.2	79.6	81.6	82.6	82.6	82.9	82.4	84.5	84.1	84.3	85.1	84.6	85.6	86.1	85.8
WBS	87.3	88.5	89.5	90.7	95	92.8	94.0	94.2	96.2	92.3	93.1	94.7	93.7	94.7	94.5
CORP (inc. nVCC and RD&I)	83.6	83.6	85.1	83.3	82.7	83.5	85.9	85.9	86.0	85.8	86.4	86.3	86.7	85.2	85.3
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Training Compliance - Fire Awareness (L2) [Dec-24 to Feb-26]															
MONTH	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
VUNHST	68.4	67.3	66.1	66.5	65.9	67.2	76.3	68.3	70.3	68.0	67.1	68.5	69.3	70.1	70.1
VCS	64.1	61.6	59.1	59.8	58.9	59.8	60	61.7	63.8	63.8	61.9	62.5	64.7	64.7	65.6
WBS	83.8	91.9	93.8	94.4	95	95.7	95.7	96.3	96.2	83.2	87.4	92.7	89.1	93.8	92.8
CORP [inc. RD&I]	70.6	70.6	76.5	70.6	70.3	79.5	76.3	74.4	76.3	84.2	83.8	86.1	77.8	75.0	66.7
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sara Moseley, Chair
PRESENTED BY	Sara Moseley, Chair
APPROVED BY	Sara Moseley, Chair
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To NOTE the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

1. SITUATION

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

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Board Development Session 12th February
- Meeting with local community representatives 16th February
- NWSSP Review Implementation Group Meeting 19th February
- Chair Peer Group Meeting (In Person) 24th February
- Schwarz Round Session – Welsh Blood Service 25th February
- Meeting with CEO NHS Wales 26th February
- Interviews for Interim Executive Director of Nursing 4th March
- nVCC visit with the COO/Chair of Aneurin Bevan UHB 4th March
- nVCC visit with CEO/Chair of Swansea Bay UHB 5th March
- Introductory meeting with Line-of-Sight Consultancy 5th March
- International Women's Day 6th March – Welsh Blood Service and Velindre
- Attendance at Blood Collection Session in Bangor, 10th March
- Attendance at the WBS Donor Awards, Caernarvon, 10th March
- Site visit to Maggie's, Velindre Cancer Centre. March 12th
- Site visit to Palliative Care Ward, Velindre Cancer Centre, March 17th
- Appraisal with Cabinet Secretary for Health and Social Care March 18th

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Session 12th February

A productive session was had with all Board members to ensure continued development and understanding of matters that the Trust are committed to. We received presentations on Portfolio projects, Neutral Assessment and mandatory Health and Safety training. Thank you to all who came and provided those insights.

3.2 Meeting with "Save the Northern Meadows" representatives 16th February

I met with representatives from our local community in Whitchurch who have been engaged in raising concerns about aspects of the development of the new Cancer Centre for several years. I was accompanied by colleagues from Communications and by Lauren Fear and Mark Trumper. This was an opportunity for me to meet and build relationships with some of our neighbours, whilst also listening and understanding their perspectives. We are scheduling workshops in April to facilitate continued discussion. I also agreed to a site visit to Lady Corey Fields and the Bowl with representatives and other interested parties. The meeting was helpful and constructive.

3.3 NWSSP Review Implementation Group Meeting 19th February

Welsh Government hosted the inaugural meeting of the implementation group following the publication of recommendations into NWSSP governance. This was attended by representatives from Velindre, Welsh Government, Public Health Wales and NWSSP. We will continue to meet and review our strategies to enable this. Jacqueline Totterdell, Chief Executive for NHS Wales commended the initiative that Velindre and NWSSP has taken on working together so far and already identifying priorities. Velindre's main focus is addressing the need to ensure improved clinical governance and those other statutory areas for which we are responsible for as hosts.

3.4 Schwarz Round Session – Welsh Blood Service 25th February

The Trust runs Schwarz Round sessions monthly where colleagues are invited to attend and reflect on chosen topics. The session I attended was titled " Why I come to work".



Three colleagues shared very inspiring stories about their motivation and how it affects their work in some very different parts of the Trust. It was very emotive and was an honour to be in their company and for them to share their very personal stories. Such sessions are important as they provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The underlying ethos for Schwarz Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care.

3.5 Interviews for Executive Director of Nursing 4th March

Following Nicola Williams' appointment to lead the RCN in Wales, we recruited an interim Executive Director of Nursing. Being on the interview panel was a positive experience and I can confirm that we have recruited Gillian Knight, Deputy Chief Nursing Officer for Wales, who comes with a strong background in cancer as well as nurse leadership, having worked at Velindre in the past. Gillian begins with us on April 9th.

3.6 New Velindre Cancer Centre visit with the COO/Chair of Aneurin Bevan UHB 4th March

Working well with our University Health Board partners is crucial for patients and staff. I was delighted to invite Nicola Prygodzicz and Leanne Watkins from Aneurin Bevan University Health Board to visit the site where the new cancer centre is

being built. This was part of a series of Health Board visits instigated by us to share updates on building and identify areas we can better work together for patients. Carl James and I, alongside the project team were able to show them the progress so far and describe what collaboration opportunities there will be when the Cancer Centre is complete. Our visitors were pleased to see the building, and we identified a number of things where we can work together to improve cancer services locally and in the wider Wales.

3.7 New Velindre Cancer Centre site visit with CEO/Chair of Swansea Bay UHB 5th March

The following day, we met with Abigail Harris, CEO and Jan Williams, Chair from Swansea Bay University Health Board. We were able to show them the progress so far and describe what collaboration opportunities there will be when the building is complete. They were particularly interested in the funding model for the new centre and in exploring ideas for collaboration and strengthening clinical resilience. We discussed the role and relationship with of the Southwest Wales Cancer Centre at Singleton Hospital, and we were invited to visit to learn more.



3.8 Introductory meeting with Line-of-Sight Consultancy 5th March

Our partner in supporting good governance and board effectiveness is now in place. I met with Emily Glover and John Murray from Line-of-Sight consultancy in their first week and they will be attending the Trust Board meeting and other committees in the future. Collectively, we will work together to align governance structures, accountability and objectives. This work will continue until May 2027 and will be an opportunity to streamline and improve how we make decisions, develop plans and scrutinise our actions, bringing more clarity and transparency for our colleagues. By working on these things, it will ensure that the Trust is in a strong and healthy position, with sufficient succession planning and robust governance in place.

3.9 International Women's Day 6th March



I spoke at two very inspiring International Women's Day events: one at the Welsh Blood Service and another at Velindre Cancer Centre, bringing together women and colleagues from across the Trust to celebrate, connect and champion one another. Hosted by Lauren Fear, Director of Place, Portfolio and Partnerships, both events shone a spotlight on the remarkable women within our

services, highlighting how their work, leadership and lived experiences make a meaningful difference every day. With this year's theme, **#GivetoGain**, we explored a wide range of topics, from research and service improvement to leadership, empowerment and personal growth, reflecting the many ways women contribute to the success of our organisation and the communities we serve. This was also an opportunity to launch our new Women's Network, jointly chaired by Lauren Fear and Kate Hannan – what a great initiative this is.

3.10 Attendance at a Blood Collection Session in Bangor, 10th March

I travelled to North Wales to meet our colleagues from the Welsh Blood Service who were running a donor collection service in the community. I met the team who facilitated this session so that blood stock levels are maintained around Wales. Nia and Ryan came to us after a career in teaching and retail – both roles where connecting with people is key. David, a blood donor for 37 years, allowed me to follow his progress through the clinic and understand his experiences as a donor. As a bonus, David works for Marie Curie in Ysbyty Gwynedd.



3.11 Attendance at the WBS Donor Awards, Caernarvon, 10th March

It was a pleasure to attend the WBS Donor Awards that were held in Caernarvon. I met some very inspiring and selfless people who frequently give their time to donate blood and platelets to maintain stock levels in Wales and beyond. I was honoured to present awards that recognised these efforts. Particularly memorable were Patsy, Mike and Brian who were on my table who were all in their 80's and had made over 360 donations between them.



3.12 Health Board Chairs & Chief Executives Meeting March 12th

Carl and I met in person with other NHS Wales Chairs and Chief Executives at Cwm Taff Morgannwg UHB's premises. The agenda included a presentation from the NHS Wales Confederation on party manifestos and likely pledges that relate to health. This was followed by a discussion and planning into how we work together to prepare for the future, including a discussion on cancer. We are continuing these discussions with Health Boards and with NHS P&I and Welsh Government.

3.13 Site visit to Maggie's, Velindre Cancer Centre, March 12th

I was honoured to be invited over to the Maggie's centre beside our Velindre hospital to meet the team and learn more about how they welcome and support beneficiaries. The staff provide a beautiful space and compassionate and caring support to cancer patients and their families. I learned a lot about how Maggie's works closely with the Velindre team – from dietitians to Clinical Nurse Specialists who all either bring patients to Maggie's or deliver sessions there. We went on to discuss our joint aspiration for the relocation of Maggie's close to the new cancer centre and we'll be working with them on this.

3.14 Site visit to Palliative Care Ward, Velindre Cancer Centre, March 17th

Palliative care is one of the very special things that we provide in the Cancer Centre and through working with near-by hospices. I joined Prof Mark Taubert and his amazing team for a few hours and went with him and medical students from Cardiff

University on a ward round. It was a huge privilege to speak to the patients and to witness some profoundly important conversations and care. I saw nurses, doctors, complementary therapists and others working together to enable end-of-life care in a way I will never forget.

3.15 Annual Performance review with the Cabinet Secretary, March 18th

All Chairs are accountable directly to the Cabinet Secretary for Health and Social Care. My objectives have been set by Jeremy Miles MS and so, at the end of the year, he also appraised my performance and explored what I have done personally in my role. It was a helpful and positive conversation. The Cabinet Secretary focused on exploring the quality and safety of care and services; how the Board knows it is able to effectively scrutinise and oversee Velindre's work; and how much we are able to focus on the future and better experiences and outcomes for donors and patients.

In turn, I cascade and set objectives for Independent Members and will be meeting each of them in turn for a similar conversation over the next few weeks. I also set the objectives for and appraise the CEO who has additional accountability to the CEO of NHS Wales and Director General for Health and Social Care.

4 IMPACT ASSESSMENT

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

EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
CHIEF EXECUTIVE'S UPDATE REPORT	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Carl James, VUNHST Chief Executive (interim)
PRESENTED BY	Carl James, VUNHST Chief Executive (interim)
APPROVED BY	Carl James, VUNHST Chief Executive (interim)
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chief Executive's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the content of the Chief Executive's report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES – N/A	

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

Senior management appointments

I am pleased to confirm that following interviews on the 4th of March, the Trust successfully appointed an Executive Director of Nursing, Allied Health Professionals and Health Sciences, to be offered as a secondment for 6 months. It is anticipated that Gillian Knight will commence in post on 9th April 2026. Gillian comes to us from the Royal College of Nursing, where her current substantive position is Deputy Chief Nursing Officer.

Key activity over the last two months:

Visits

WG DHSC Cab Sec visit to WBS HQ – 29th January 2026



On the 29th January, I attended a visit by the Cabinet Secretary for Health and Social Care, to the Welsh Blood Service Headquarters, where he was joined by Welsh Government colleagues. During the visit, he toured key areas of the building, with particular focus on the WBS transfusing laboratories. This was an opportunity for him to see first hand the scale, expertise and importance of the work which underpins patient care every day in Wales.

Other discussions with staff included the future infrastructure and plasma for medicines, national and international impact of transplantation services, recent success of the stem cell recruitment campaign and the importance of increasing donor diversity to improve match likelihoods for patients from BAME backgrounds.

Visits to nVCC with Chief Operating Officer and CEO of Aneurin Bevan UHB – 4th March 2026 and Chair and CEO of Swansea Bay UHB – 5th March 2026

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

Visit to Christie's NHS Foundation Trust – 13th March 2026

Along with other senior Trust colleagues, I attended a visit to Christie's NHS Foundation Trust, Manchester. The purpose of the visit was to see around the cancer centre to identify any examples the Trust could learn from in relation to the nVCC in addition to exploring how the Trust could forge partnership links with Christie's.

In addition to visiting services such as SACT/Immunotherapy, Acute Oncology and Multi-professional led services, we also wished to hear more about the Christie's research journey from a clinical trial, radiotherapy trial and professional research perspective, to assist with the enhancement of our own research portfolio.

Visit of First Minister Velindre @ Nevill Hall Radiotherapy Unit – 16th March 2026

On the 16th March, I attended a visit to the Nevill Hall Radiotherapy Unit with the First Minister, Eluned Morgan MS, Chair and Chief Executive of Aneurin Bevan University Health Board, and the Trust's Vice Chair, Lindsay Foyster. The visit included a welcome and introduction from senior leaders of Aneurin Bevan UHB, followed by an overview of the unit (including patient and clinical spaces and technology in use) and its role within regional cancer services. The First Minister was given the opportunity to meet clinical staff and learn about the early use of the unit and the benefits for patients. The visit concluded with informal discussion and photo opportunities.



Meetings of note

National Cancer Leadership Board meetings – 30th January & 20th March 2026

I attended the January and March National Cancer Leadership Board meetings with Nick Wood (NHS Wales Deputy CEO) and James Calvert (NHS Wales Deputy Chief Medical Officer) and colleagues, focusing on the following areas:

- Progress against the cancer workplan
- Cancer performance overview across all Health Boards in Wales
- Updates regarding Data Development Roadmap
- PET and CT scan access in North Wales
- Cancer assurance and accountability arrangements

NHS Wales Leadership Board meeting – 17th February

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

- Organisational Performance (all Trusts and Health Boards)
- Financial position for 2026-27
- Workforce challenges, issues and opportunities, particularly in relation to productivity, digital developments and wider system change.

Chief Executive Management Team (CEMT) meetings – 3rd February and 3rd March 2026

I attended the February and March meetings of the Chief Executive Management Team. Discussions included mental health strategy, education and training, regional partnerships and future collaborative opportunities, digital blueprint and ways of working and apheresis commissioning.

NHS Wales Shared Services Partnership Review Implementation Group –19th February

On the 19th February, I attended the inaugural meeting of the NWSSP Review Implementation Group, along with the Trust's Chair, Senior Shared Services Colleagues and Welsh Government Colleagues. This Welsh Government-led group has been established to oversee, coordinate and support the delivery of the agreed

recommendations arising from the Independent Review, to strengthen governance and accountability arrangements for NHS Wales Shared Services Partnership (NWSSP). The group ensures that the recommendations are translated into clear, actionable workstreams, to be implemented collaboratively and effectively within agreed timeframes.

Acorn Liaison Committee Meeting – 25th February 2026

I attended the February Acorn Liaison Committee meeting with the nVCC Project Director, Senior Responsible Officer and Acorn Colleagues, to review construction, equipment, digital and commissioning, stage 4 design and status of the proposed commercial deal. Additional discussion also included recent media interest, reputational implications and measures taken to reduce a recurrence of the latest press release.

nVCC Project Readiness Board – 25th February 2026

Following the inaugural meeting of the newly established nVCC Readiness Board on 28th January 2026, the second meeting, chaired by myself, focused on the master plan and requirements for robust delivery plans, rationalisation of project management arrangements, reporting arrangements, risk and project success factors.

It is anticipated that the Board will continue to meet until March 2028; this aligns with the IMTP planning cycle, the Trust's end of financial year, and will allow for a period of embedding to take place once the new Velindre Cancer Centre is occupied.

VCS / WBS Divisional Performance Review Meetings – 17th and 19th March 2026

New Divisional Performance Review meetings have been established to bring together the Executive and the respective senior leadership teams of the Divisions. The forum provides a structured opportunity to review performance, share achievements, and reflect on key areas of good practice across whilst strengthening our collective oversight of statutory responsibilities, emerging challenges, and organisational risks.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: Outstanding for quality, safety and experience ☐ An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ A beacon for research, development and innovation in our stated areas of priority ☐ An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Choose an item N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR JANUARY 2025/26	
DATE OF MEETING	26/03/2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE, INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	1. Carl James, Chief Executive Officer (interim) 2. Anne Carey, Chief Operating Officer 3. Sarah Jenkins, Executive Director OD & Workforce, 4. Carl Taylor, Chief Digital Officer, 5. Lauren Fear, Director of Place, Portfolio & Partnerships 6. Matthew Bunce, Executive Director of Finance
APPROVED BY	Carl James, Chief Executive Officer (interim)
EXECUTIVE SUMMARY	PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in Section 1 which focus on the key issues to be raised and discussed for the month of January 2026.
RECOMMENDATION / ACTIONS	The Trust Board is asked to take ASSURANCE from the Performance Management Framework for the month of January 2026.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
WBS SLT / Performance Review	(11/02/2026)
VCS SLT / Performance Review	(18/02/2026)
Executive Management Board	(23/02/2026)
Quality Safety and Performance Committee	(12/03/2026)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered and endorsed at the VCS and WBS Performance Review meetings and Executive Management Board, Quality Safety and Performance Committee and is presented to the Trust Board for assurance on the Trust's performance for January 2026. The full record of matters of note discussed at the QSP Committee will be recorded in the QSP Committee approved minutes. Some specific items are highlighted for Trust Board awareness below:

- Performance delivery, particularly within cancer pathways, continues to be constrained by administrative and scheduling capacity and process complexity. This represents a system level enabler issue rather than a clinical or prioritisation concern.
- The QSP Committee highlighted that digital and data limitations continue to affect performance oversight, with reliance on manual processes limiting real time visibility and placing pressure on capacity. This is escalated as a key enabler risk impacting the robustness of performance management.
- Variation in performance across tumour sites was discussed, with targeted deep dives planned to understand and address specific bottlenecks. This is highlighted for Board awareness as part of ongoing performance improvement activity.
- The Committee noted that while improvement actions are in place, the pace of performance improvement is constrained by wider capacity and system pressures.
- It should be noted that the levels of assurance in the table below are for January 2026 only, as the QSP Committee considered that the outdated information on previous level summaries was unhelpful, and have been removed to allow discussion to focus on the current level.

7 LEVELS OF ASSURANCE

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

APPENDICES

	Not applicable

ACRONYMS AND INITIALISM

EMB	Executive Management Board
KPI	Key Performance Indicator
LINAC	Linear Accelerator
MHRA	Medicines Healthcare (products) Regulation Agency
PADR	Performance appraisal and Development Review
PMF	Performance Management Framework
PPM	Planned Preventative Maintenance
QSF	Quality Safety Framework
QSP	Quality Safety and Performance Committee
RD&I	Research Development and Innovation

RIDDOR	Reporting Injuries Diseases Dangerous Occurrences Reporting
RT	Radiotherapy
SABRE	Serious Adverse Blood Reactions and Events
SACT	Systemic Anti-Cancer Therapy
SLA	Service Level Agreement
WBS SLT	Welsh Blood Service Senior Leadership Team
VCS Tri	Velindre Cancer Service Triumvirate
SMART	Relating to goal setting “Specific, Measurable, Achievable, Relevant, Timely”
SPC	Statistical Process Control Charts
VAI	Velindre Acquired Infections
VUNHST	Velindre University NHS Trust
WHC	Welsh Health Circular
WHO	World Health Organisation

1. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR JANUARY 2026

1.1 Overall High-Level Quality Performance Summary

A selection of the most critical Quality Performance Management Framework (PMF) Key Performance Indicators (KPIs), taken from the full PMF Scorecards. This Trust-wide Scorecard table (presented below) is followed by a number of PowerPoint slides highlighting certain issues 'by exception'.

1.2 Work continues on the development of the quality and safety metrics that need to be in place at Board level. This month we have included an analysis of performance against the 62-day Single Cancer Pathway (SCP) in section 2.2 of this report (pages 19 to 23).

Quality Domain	Trust-wide Safety Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safe	Total Number of Velindre Acquired Infections (VAIs) across all bacteraemia types (WHC 2024 (38) target) Cumulative 25/26 versus 24/25	National	Monthly	23/24 Base 13	<13 24/25	4 25/26	✓	➔	
	SACT 30 Day Mortality Benchmark	Curative	Monthly	2.00%	2.00%	0.192% Dec	✓	➔	
	Inpatient Mortality Target under development/to be agreed	Inpatient	Monthly	N/A	N/A	4 Jan	✓	➔	
	Number of National Reportable Incidents	National	Monthly	0	0	1	✗	✓	Minor Variance
	WBS Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority	Local	Monthly	0	-	2	✗	➔	Minor Variance
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	Local	Monthly	New	<5%	0%	✓	⬇	Pages 24-27
	Number of incidents triggering Duty of Candour	National	Monthly	0	0	1	✗	➔	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ⬆ stable ➔ fluctuating ⬆⬆ deteriorating ⬇									

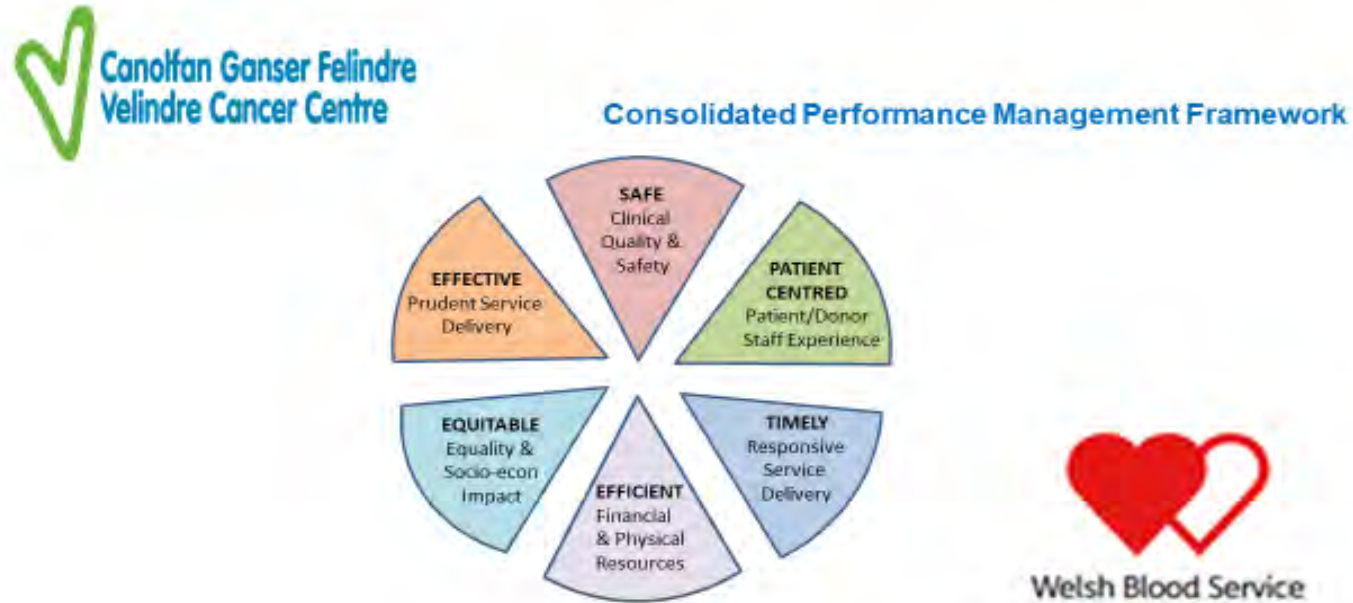
Quality Domain	Trust-wide Timeliness Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timely	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	22% 79%	X	↓	Pages 9-14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	18% 71%	X	→	Pages 9-14
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	83% 100%	✓	↑	
	% Patients Beginning Non-Emergency (Routine) SACT within 21 days	National	Monthly	98%	98%	38%	X	↕	Pages 15-19
	% Patients Beginning Emergency SACT within 2 days	National	Monthly	100%	98%	100%	✓	↑	Pages 15-19
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	93.7%	✓	↓	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	99%	✓	↓	Pages 24-27
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%	100%	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↕ deteriorating ↓									
Quality Domain	Trust-wide Effectiveness Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effective	Number of Cancer Pathway of Care Delays	National	Monthly	1	0	3	X	→	Minor Variance
	Clinical demand for red cells met (% manufactured to issued)	Best practice	Monthly	104%	100%	110%	✓	↓	
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	127%	✓	↓	
	New stem cell volunteers	National	Monthly	3341	333	486	✓	↑	
	New Apheresis Donors	Local	Quarterly	21	14	12	✓	↓	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↕ deteriorating ↓									

Quality Domain	Trust-wide Efficient Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	N/A	99%	N/A	✓	↕	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£0	£0	£29k	✓	↕	Minor Variance
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£180k	£180k	£312k	✗	↕	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 as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	7.91%	✓	↑	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	7.05%	✗	↑	
	% of Workforce <u>who have declared</u> Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	96.50%	✗	↑	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↕ deteriorating ↓									
Quality Domain	Trust-wide Experience Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Person Centred	% of Patients Who Rate Experience at VCS as good or very good	Prof. Std.	Monthly	95	85%	98%	✓	→	
	% of 'formal' VCS concerns responded to within 30 working days	Local	Monthly	100	85%	100%	✓	→	
	Whole blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	90%	✓	↑	

	Resolution of WBS formal concerns within 'Putting Things Right' regulations timescale	National	Monthly	100%	100%	100%	✓	➔	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	82%	X	↕	Page 28-32
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.37%	X	↑	Page 28-32
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	Local	Monthly	N/A	27 25/26	5 Oct 30 cum	X	↓	Minor Variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✕ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↕ deteriorating ↓									

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION BY EXCEPTION FOR SEPTEMBER 2025

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



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

3. KEY ISSUES HIGHLIGHTED BY EXCEPTION

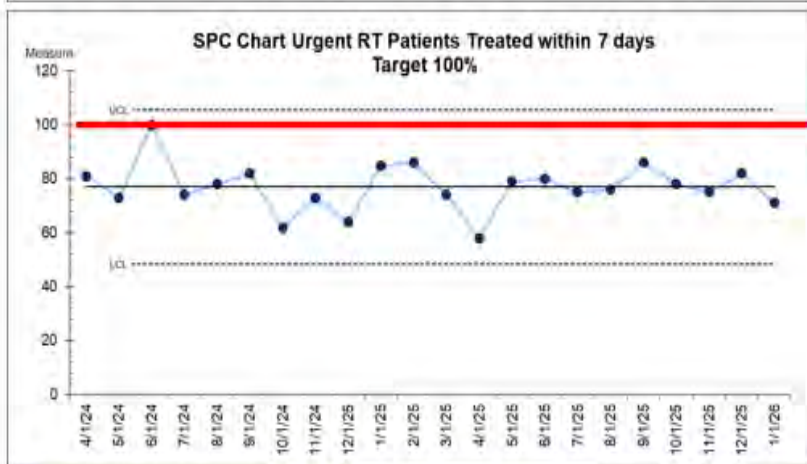
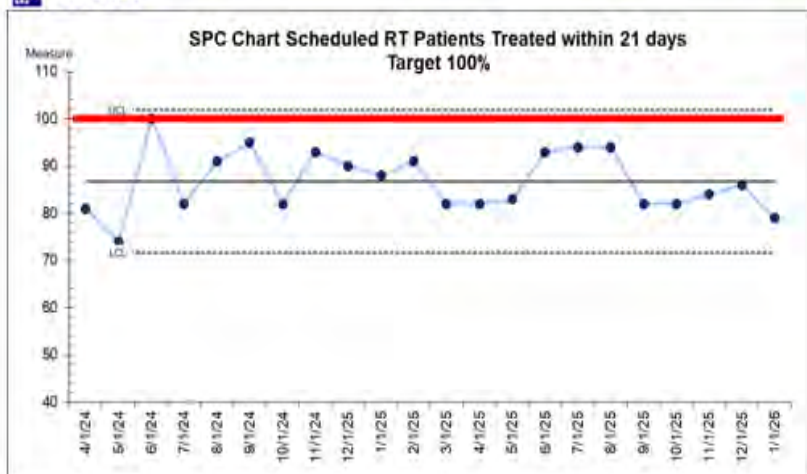
3.1 Velindre Cancer Service Radiotherapy

Radiotherapy Waiting Times activity

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

Radiotherapy Waiting Times activity

Jan 2026



Shadow Reporting Jan 2026

	Target	January 2026		January 2026 with pauses	
Scheduled	Number of referrals	214		214	
	% within 14 days (80%)	45	22%	45	22%
	% within 21 days (100%)	163	76%	155	72%
Urgent SC	Number of referrals	28		28	
	% within 2 days (80%)	5	18%	5	18%
	% within 7 days (100%)	20	71%	20	71%
Emergency	Number of referrals	23		23	
	% within 1 day (80%)	15	65%	15	65%
	% within 2 days (100%)	23	100%	23	100%
Elective Delay	Number of referrals	75		75	
	% within 9 days (80%)	71	95%	71	95%
	% within 14 days (100%)	71	95%	70	93%
Design		0		0	
Total number of referrals		341		341	

COSC WG optimal standards (stretch targets) are indicated in grey

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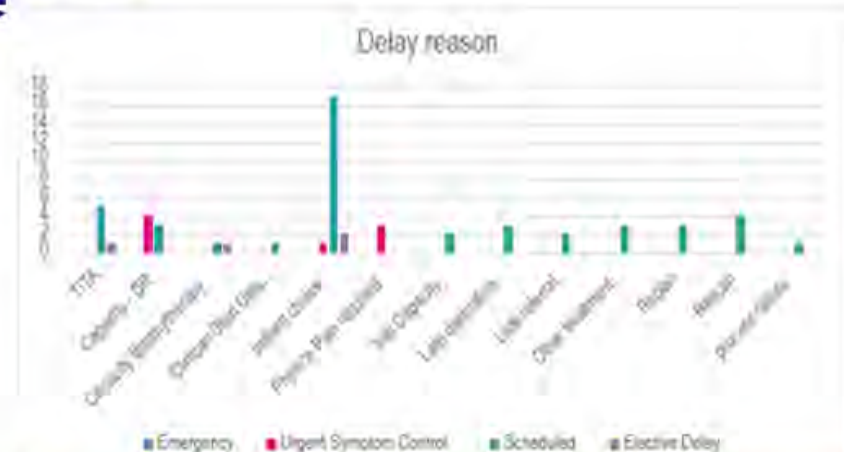


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Radiotherapy – Performance Narrative

Performance update: January

- Emergency patients treated within 2 days – 83%
- Compliance with the scheduled time-to-treatment 21-day target was 79% (with pauses, 91%). Longest wait to commence a scheduled treatment was 71-days due to a late referral (a Datix has been submitted and investigation instigated).
- Compliance with the urgent symptom control time-to-treatment target was 71% (with pauses, 75%).
- Elective delay performance was 95% (with pauses, 99%).
- Planned pre-treatment CT capacity was 24.5hrs per day (17 hours at VCS, Cardiff and 7.5 hours at V@NHRU).
- Planned linac capacity was at 78 hours per day.



Key breach reasons relate to the requirement to undertake a pre-treatment re-scan, patient choice and instances when patients were too unwell to begin treatment as scheduled..

January saw a significant number of instances of patient choice identified as the reason for delayed treatment start. This is where a patient makes a decision not to accept a date for treatment.

'Other treatment' relates to other medical intervention required, impacting on the ability to give a defined date for RT -e.g. PEG insertions, Dental extraction, potentially unavoidable breach

All Wales Comparative Performance

January 2026

COSC Mandatory Quality Standards													
Site	Case Mix		Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
VCC	Scheduled	21 days	100%	81%	83%	93%	94%	85%	82%	82%	84%	86%	79%
SWWCC	Scheduled	21 days	100%	75%	60%	43%	34%	66%	80%	41%	18%	33%	17%
NWCTC	Scheduled	21 days	100%	24%	70%	56%	47%	51%	82%	79%	34%	23%	21%
VCC	Urgent SC	7 days	100%	58%	79%	80%	75%	76%	86%	78%	75%	82%	71%
SWWCC	Urgent SC	7 days	100%	75%	71%	73%	71%	63%	52%	65%	74%	59%	76%
NWCTC	Urgent SC	7 days	100%	66%	83%	79%	80%	86%	91%	81%	84%	73%	88%
VCC	Emergency	2 days	100%	100%	100%	95%	100%	100%	100%	90%	100%	95%	100%
SWWCC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92%
NWCTC	Emergency	2 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VCC	Elective Delay	14 days	100%	98%	99%	96%	99%	99%	97%	97%	100%	96%	95%
SWWCC	Elective Delay	14 days	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%
NWCTC	Elective Delay	14 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%

COSC Stretch Quality Standards													
Site	Case Mix		Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
VCC	Scheduled	14 days	80%	16%	31%	23%	26%	16%	14%	20%	22%	29%	22%
SWWCC	Scheduled	14 days	80%	28%	11%	7%	9%	19%	28%	7%	9%	12%	7%
NWCTC	Scheduled	14 days	80%	5%	13%	20%	10%	9%	12%	6%	9%	9%	12%
VCC	Urgent SC	2 days	80%	11%	8%	18%	14%	11%	9%	6%	14%	35%	18%
SWWCC	Urgent SC	2 days	80%	39%	48%	42%	32%	49%	26%	45%	29%	19%	36%
NWCTC	Urgent SC	2 days	80%	24%	48%	18%	20%	35%	35%	25%	28%	24%	23%
VCC	Emergency	1 day	80%	88%	91%	86%	95%	87%	91%	83%	82%	91%	83%
SWWCC	Emergency	1 day	80%	100%	100%	100%	88%	100%	100%	83%	100%	100%	92%
NWCTC	Emergency	1 day	80%	100%	100%	92%	100%	100%	100%	100%	100%	100%	100%
VCC	Elective Delay	7 days	80%	98%	96%	94%	99%	98%	95%	97%	98%	96%	95%
SWWCC	Elective Delay	7 days	80%	96%	98%	97%	100%	94%	97%	93%	98%	100%	99%
NWCTC	Elective Delay	7 days	80%	83%	97%	100%	97%	100%	100%	98%	100%	95%	100%

COSC quality standard

- VCS performed better than both SWWCC and NWCTC for scheduled treatments.
- SWWCC and NWCTC performed better than VCS for urgent symptom control treatments in January.
- All VCS emergency patients began treatment within target.

COSC stretch quality standards

- VCS performed better than both SWWCC and NWCTC for 14 day scheduled treatments.
- SWWCC and NWCTC performed better than VCS for urgent symptom control treatments in January.
- VCS performed less well than SWWCC and NWCTC for emergency treatment but, compliance at VCS exceeded the quality target
- For elective delays, VCS compared favourably with SWWCC at 95% which was above the 80% quality target.

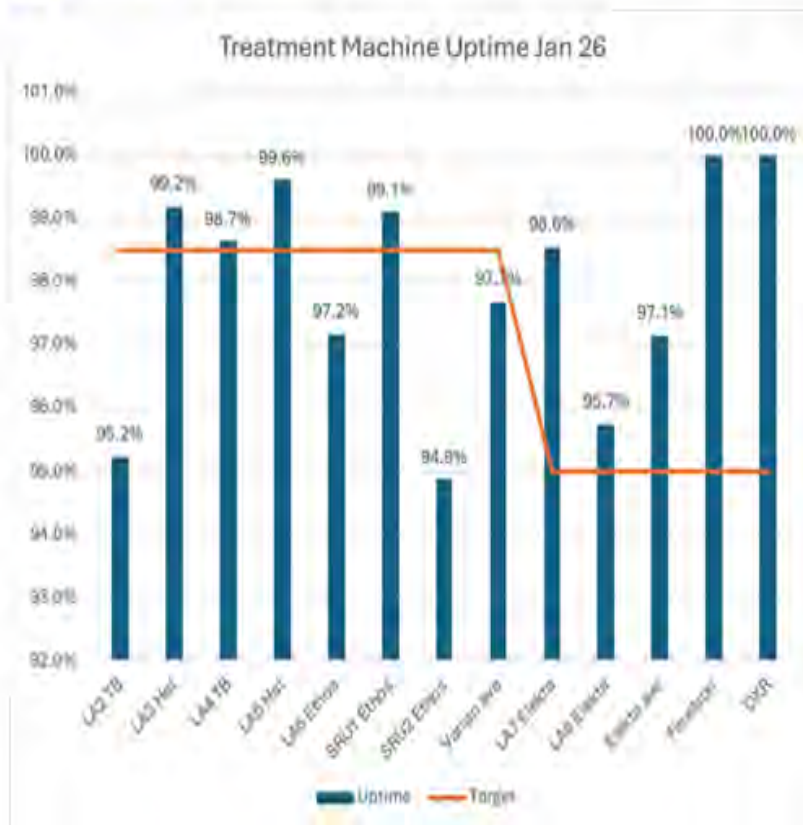
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Radiotherapy – treatment machine (Linac) uptime

January 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 97.7% (slightly below the December percentage of 99.4%) which is below the target of 98.5% for the IRS contract.
- The Elekta average uptime was 97.1%. This was a marginal decrease relative to the reported percentage uptime in December (97.7%) but, was above the in-house target of 95%.
- The combined Linac, Flexitron and DXR uptime was 99.2%.

Radiotherapy Waiting Times activity

Updates

Pilot for Ethos Palliative solution for V@NHRU taking place January 2026

Progress with addressing workforce capacity gaps including:

- Bank Radiographer appointed 12months, commenced in post January 2026 to cover unfunded vacancies
- Fixed term business case extended to provide cover for maternity leave in order to maintain Linac Capacity at VCS Cardiff and V@NHRU
- Development of reactive management of scheduled interruptions in treatment delivery – improved utilisation of available capacity

Data warehouse issues identified and escalated for analysis and resolution.

Linac (LA6) upgraded to ethos which will provide more flexibility for treatment options across the fleet pending full transition to nVCC.

Risks/issues

- Fragility of existing fleet (LA7, LA8) due to aging equipment and consequential breakdown of linacs. Additional capacity sourced from V@NHRU and LA1 where instances occur.
- LA1 is out of support and is only used if LA7 or LA8 is broken down.

Actions for next month

- Review Ethos palliative solution for V@NHRU that was piloted in January.
- Continue review of data capture on Aria with data and insights, finance, and Radiotherapy physics computing, to better reflect RT activity
- Continue to prepare for Aria Core InSights (Oncology Specific Analytics) implementation
- Development of activity reporting for Brachytherapy – following paperless go live
- Development of activity reporting – following paperless go live
- Ongoing benchmarking with BCUHB and SBUHB, The Royal Marsden and Clatterbridge
- Reintroduce palliative radiotherapy clinic January 2026

Mitigation

- The implementation of Aria Core Insights through IRS will result in more sophisticated pathway analysis and reporting and targeted improvement proposals
- Implementation of Carepath for Radiotherapy IR(ME)R practitioners – improved visibility of the pathway
- Weekly MDT capacity planning meeting to review any capacity concern and forecast planning for following week
- Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.

SACT Definitions and timings

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

SACT Performance Reporting

Systemic Anti Cancer Therapy Clinical Quality Performance Indicators

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

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

SACT Performance Reporting VCS

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

National SACT Data Group

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

Next steps

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

SACT Performance – Updated – Jan 2026

The performance in January against ALL treatment intent standards (ie P2 standards at 14 days and P3 standards at 21 days) was 47% - this is a combination of the IV and oral performance

SACT Performance Overview

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Total referrals (IV & Oral)	314	355	303	337	353
Total Number of breaches	151	182	125	154	185
Percentage Compliance	52%	49%	59%	54%	48%

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
IV first treatment	234	269	218	237	234
Total IV breaches	125	159	102	122	151
% compliance	47%	41%	53%	49%	35%
Oral first treatment	80	81	85	100	119
Total Oral Breaches	26	20	23	32	35
Percentage compliance	68%	75%	73%	68%	71%

SACT Performance by Treatment Intent – January 2026

SACT waits by Treatment Intent

	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
(P1): Emergency referrals	4	7	4	7	1
Total Breaches	1	3	0	4	0
% Within 2 days	75%	57%	100%	43%	100%
(P2): Primary Definitive referrals	27	29	21	27	17
Total Breaches	16	23	16	19	12
% Within 14 days	41%	21%	24%	30%	29%
(P2): Neo-Adjuvant referrals	44	64	43	53	41
Total Breaches	22	38	13	27	30
% Within 14 days	50%	41%	70%	49%	27%
(P2): Palliative referrals	106	124	102	98	112
Total Breaches	65	85	63	59	76
% Within 14 days	39%	31%	38%	40%	32%
(P3): Adjuvant referrals	55	46	48	55	64
Total Breaches	20	10	10	13	32
% Within 21 days	64%	78%	79%	76%	50%
No intent on allocation (14 day target applied)	78	85	85	97	118
Total Breaches	27	23	23	32	35
% within 14 days	65%	73%	73%	67%	70%

Data has been amended to exclude specific drugs in line with the clinical guidelines.

New reporting removing cycle 1 regimens not related to first cycle of treatment

P1 – 1 patient validated off report. Patient was referred for emergency treatment in January. The treatment start date was specifically requested by the referring consultant and in line with this the patient began treatment within 5-days.

P2 – 31% of patients received treatment within 14 days (118 breaches from 170 DTT date):

- P2 first definitive- 12 patients did not begin treatment within target.
- P2: neoadjuvant - 30 patients did not begin treatment within target.
- P2 Palliative: 76 patients did not begin treatment within target.

P3:Adjuvant: 32 patients did not begin treatment within target.

14 day target applied where intent on allocation is not recorded. Of these (118) 35 patients did not begin treatment within target.

Top three hospital related IV breach reasons for all priorities (81 total) in January based on reviews carried out under previous reporting were as follows:

- Daycase capacity (33)
- Concurrent RT (13)
- Scheduling delays (24)

(monthly comparative breach data not available due to change in reporting)

Larger drop in performance (IV) for specific treatment intents due to delays in scheduling and as such clinical prioritisation taking place.

SACT Updates/Actions January 2026

Update from last month

- Reporting at VCS in line with P1/P2/P3 national priorities now in place
- Data quality issues now excludes i.e. non-reportable breaches related to specific drug treatments in line with national guidance and removal of all cycle 1 incorrectly recorded 'first' cycles
- SACT booking team being supported by admin teams to release capacity to support SACT booking

Key risks/issues

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

Mitigation

Booking capacity remains a challenge:

- Focused scheduling of Nantgarw Support Unit capacity to maximise this capacity.
- Daily update on Pending report to show number of referrals, no. of patients booked and no. of patients waiting to be scheduled.
- Team exploring further options to transfer some activities and tasks to other admin teams to release SACT scheduling capacity.
- Recruitment to vacant posts underway.
- All sickness and absence being managed in line with Trust policy.
- Overtime being supported.
- Team continue to liaise with Clinical Trials to utilise any available trial chair capacity
- Increase in overbooking cap at Nantgarw Support Unit agreed with Lloyds

Actions for next period

- Head and neck – support on-going discussions at a national level on whether chemo / radiotherapy time to treatment breaches should be included in systemic therapy performance reporting – SACT enables radiotherapy treatment but, breaches aren't typically reported as radiotherapy breaches
- Commence consultant level pathway review by SST to baseline typical pathway length and composite waits.
- Weekly Access Meetings in place
- SACT PTL to be used to review and record breaches
- Recruitment into vacancies
- Reach out to System C / Chemocare to review SACT booking process and opportunities for efficiencies

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3.2 Single Cancer Pathway (SCP)

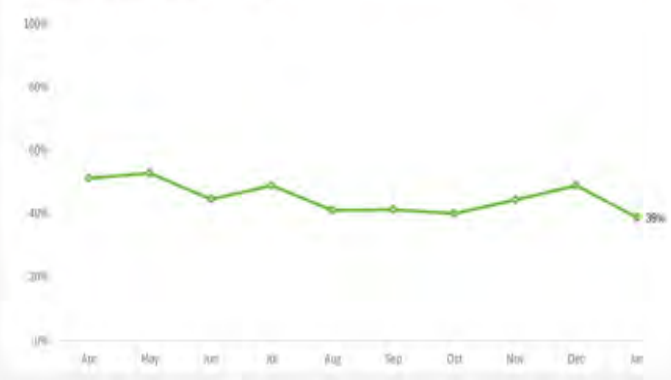
Single Cancer Pathway Performance Overview (62days)

Percentage of SCP referrals received by Velindre that are treated within 62 days of Point of Suspicion.
Treatment started April 2025 - January 2026



- For January 2026, 28% of patients on a SCP were referred to VCS for their FDT (first definitive treatment) i.e. the pathway was completed at VCS and treated within the 62-day pathway.
- National standard is 75% treated within 62 days from point of suspicion to FDT
- Of the patients referred to VCS, 39% were treated within 24 days from receipt of referral to FDT during January [this is a locally agreed target for which VCS would contribute to the whole patient pathway]

Percentage of people starting treatment within 24 days of SCP referral to Velindre.
Treatment started between April 2025 - January 2026



SCP Referrals by Healthboard – January 2026

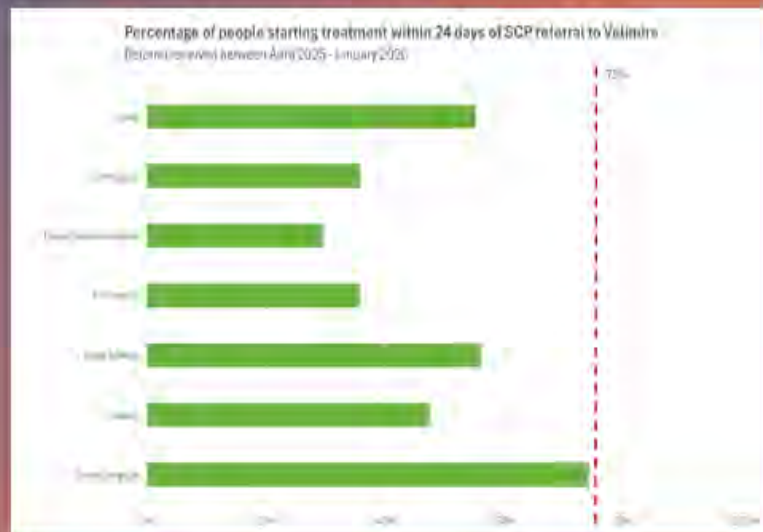
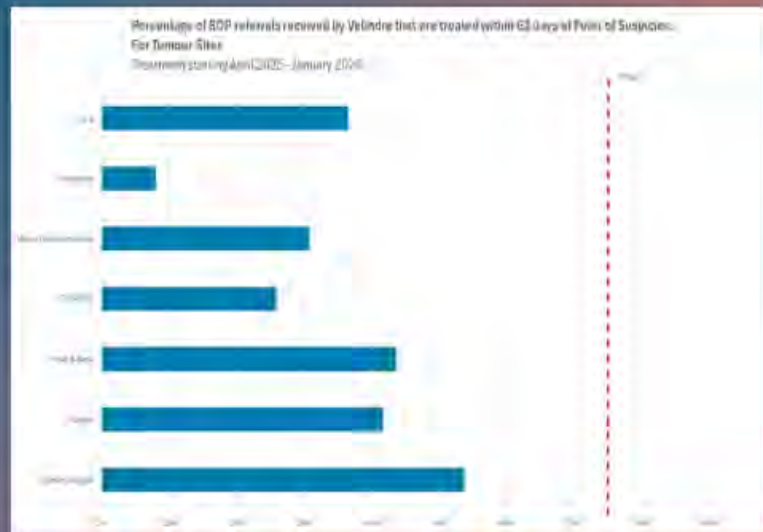
Referrals received:
April 2025-January 2026



	2025										2026	
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Grand Total	
ABHB	52	63	55	71	69	79	66	70	66	50	641	
CAV	60	60	61	54	49	51	61	45	41	43	525	
CTM	29	26	31	46	30	34	43	40	47	31	367	
SBUHB	35	20	17	24	20	27	23	12	19	13	210	
OTHER	17	15	17	18	5	16	8	11	12	15	134	
HOUHB			1								1	
Grand Total	203	185	191	213	173	207	201	178	175	152	1275	

Referrals – a **mean of 188 referrals per month that are linked to SCP** are received by Velindre. This accounts for **53% of new referrals** received, other new referrals will be related to subsequent treatment (e.g. post surgical-treatments) and therefore, not related to the SCP. AB is the largest referring HB to VCS.

SCP Pathway Analysis (April 2025-January 2026)

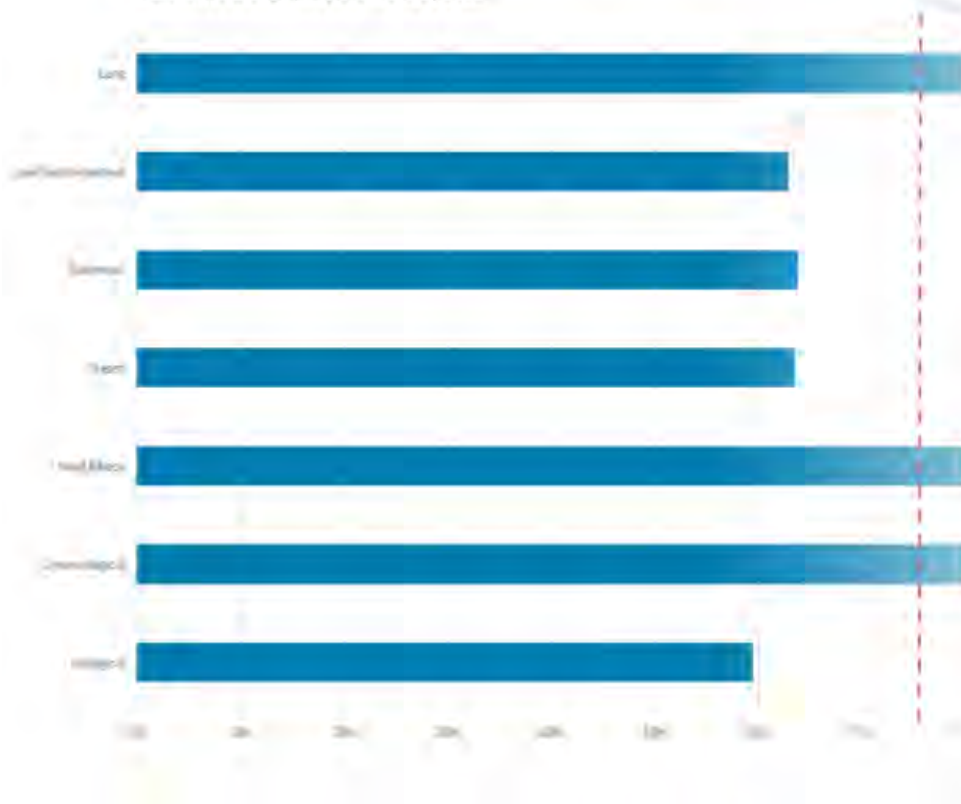


- **Chart 1** - shows the percentage of patients who are treated within 62 days of point of suspicion by tumour site irrespective of the referring HB.
- **Chart 2** - shows the percentage of patients who are treated within 24 days from the referral received into VCS by tumour site, irrespective of referring HB.
- **Shared Breach Standard @ VCS** - 75% of patients treated within 24-day target from referred. [by March 2027].
- **Next steps:** A trajectory and improvement plan is being developed within VCS, in collaboration with data and insights, to identify the key bottlenecks across the VCS pathway and to develop an associated improvement plan – three SST have been identified as the main area of focus – Breast, Head and Neck and Lung.

SCP Pathway Analysis – Patients referred by day 38 of PoS

- This chart shows the proportion of patients who start treatment within 62 days of POS where the referral is made from the HB within 38 days – this is based on the period April 2025- January 2026

Where referral received by Velindre within 38 days of PoS, proportion of patients that are treated within 62 days of PoS. For Tumour Sites
Treatment starting April 2025 - January 2026

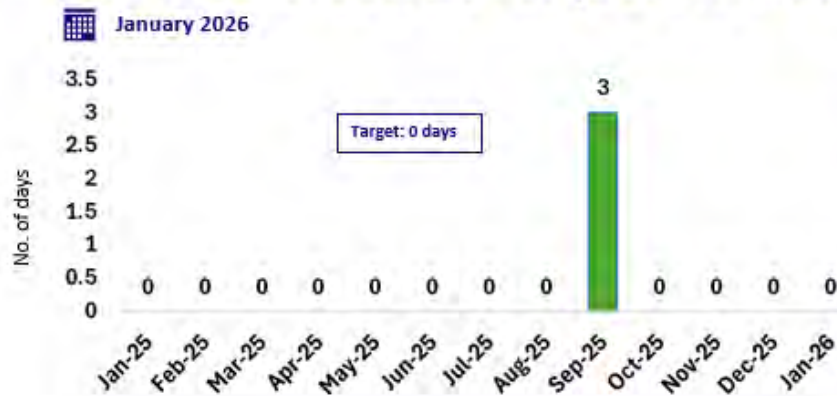


3.3 Welsh Blood Service

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



Gwasanaeth Gwaed Cymru
Welsh Blood Service



Key Issues / Risks:

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

Action / Mitigation Underway:

- Daily Resilience meetings to ensure immediate operational responses and mitigate any arising issues.
- Monthly Blood Supply Chain Planning Group meetings with focus on medium and long-term planning.
- Operational Assurance Framework in development - first iteration by Qtr. 4.
- Exploring a donor recruitment and retention study with Health Technology Wales; bid submission planned Qtr. 4.

Updates on last month:

- All clinical demand was met for O, A & B+ groups.
- Red Blood Cells manufactured reached 110% of demand, enabling stock levels to be rebuilt and strengthening overall service resilience.

Forecast / Next Month:

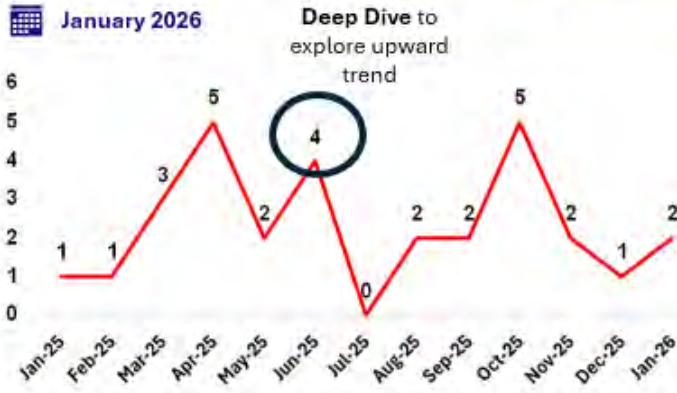
- Performance remains good and is likely to continue in February 2026.

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WBS Incidents Reported to Regulator / Licencing Authority



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

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

SABRE 153: The donor had been bitten by a monkey in 1983 and had declared this previously but had not been deferred as required. The root cause was ambiguous wording of the primate / animal bite eligibility questions that led to misinterpretation at the previous attendance.

SABRE 154: A patient with a known anti-S antibody required cross matched blood. The patient's sample was tested and found negative for this antibody on this occasion. Although compatible crossmatched units were issued, these were not negative for the known antibody. Root cause has been identified as a manual review of a request form that is difficult to interpret.

Action / Mitigation Underway:

- Both SABRE incidents above were caused by human error arising from misinterpretation.
- Work to simplify donor eligibility assessments and implementation of a new digital system by August 2026 will reduce donor-eligibility and transcription errors seen previously.

Quality Assurance – Incidents & Audits

January 2026

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

↑ 1 exceeding target date for closure (in reporting month)	Target: 0
↑ 0 that remains overdue at month end	Target: 0
↑ 0% overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

→ 6 exceeding target date for closure (in reporting month)	Target: 0
↑ 13 that remain overdue at month end	Target: 0
Age of oldest open overdue incident – 159 days	No target set

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

0 from internal audits in the last month	No target set
0 from external audits in the last month	No target set
↑ 13.9% overdue actions from open audit action plans	Target: <5%

Action / Mitigation underway:

- An action plan has been developed to address the overdue incidents, supported by clearer accountability, weekly monitoring, targeted backlog sessions, and new training resources. This includes developing quick reference guides, a 'how-to' video, and bitesize learning sessions, after a deep dive identified that many issues stem from limited awareness of processes and system requirements.

Key:

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

Time Expired Platelets



Updates on Last Month:

- Platelet expiry held at 12% this month, close to the 10% target, driven by December-January demand variability. No improvement was expected in January due to Christmas and New Year operational disruptions.
- Forecasting uses the previous six weeks of issuing data plus a 10% buffer (one standard deviation), allowing the model to self-correct over time. Reductions must be gradual to avoid platelet shortages.



Gwasanaeth Gwaed Cymru
Welsh Blood Service

Key Issues / Risks:

- Difficult to match supply and demand due to short shelf life.
- High risk of wastage if demand forecasting is inaccurate.
- Potential shortages impacting patient care during unexpected surges in demand.

Action / Mitigation Underway:

- Continue using the six-week rolling average plus one standard deviation to allow gradual self-correction and avoid sharp reductions.
- Implement daily review of platelet stock levels against forecast demand to identify early signs of imbalance.
- Continue to embed the Platelet Planning Tool as part of the launch of the new Platelet Operational Plan.

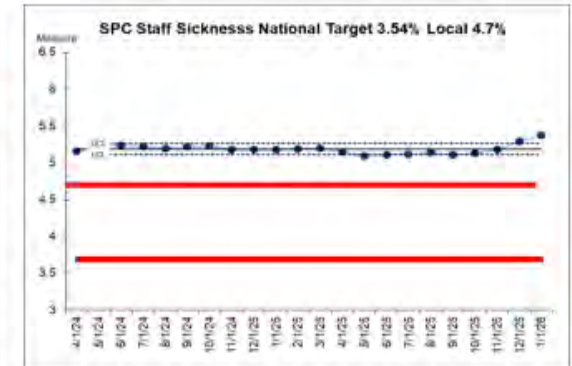
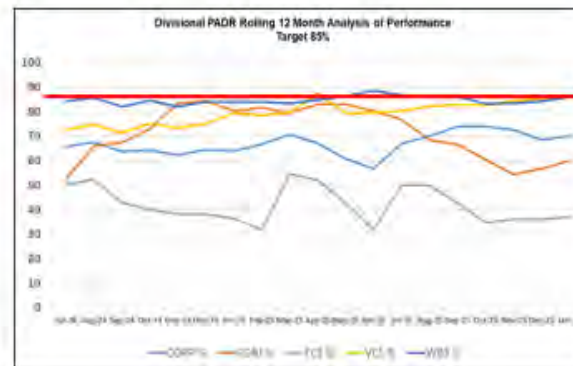
Forecast / Next Month:

- Performance likely to improve in February 2026.

3.4 Workforce and Wellbeing

People, Wellbeing & Organisational Development

January 2026



Updates on Last Month:

- PADR – Ongoing management of action plans
- Sickness – Trust action plans following detail absence analysis are ongoing and progress towards target is being monitored

Forecast / Next Month:

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

Action / Mitigation Underway:

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

Key Issues / Risks:

- Capacity of management time to undertake effective people management activities alongside clinical workload
- Capability and confidence of managers to effectively undertake people management activities

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Gofal ardderchog, dysgu ysbrydoledig, pobl iachach



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People KPIs Heatmap

January 2026

	PADR	Sickness Absence FTE Rolling	Stat & Mand	Welsh Language Awareness	Anti Racism	Turnover FTE Rolling	Job Plan
Velindre NHS Trust	81.81	5.37	88.92	83.49	88.13	9.10	88.12
Corporate Services	70.14	4.44	85.23	85.98	86.36	10.74	N/A
Research Developments and Innovation	60.00	4.22	88.36	82.19	89.04	12.69	N/A
Transforming Cancer Services	37.84	1.10	90.29	77.14	82.86	6.50	N/A
Velindre Cancer Service	85.97	5.51	87.62	83.37	86.23	7.74	87.63
Welsh Blood Service	86.08	6.05	88.92	83.04	93.70	10.83	100.00
Target	85%	3.54%	85%	90%	85%	7%	90%

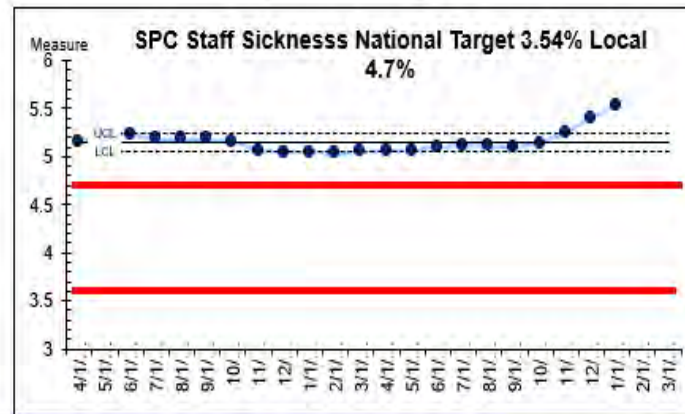
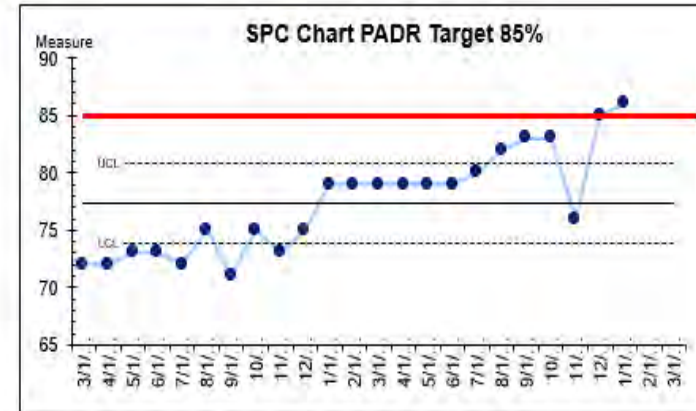
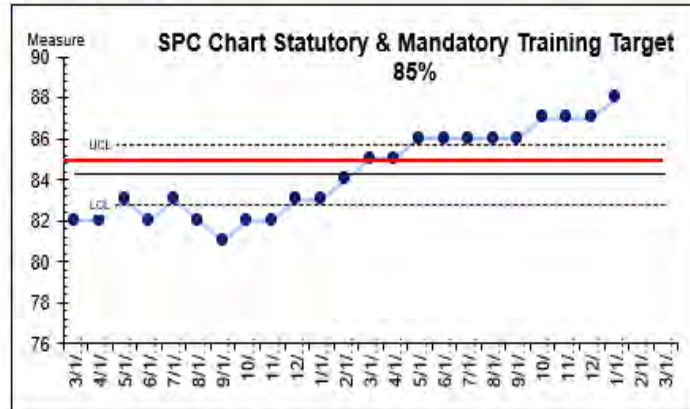
People - NHS Staff Survey Culture Metrics - 2024

	Response Rate %	Staff Engagement Index %	We are able to speak up %	We are compassionate and inclusive %	We are continuously learning and improving %
Velindre University NHS Trust	33.7	77	72.1	77.9	69
Corporate Services	59	79.5	74.8	80.7	75.2
Research Development and Innovation	22.6	74	68.6	79	69.8
Transforming Cancer Services	34.8	suppressed	suppressed	suppressed	suppressed
Velindre Cancer Service	30.9	74.9	72.6	79.2	68.5
Welsh Blood Service	31.1	77	69.4	73	64.4
NHS Wales	21.9	72	70.5*	74.6*	70.4*

Data from NHS Wales Staff Survey 2024 App. All figures taken from the dashboard, except for Staff Engagement Index for Divisions, which is taken from the paginated report.
TCS received 8 responses therefore the results are suppressed at Divisional level.
Green is higher than NHS average, pink is lower than NHS average.
*Average of benchmarking group of Trusts and Authorities.

People, Wellbeing & Organisational Development VCS

January 2026



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People, Wellbeing & Organisational Development – Spotlight on VCS

 January 26

- Sickness absence rates for the last 12 months

Sickness Rolling % Velindre Target Figures	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Velindre Cancer Services	5.07	5.07	5.07	5.07	5.10	5.18	5.16	5.15	5.18	5.28	5.46	5.53

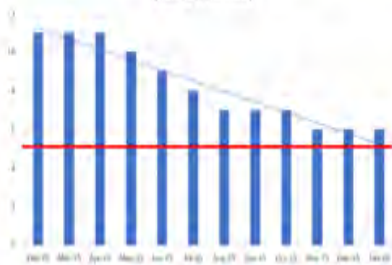
- In Spring/Summer rates were close to our Trust target of 4.70%
- Sickness remains cyclical with increased rates in Winter months

3.5 Digital Services

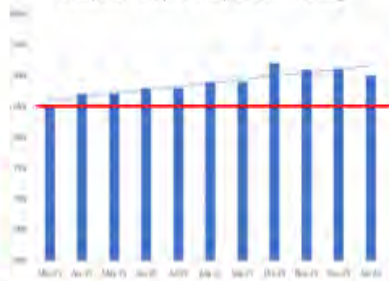
Digital Services

January 2026

Number of Significant IT Business Continuity Incidents (Rolling 12 months)



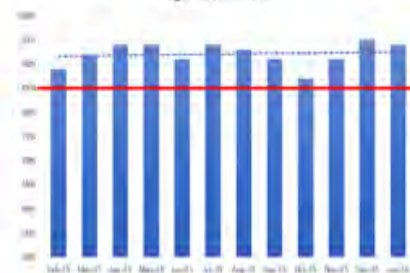
% Compliance with Cyber Security Stat. & Mand. Training



% Digital Service Desk requests resolved within agreed timescale



% Digital Service Desk incidents resolved within agreed timescale



Updates on Last Month:

- Service performance – Our performance remains above the agreed percentage; Incidents performance decreased slightly in January. Factors to consider is the Windows 11 migration project.
- No significant IT business continuity incidents raised in January. Target met again.
- 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 97% complete with the remainder Windows 10 on extended support and due for replacement.

Action / Mitigation Underway:

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

Key Issues / Risks:

- Capacity v Demand of requests on the IMTP.

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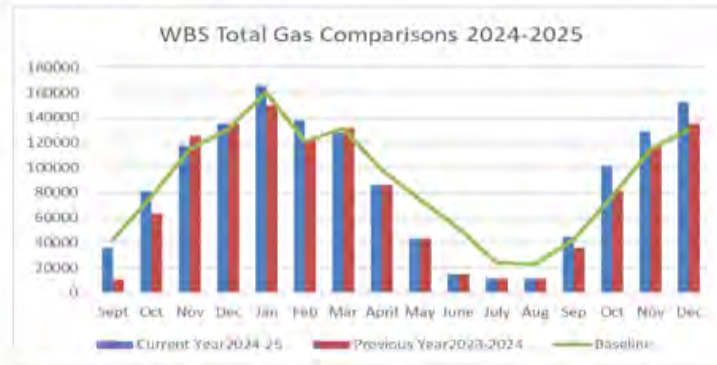
3.6 Estates Infrastructure and Sustainability

Estates Sustainability

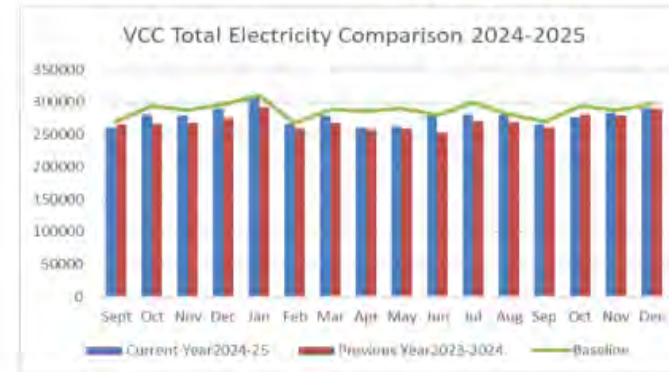


December 2025

Gas- Talbot Green



Electricity – VCC Hospital



Updates on Last Month:

- **Gas consumption** increased across the Trust in line with the colder temperatures and heating coming on. Unusual increase in WBS TG action point of reviewing Trust BMS access. AMR fault in VCC Hosp gas meter meaning data has been skewed.
- **Electricity consumption** remains steady across the Trust.
- **Staff engagement events** were held highlighting energy and waste reduction initiatives, including: The Great Big Paper Cut campaign/Promoting correct segregation of waste across Trust sites/Encouraging

Forecast / Next Month:

- **Waste management:** Recycling rates expected to improve following compactor repair; food waste collection expanded at additional sites.
- **Cost monitoring** continues through WEOG; potential price increases to be mitigated through operational efficiency and staff engagement.
- Continued focus on long-term sustainability initiatives, including LED lighting upgrades, renewable energy planning, and circular procurement practices.

Action / Mitigation Underway:

- Internal energy audits and ongoing BMS monitoring to identify hotspots and reduce consumption.
- **LED lighting upgrades** with motion and daylight sensors in identified areas, work started
- **Compactor at VCS repaired;** food waste bins rolled out at multiple sites.
- **Renewable energy feasibility study** planned for next quarter.
- **Electric vehicle charger up and running** (awaiting install of staff/donor charger at Talbot Green)
- **Staff engagement campaigns** on energy saving and correct waste segregation.

Key Issues / Risks:

- **High energy costs:** Electricity and gas prices remain elevated; monitored through the Welsh Energy Operational Group (WEOG).
- **Recycling performance:** The new waste contract is in place.
- **Operational demand:** noticing increase in gas across the Trust, in line with previous years, due to heating being turned on,

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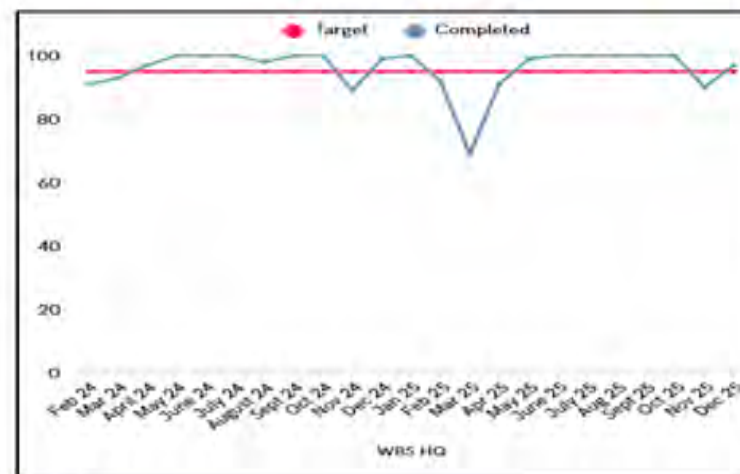
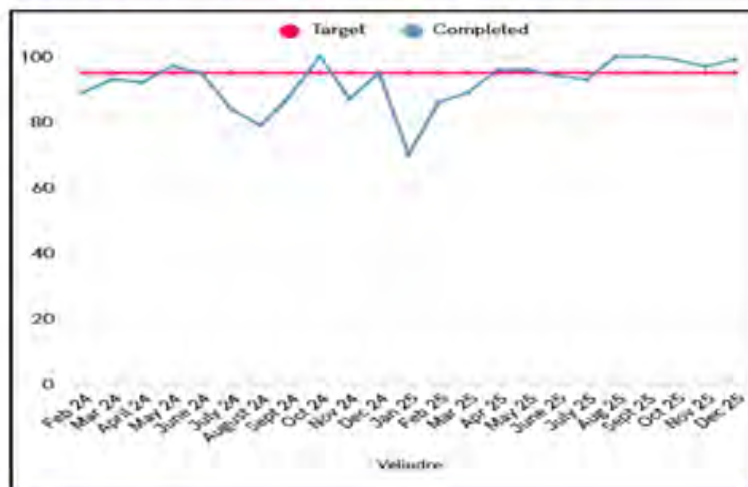
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Estates and Infrastructure

December 2025



Updates on Last Month:

- VCS – 97 PPM – Reactive – 98%
- Wrexham – 82% PPM Reactive – 100%
- Trust HQ – 83% PPM Reactive – 100%
- Dafen – 100% PPM Reactive – 100%
- WBS HQ – 99% PPM Reactive 100%
- Bangor – 100% PPM Reactive – 100%

Forecast / Next Month: January 2026

- 193 PPMs planned for VCC
- 89 PPMs planned for WBS sites.
- 39 PPM planned for Nantgarw

Action / Mitigation Underway:

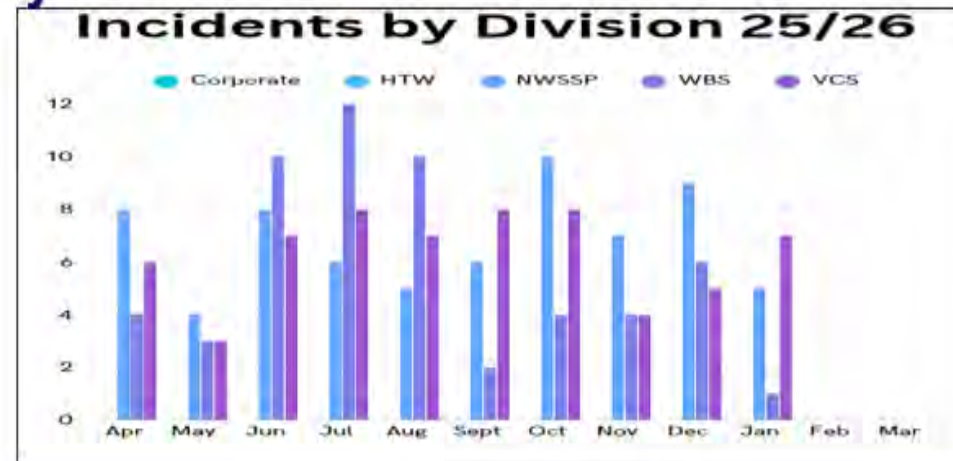
PPM compliance experienced a temporary dip in December 2025 at Trust Headquarters and the Wrexham site; however, this has now been fully rectified and compliance levels have returned to expected standards. Additional management support has been recruited to further strengthen compliance monitoring and support consistent implementation across the Trust.

Key Issues / Risks:

- Development updates on the CAFM system are being monitored via a work platform and are expected to be completed by March 2026. Monthly progress meetings taking place.
- An action plan has been developed by the CAFM provider, and the Trust is closely monitoring progress through monthly meetings with the system provider.

Health & Safety

Jan 2026



Updates on Last Month: Total of incidents

- NWSSP - 5
- VCS - 7
- WBS - 0
- MIM (Trust Managed) - 0
- RIDDOR - 0

Action / Mitigation Underway:

- VCS & WBS - Continued development of the Health & Safety Management System (Principle 1).
- ISO 45001 training completed; DGSA training scheduled.
- Health & Safety Legal Register in development.
- Divisional engagement underway to streamline reporting (FRESH), including improving WBS reporting access.
- March commencement of Annual Report data collation and topic audit development.
- Targeted controls in place for sharps, slips/trips and manual handling.
- WBS cold burn incident investigated; controls reviewed.
- Pregnancy Risk Assessment page refreshed and pending rollout.

Forecast / Next Month:

- VCS & WBS - Continuation of the HSMS governance framework.
- Progression of the Legal Register toward implementation.
- Completion of DGSA training.
- Rollout of refreshed Pregnancy Risk Assessment guidance.
- Annual report data gathering and audit development.
- Ongoing monitoring of incident trends, with sharps and slips/trips likely to remain predominant categories.

Key Issues / Risks:

- VCS & WBS - Sharps and Slips/Trips remain the highest incident categories; stable but persistent.
- Reporting accessibility and culture, particularly within WBS, presents potential underreporting risk.
- Management system maturity – until KPIs, legal register and audit framework are fully embedded, residual assurance risk remains.
- Regulatory compliance risk linked to dangerous goods oversight and statutory monitoring (mitigation underway).

Health & Safety

Jan 26

This slide demonstrates that most incidents were low harm. There was one Severity 3 incident, related to a manual handling injury resulting in more than seven days absence. There were no catastrophic or major harm events.



Level 3 Incident Summary (6/05/2025)

- Incident type: Manual Handling Injury
- Area: WBS Collections
- Severity outcome >7 consecutive days lost work case
- Clinical outcome: No fracture or permanent harm
- Current status: Staff returned to work

Fire Safety

January 2026



FIRE RISK ASSESSMENT (Jan 26)												
FIRE RISK ASSESSMENT (Jan 26)	CRITICAL (1-2)				SIGNIFICANT (3-4)				ACTIONABLE (5-6)			
	NO.	1-2	3-4	5-6	NO.	1-2	3-4	5-6	NO.	1-2	3-4	5-6
COMPLIANCE (L1)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
COMPLIANCE (L2)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
COMPLIANCE (L3)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Updates on Last Month:

STRATEGIC

- Continuation with development of fire safety protocols [Q4 (March 2026)]
- Completion of FRA actions slightly improved but still below acceptable performance.

VCS

- Continued improvement in fire safety training compliance for both L1 and L2 training
- Evacuation drills undertaken in non-clinical areas in line with agreed schedule.

WBS

- Continued improvement in fire safety training compliance for L1 and L2 training: BDT staff received fire training [Oct & Nov. 2025]
- Work with BDT on electrical safety at venues.

Corporate

- Further conversation on n-VCC fire strategy

Forecast / Next Month:

STRATEGIC

- Continuation with development of fire safety protocols [Q4 (March 2026)]
- Continued engagement with WOD around improving delivery of fire safety training / development of 2026 prospectus
- Continued engagement with FRA risk owners on actions.
- Review of nVCC fire strategy

VCS

- Continued improvement in fire training compliance
- Remedial works on fire dampers to be completed

WBS

- Continued improvement in fire training compliance
- Remedial works on fire dampers to commence

CORPORATE

- Further work on FRA actions

Action / Mitigation Underway:

VCS

- Review of fire risk assessments ongoing against schedule – 31 migrated to new FARS / 2 in date and
- Further engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved.

WBS

- Further engagement with Risk Owners and Risk Handlers to ensure FRA actions are being resolved.
- Evacuation Warden training scheduled for February – March 2026.

CORPORATE

- Review of FRA highlighting non-compliances
- Risk owners contacted to remind to close out FRA actions.

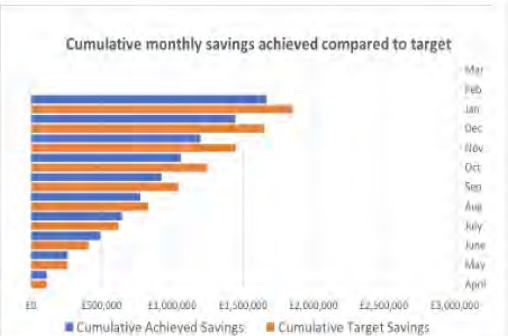
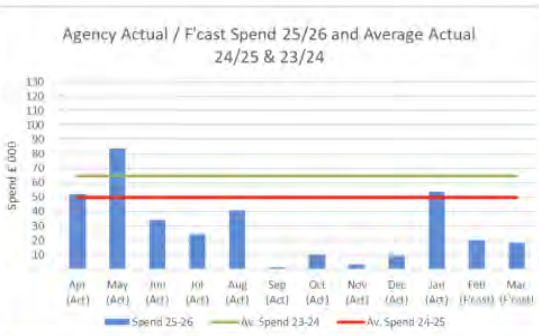
Key Issues / Risks:

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

Financial Performance

January 2026

Trust Revenue Position (core)	24/25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Actual Cum £k	42	0	9	2	7	5	4	2	4	27	29		
Target		0	0	0	0	0	0	0	0	0	0	0	0
Trust Capital Position	24/25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Actual Cum £m	35,072	0.915	1.565	2.594	3.880	4.608	5.811	8.338	9.495	10.871	13.724		
Target £21.150m CEL		0.915	1.565	2.594	3.880	4.608	5.811	8.338	9.495	10.871	13.724		



Updates on Last Month:

- The Trust has reported a small year to date underspend of £0.029m at the end of January and is currently in line with the 2025-26 IMTP planning assumptions.
- The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSP) target of paying 95% of Non-NHS invoices within 30 days for 2024-25.
- At this stage, the Trust is expecting to achieve the Capital Expenditure Limit (CEL).
- All savings schemes were RAG rated green earlier in the year. Some are now underperforming and have been replaced with new schemes.

Forecast / Next Month:

- The Trust is expecting to maintain a forecast breakeven outturn position for 2025-26.
- At this stage, the Trust is expecting to achieve the Capital Expenditure Limit (CEL) for 2025-26.
- Revised savings plans are expected to continue to deliver, and cost pressures that are emerging will need to be mitigated.

Action / Mitigation Underway:

- Urgent action required from Divisional / Executive Directors and SLT / SMT to ensure that saving schemes are delivered for 2025-26.

Key Issues / Risks:

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

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust’s strategic goals:	
Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience ☒	
• An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations	
• A beacon for research, development and innovation in our stated areas ☐ of priority	
• An established ‘University’ Trust which provides highly valued ☐ knowledge for learning for all.	
• A sustainable organisation that plays its part in creating a better future ☐ for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 -Organisational and Clinical Governance Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government’s Quality and Safety Framework: Learning and Improving (2021).
	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives

QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision	
<i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Health and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it.	
	As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required	
For more information: https://www.gov.wales/socio-economic-duty-overview	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].	
	Click or tap here to enter text	
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT		
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:		
YES - Select Relevant Goals below		
If yes select the relevant goals:		
A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities.	☐	
A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.	☐	
A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health	☒	
A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances	☐	

A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities.	☐
A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation.	☒
A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being	☐
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	<i>This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case.</i>
	Narrative in this section should be clear on the following:
	Source of Funding:
	Choose an item
	Please explain if 'other' source of funding selected:
	Type of Funding:
	Choose an item
	Scale of Change
	Please detail the value of revenue and/or capital impact:
	Click or tap here to enter text
	Type of Change
	Choose an item
	Please explain if 'other' source of funding selected:
	Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

5. RISKS

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

TRUST BOARD	
FINANCE REPORT FOR THE PERIOD ENDED 31ST JANUARY 2026 (M10)	
DATE OF MEETING	26/03/2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden – Head of Financial Planning & Reporting Steve Coliandris – Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of January 2026. The three main issues are highlighted below: 1. Long Term Agreement (LTA) Financial values, Contract Rebase & VCS LTA Financial Performance <u>LTA Financial Values</u> The Trust has signed LTAs with all Commissioners including the 1.77% (£1.548m) uplift, although to avoid arbitration agreed a £0.825m reduction in income with Hywel Dda UHB.

	- Commissioners have not agreed additional funding above the 1.77% general uplift, for either WBS or VCS. The Trust is managing the cost pressure for additional investment in capacity and quality & safety improvements across its services. <u>Contract Rebase</u> - All Wales DoFs have agreed to establish an LTA / commissioning group to review the historical LTAs across NHS Wales and make recommendations for how these are updated to current activity and cost. This will include recommendations on the principles around how commissioners manage the financial impact (gain / loss) of LTA re-basing. This group is unlikely to report back until the end of 2026/27 to inform 2027/28 financial planning. <u>VCS LTA Financial Performance</u> - The IMTP planned overperformance against 2019/20 baseline contract levels is £7.061m, this is a forecast increase in contract income of £1.370m against the 2024-25 out-turn and plan set at IMTP. The marginal income overachievement is being held to support the underachievement on Radiotherapy activity and underlying cost pressures within VCS. 2. Integrated MediumTerm Plan (IMTP) – Financial Plan / Forecast - A balanced three-year IMTP financial plan, covering the period 2025--28 was approved by Welsh Government. - The Trust is forecasting a balanced year-end financial position, on the basis that savings schemes implemented deliver the target set for 2025-26, all anticipated income is received, and all risks and new emerging costs pressures are

	either be mitigated or funded at Divisional level. • The ability to maintain a balanced underlying position is continuing to prove to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP as described in the main body of the report. • The draft financial plan developed as part of the IMTP 2026-29 reflects a brought forward underlying deficit position of c£0.990m which will be managed in 2026-27 via the core funding uplift and increased savings target, with the plan returning to a recurrent underlying balanced position in 2027-28. • The general discretionary uplift of 1.1% (£1m) that has recently been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment. • The Trust continues to face a further significant income risk with Hywel Dda UHB beyond 2025-26 relating to the historic shares' activity baseline funding of c£200k which will be removed in 2026-27. • The Trust has faced further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding and the National Discretionary uplift which total £0.474m and are provided to the Trust via the LTAs as per the Trust funding model. Following engagement with WG colleagues, HD have been advised that they must continue to transfer the funds to the Trust until WG can amend the allocation tables. The latest correspondence from HD states that their position is they receive no allocation from Welsh Government which is ringfenced for Velindre. The Trust is continuing to negotiate with HD however at the moment a resolution does not seem realistic given the HD hard

	stance to only pay on actual activity and not recognise any of the baseline costs. This will leave the Trust with no option other than to commence work on a case to request Welsh Government arbitrate on this matter and their unilateral rebasing of the LTA to enable the 2026-27 LTA to be agreed within the required timelines. 3. Key Financial Targets / KPIs • Revenue Balance: The Trust has reported an underspend of £0.029m as at 31st January 2026 and is forecasting breakeven outturn position for 2025-26, but with a c£0.791m underlying deficit as noted above. • Public Sector Payment Performance (PSPP): The Trust is currently overachieving and expected at this stage to meet the PSPP target of paying 95% of Non-NHS invoices within 30 days. • Capital Expenditure Limit (CEL): The Trust is expecting to achieve the CEL. • Savings Target: All savings schemes were RAG rated green earlier in the financial year. c£0.300m of recurrent schemes are not going to achieve the full value of savings planned and have been replaced with non-recurrent schemes. This has contributed to the underlying deficit the Trust is carrying forward into 2026-27 within the draft IMTP 2026-29.
RECOMMENDATION / ACTIONS	The Trust Board is asked NOTE the contents of the January 2026 financial report and in particular: • The year to date and forecast revenue and Capital out turn position, and PSPP performance. • The latest position on Velindre Cancer Service LTA income for 2025-26 from our commissioners.

	• The position with commissioners on the contract rebase agreement, and the potential dispute with HD UHB regarding the WG direct funding allocations. • The latest position of the Trust savings delivery.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	23/02/2026
Quality, Safety & Performance Committee	12/03/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

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

1. SITUATION / BACKGROUND

- 1.1 The attached report outlines the financial position and performance for the period to the end of January 2026.
- 1.2 The financial information included within this report relates to the Core Trust (including HTW). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.029	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.253	13.724	21.327
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.6%	96.5%	95.0%

2.2 Revenue Budget

The core Trust has reported an in month underspend of £0.002m leading to a **year to date underspend of £0.029m** position as at 31st January 2026.

The position remains in line with a year end forecast outturn of **breakeven**.

The ability to maintain a balanced underlying position is however now proving to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP as described in the main body of the report.

The current draft of the IMTP 2026-29 reflects a brought forward underlying position of c£0.791m which will be managed in the first year of the IMTP via the Discretionary funding uplift and an increased savings target, with a view to returning to a balanced recurrent underlying position in year 2.

Savings

All schemes were RAG rated green earlier in the year. However, some recurrent schemes are now not forecast to achieve the full value of savings planned and have therefore been replaced with other schemes. Some of the underperforming schemes were expected to deliver recurrent savings (c£0.300m) and have been replaced with non recurrent savings schemes. This has contributed to the underlying deficit the Trust is carrying forward into 2026-27 within the draft IMTP 2026-29.

It is expected that cost pressures will be managed by budget holders in line with the Trust's budgetary control procedures to ensure the delegated expenditure control limits are not exceeded.

LTA Income

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

A risk has emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) is not expected to match the level of investment in the Workforce. The forecast impact as at month 10 is an issue of £0.500m for 2025-26, after mitigations have been put in place, such as holding of vacancies and increased activity performance in year. A regular review of the impact and forecast position is being undertaken with the latest expected forecast position remaining at c£0.500m shortfall against plan with £0.412m phased into the year to date position. A risk of a further £0.250m cost pressure remains at this stage.

In addition, the Trust wrote to its Commissioners on the 8th August requesting funding support of £0.278m for the additional recurrent costs that have emerged since the FBC and the go live date where the first patient was treated on the 19th June 2025. The Trust has since been informed that they will not be supporting these additional costs, the impact of which has been factored into the c£0.500m shortfall against plan, whilst noting the continued risk of further deterioration against plan.

LTA Contract Position

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

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust continues to face a further significant recurrent income risk with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£200k which will be removed recurrently in 2026-27. The general discretionary uplift of 1.1% that has recently been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment.

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

LTA Contract Rebase

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-5 to a 'current activity' baseline and NICE consumption. How commissioners decide to manage the financial impact (gain / loss) is for them to agree, but that should not prevent the Trust from moving to charging on current activity and consumption from 2026-27. However, it's important to note that without commissioners collectively agreeing how the financial impact will be managed across Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards.

The Trust has faced further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding and the National Discretionary uplift which total £0.474m and are provided to the Trust via the LTAs as per the Trust funding model. Following engagement with WG colleagues, HD have been advised that they must continue to transfer the funds to the Trust until WG can amend the allocation tables. The latest correspondence from HD states that their position is they

receive no allocation from Welsh Government which is ringfenced for Velindre. The Trust is continuing to negotiate with HD however at the moment a resolution does not seem realistic given the HD hard stance to only pay on actual activity and not recognise any of the baseline costs. This will leave the Trust with no option other than to commence work on a case to request Welsh Government arbitrate on this matter and their unilateral rebasing of the LTA to enable the 2026-27 LTA to be agreed within the required timelines.

The Trust is reporting a year end forecast revenue breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2025-26.

2.3 PSPP Performance

During January 2026 the Trust (core) achieved a compliance level of **96.6%** (December 94.9%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of **96.5%**. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

2.4 Reserves

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

A review of the recurrent and non-recurrent reserve position remains underway and is being considered alongside several key factors such as the VCS marginal income risk, LTA contract rebase risk, achievement of the 2025-26 savings target, and a review of currently committed support towards Trust investment, transformation and delivery programmes.

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

2.5 Financial Risks

There are several financial risks that could impact on the successful delivery of a balanced position for 2025-26, the material risks which have been flagged to WG and considered to be either high or medium risk include the activity risk associated with the underachievement of Radiotherapy activity income, the Trust Commissioners not supporting service investment / Growth in VCS, and the management of operational cost pressures.

There are a number of opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the remaining emergency reserve which would be used to support these risks should they crystallise.

2.6 Capital

All Wales Programme

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

The Trust has been provided a funding award letter towards the OBC/ FBC stage for the WBS TGI infrastructure scheme, however progression is currently paused whilst the Trust works with the contractor to understand the proposed step up in costs for delivery of the scheme. In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed cost is not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained. The revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard. The updated OBC must be submitted by the end of the 2025/26 financial year to align with WG funding timelines and strategic priorities.

Discretionary Programme

The discretionary allocation of £2.000m represents an increase of 4.65% on the £1.911m provided during 2024-25 which was fully spent.

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

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below

If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒													
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	08 - Trust Financial Investment Risk												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below												
	<table border="0"> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☒</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☒</td> </tr> <tr> <td>Patient Centred</td> <td>☒</td> </tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed, and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Click or tap here to enter text													
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision</i>	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered												

on the Health and Care Quality Standards.	strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream

	The Trust reported a revenue financial position of an underspend of £0.029m for January 2026, which is currently in line with the IMTP plan. Source of Funding: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text Type of Funding: Choose an item Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Board Assurance Framework (BAF).

WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Recipients are provided with detail on the risks and any actions required from them to mitigate / remove the risk are highlighted.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Individual risks to be managed with the financial envelope for 2025-26. Overall financial and sustainability risks reported and managed through the BAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Availability of resources to implement work / changes needed and successful negotiations with Commissioners.
All risks must be evidenced and consistent with those recorded in Datix	



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31ST JANUARY 2026

**TRUST BOARD
26TH MARCH 2026**

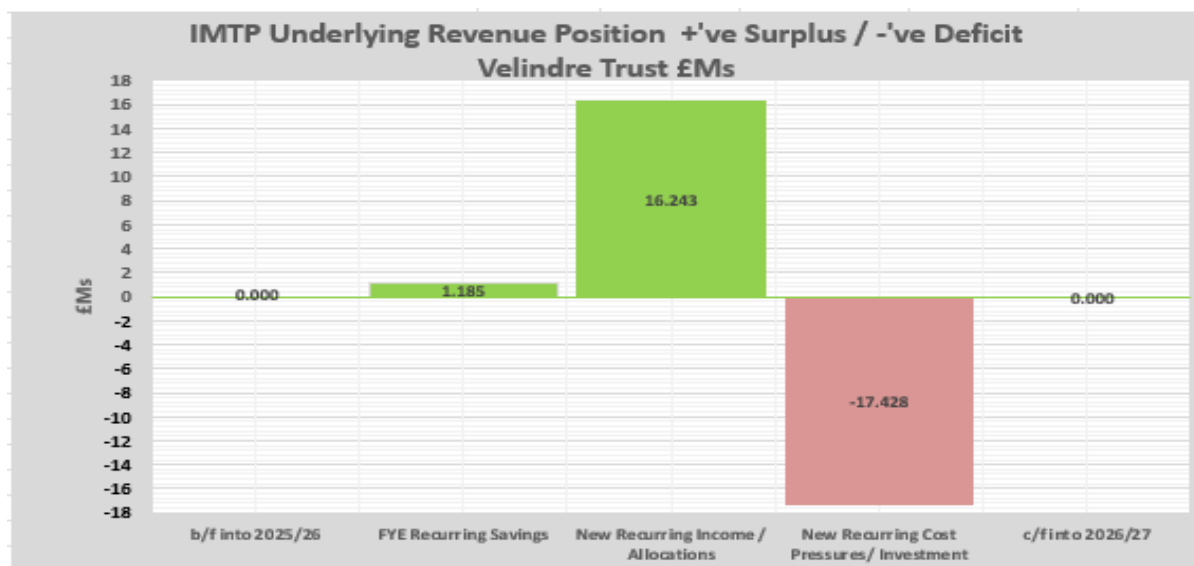
1. Introduction

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

2. Background / Context

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

- The Trust submitted a balanced three year IMTP, covering the period 2025-26 to 2027-28 to Welsh Government on the 31st March 2025.
- For 2025-26 the Plan included:
 - A balanced position brought forward from 2024-25,
 - **FYE of new cost pressures / Investment of -£17.428m,**
 - offset by **new recurring Income of £16.243m,**
 - and recurring FYE **savings schemes of £1.185m,**
 - Allowing **a balanced position** to be carried into 2026-27.
- The 1.77% core discretionary uplift (sustainability) funding will be required to fund the significant underlying cost pressures, investment in capacity beyond marginal cost, and the revenue investment decisions in relation to the Trust's major infrastructure and equipment projects.
- **To achieve a balanced financial position, the savings target set for 2025-26 is required to be achieved, all anticipated income will need to be received, and any new emerging costs pressures will need to be either mitigated at Divisional level or managed through the Trust reserves.**



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.029	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.253	13.724	21.327
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.6%	96.5%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.064)	(0.184)	0.000

Revenue

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust has also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£124k which will be removed recurrently in 2026-27, and is facing a further challenge from HD on the baseline funding of £0.474m. The general discretionary uplift of 1.1% that has been confirmed by WG for 2026-27 is expected to be passed through from Commissioners without adjustment.

Capital

The approved Capital Expenditure Limit (CEL) for the year ended 31st March 2026 is **£21.180m**. This represents all Wales Capital funding of **£19.180m**, and Discretionary funding of **£2.000m**.

The year end forecast spend of £21.237m in the table above is £0.147m higher than the current CEL value due to the following forecast variances that are being discussed with WG colleagues:

All Wales Scheme	Forecast year end spend vs current CEL allocation £m
nVCC Enabling Works	(0.043)
nVCC Enabling Works QRA*	(0.175)
nVCC Project	(0.115)
nVCC Project QRA - Enabling Works HV Intake*	(0.250)
nVCC Project QRA - MIM*	(0.064)
Integrated Radiotherapy Solution (IRS)	0.048
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	0.172
Whitchurch Hospital Site Disposal - contingency*	0.280
Total	(0.147)

QRA & contingency schemes denoted with * are approved budgets held by WG and not allocated to the CEL until the expenditure has been agreed by WG. Other expected variances have been highlighted to WG and discussions as to how the variances will be managed are taking place. The expectation is that at this point in the year they are likely to require management as part of the Trust's overall capital allocation.

The Trust reported total Capital spend to 31st January 2026 is £13.724m, with all funds expected to be fully spent during 2025-26. It is vital that divisions ensure their discretionary capital plans are being progressed at pace to ensure all orders are fulfilled and goods & services provided prior to 31st March 2026.

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

	Opening CEL	Movement	Current CEL
	£m	£m	£m
All Wales Capital:			
nVCC Enabling Works	4.012	-0.329	3.683
nVCC Enabling Works QRA*	0.000	0.332	0.332
nVCC Project	11.059	-4.683	6.376
nVCC Project QRA - Enabling Works HV Intake*	0.000	0.257	0.257
nVCC Project QRA - MIM	0.000	0.068	0.068
nVCC Project QRA - MIM*	0.000	0.150	0.150
Integrated Radiotherapy Solution (IRS)	2.040	-0.640	1.400
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	1.200	-0.520	0.680
Whitchurch Hospital Site Disposal	0.840	0.000	0.840
Whitchurch Hospital Site Disposal - contingency*	0.000	0.300	0.300
WBS HQ Continuity Business Case OBC/FBC fees	2.142	-1.142	1.000
WBS Fleet Replacement Programme	0.364	0.241	0.605
DPIF - RISP	0.000	0.214	0.214
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.000	0.416
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.000	0.185
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086
WBS Plasma for Fractionation	0.000	0.030	0.030
Non-Radiology Ultrasound Replacement	0.000	0.048	0.048
Radiology Ultrasound Replacement	0.000	0.132	0.132
VPAG Funding - Equipment	0.000	0.037	0.037
Positron Emission Tomography (PET) Fees nVCC	0.000	0.298	0.298
Additional Digital Allocation	0.000	0.386	0.386
End of Year Funding	0.000	0.568	0.568
End of Year Equipment funding December 2025-26	0.000	0.024	0.024
End of Year Digital funding January 2025-26	1.000	0.065	1.065
Total All Wales Capital Programme	23.344	-4.164	19.180
Discretionary Capital	2.000	0.000	2.000
Total CEL	25.344	-4.164	21.180
* QRA budget held by WG; spend will be added to CEL once confirmed & agreed by WG			

PSPP

During January 2026 the Trust (core) achieved a compliance level of **96.6%** (December 94.9%) of Non-NHS supplier invoices paid within the 30-day target which gives a cumulative year to date position of **96.5%**. The Trust year to date compliance (including hosted) is **97.4%** compared to the target of 95%.

Efficiency / Savings

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

The overall Trust savings performance as at 31st January 2026 shows the year to date planned savings of £1.854m were **underachieved by £0.184m**. **Actual delivery to date is therefore £1.670m**.

All savings schemes are now identified and RAG rated green, although there remain some challenges in achieving the full values currently planned, in particular the achievement of recurrent saving schemes with the savings target for 2025-26 being achieved via replacement schemes that are non-recurrent in nature. This is currently resulting in a c£0.300m negative underlying position, reflected as such in the draft IMTP 2026-29.

Revenue Position

Cumulative				Forecast		
Breakeven				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(216.871)	(219.591)	2.721	(148.335)	(151.057)	2.722
Pay	90.063	89.330	0.733	108.822	108.089	0.733
Non Pay	126.808	130.232	(3.424)	133.579	137.058	(3.454)
Total	0.000	(0.029)	0.029	94.066	94.090	0.000

The overall position against the profiled revenue budget to the end of January 2026 is **an underspend of £0.029m**, with a yearend outturn forecast position of **breakeven**.

Revenue Position Highlights / Key Issues

Underlying Position

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

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

The ability to maintain a balanced underlying position is, however, now proving to be a challenge due to the significant cost pressures and risks which have materialised since the submission of the IMTP. The current draft of the IMTP 2026-29 reflects a brought forward underlying position of c£0.791m which will be managed in the first year of the IMTP via the Discretionary funding uplift and an increased savings target, with a view to returning to a balanced recurrent underlying position in year 2 although this is expected to reduce or be removed completely as a review of non-recurrent measures that was used to balanced the position during 2025-26 is underway and will be complete prior the final IMTP.

Income

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

Cumulative			
(£2.720m overachieved)			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Core Income - HB / WHSSC	95.190	95.218	-0.027
Nice/ High Cost Drugs	56.149	55.808	0.342
WBS Wholesale Blood Products	25.849	25.854	-0.006
WBS Transplantation Services	0.032	0.032	0.000
WBS Blood Components	0.629	0.874	-0.245
Home Care Drugs	1.894	2.089	-0.195
Private Patient	2.414	2.957	-0.543
VCC Over Activity	5.884	7.076	-1.192
Radiotherapy Activity Income	2.770	1.762	1.008
IRS Programme	0.660	0.660	0.000
Radiation Protection	0.978	1.034	-0.056
Staff Recharges	0.702	0.653	0.048
One Wales Palliative and EOL Care	1.194	1.261	-0.067
Velindre Charity	2.935	3.000	-0.065
Other Charity	0.000	0.027	-0.027
RD&I*	4.128	4.501	-0.373
HTW	1.433	1.291	0.142
Other Operating Income	14.031	15.494	-1.463
Total	216.871	219.591	-2.720

*RD&I full year budget includes £1.731m of Velindre Charity income.

The variance reported against the Radiotherapy Activity income as at month 10 is offset by £0.354m vacancy factor and £0.237m non pay reductions: these are non-recurring mitigations in addressing the underperformance against planned contract income levels as per business case. The underperformance of income will be recurrently offset in part via the allocation of contract income from wider Cancer services and anticipated growth in future financial years. In the current financial year the income deficit will be further offset by non-recurring mitigations as part of the year-end closure. The correct overall variance reflected later in this report is a shortfall of £0.417m, with additional risk of a further £0.250m variance by 31st March 2026 also highlighted.

The HTW variance will be cleared by 31st March 2026, as expenditure is due to remain within the allocation and will therefore be matched by income from WG.

The table reflects the pass through by the Trust's Commissioners of the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix. The 2025-26 pay inflation has now been confirmed by Welsh Government, although any shortfall such as staff increments will need to be met by additional savings or absorbed by Service Divisions and Corporate Departments. Funding from Welsh Government in respect of the additional Employer's National Insurance Contributions from April 2025 has been confirmed at 82.93% of that required in 2025-26, leaving a shortfall of £0.345m met by an element of the planned unallocated Trust reserve this year, and in future as WG have directed the Trust to allocate this reserve in future years plans and not retain it for emergencies.

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

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

VCS Long Term Agreement (LTA) Contract Performance

The Trust has agreed with Commissioners an uplift to LTA values of 1.77% which amounts to £1.548m in 2025-26 less £0.825m loss in income recurrently from Hywel Dda UHB. The Trust has also had to accept a recurrent income reduction with Hywel Dda UHB beyond 2025-26 based on the historic shares activity baseline funding of c£0.124m which will be removed recurrently in 2026-27. The general uplift of 1.1% for 2026-27 that has recently been confirmed is expected to be passed through from Commissioners without adjustment.

To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-05 to a 'current activity' baseline and NICE consumption. How Commissioners decide to manage the financial impact (gain / loss) is for them to agree, but that should not prevent the Trust from moving to charging on current activity and consumption from 2026-27. However, it's important to note that without Commissioners collectively agreeing how the financial impact will be managed across Wales, the dispute between the Trust and Hywel Dda UHB will simply transfer to a dispute between the Trust and other Health Boards.

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

The Trust has faced further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding and the National Discretionary uplift which total £0.474m and are provided to the Trust via the LTAs as per the Trust funding model. Following engagement with WG colleagues, HD have been advised that they must continue to transfer the funds to the Trust until WG can amend the allocation tables. The latest correspondence from HD states that their position is they receive no allocation from Welsh Government which is ringfenced for Velindre. The Trust is continuing to negotiate with HD however at the moment a resolution does not seem realistic given the HD hard stance to only pay on actual activity and not recognise any of the baseline costs. This will leave the Trust with no option other than to commence work on a case to request Welsh Government arbitrate on this matter and their unilateral rebasing of the LTA to enable the 2026-27 LTA to be agreed within the required timelines.

A risk has emerged, and crystallised in part, this year whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Neville Hall) is not expected to match the level of investment in the Workforce. The forecast impact as at month 10 is an issue of £0.500m for 2025-26, after mitigations have been put in place, such as holding of vacancies and increased activity performance in year. A regular review of the impact and forecast position is being undertaken with the latest expected forecast position remaining at c£0.500m shortfall against plan with £0.412m phased into the year to date position. A risk of a further £0.250m cost pressure remains at this stage.

In addition, the Trust wrote to its Commissioners on the 8th August requesting funding support of £0.278m for the additional recurrent costs that have emerged since the FBC and the go live date where the first patient was treated on the 19th June 2025. The Trust has since been informed that they will not be supporting these additional costs, the impact of which has been factored into the c£0.500m shortfall against plan, whilst noting the continued risk of further deterioration against plan.

The tables below set out the projected year end LTA income performance based on data to 31st December 2025 (note the data supplied is one month behind the rest of this report due to reporting timelines) by Commissioner and main service delivery areas. The forecast increase in marginal income represents activity performance in excess of 2019/20 baseline contracted activity volumes.

The IMTP planned overperformance against 2019/20 baseline contract levels is £7.061m (this is a forecast increase in contract income of £1.550m against the 2024-25 out-turn and plan set at IMTP stage), split across organisations as shown below:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda (7A2)	0.865	-0.027	0.837	-3%	0.015	-0.043
Swansea Bay (7A3)	0.455	-0.001	0.491	-0%	0.014	-0.015
Cardiff & Vale (7A4)	16.048	2.964	20.045	19%	2.520	0.445
Cwm Taf Morgannwg (7A5)	14.285	2.175	17.547	16%	1.937	0.238
Aneurin Bevan (7A6)	19.812	3.061	24.363	16%	2.462	0.599
Powys (7A7)	1.080	0.285	1.446	26%	0.120	0.165
NHS Wales Joint Commissioning Committee	2.259	0.155	2.564	7%	-0.007	0.162
Total	54.803	8.611	67.295	16%	7.061	1.550

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	5.905	0.276	6.181	5%	0.022	0.254
Radiotherapy Delivery	13.508	-0.222	13.285	-2%	-0.174	-0.049
Nuclear Medicine	1.031	-0.055	0.976	-5%	-0.032	-0.023
Radiology Imaging	3.149	0.739	3.887	23%	0.646	0.093
Preparation for Systemic Anti-Cancer Therapy	2.918	0.967	3.884	33%	0.659	0.308
Delivery of Systemic Anti-Cancer Therapy	6.884	1.851	8.734	27%	1.926	-0.076
Ambulatory Care Services	1.405	0.463	1.868	33%	0.367	0.096
Outpatient Services	10.455	4.220	14.675	40%	3.443	0.777
Inpatient Admitted Care	6.162	0.373	6.535	6%	0.203	0.170
Contract Adjustments	3.388	0.000	7.269	0%	0.000	0.000
Total	54.803	8.611	67.295	16%	7.061	1.550

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

Activity Performance Per Contract Currency	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Radiotherapy Planning	3,916	3,913	- 3	-0%	3,794	119
Radiotherapy Delivery	53,586	48,931	- 4,655	-9%	50,060	- 1,129
Nuclear Medicine	1,738	1,543	- 195	-11%	1,528	15
Radiology Imaging	9,103	15,002	5,899	65%	14,002	1,000
Preparation for Systemic Anti-Cancer Therapy	25,262	38,384	13,122	52%	37,202	1,182
Delivery of Systemic Anti-Cancer Therapy	31,867	47,486	15,619	49%	47,751	- 265
Ambulatory Care Services	7,874	10,817	2,943	37%	9,701	1,116
Outpatient Services	59,960	92,987	33,027	55%	91,043	1,944
Inpatient Admitted Care	9,072	10,118	1,046	12%	9,652	466
Contract Adjustments	-	-	-	0%	-	-
Total	202,378	269,180	66,802	33%	264,733	4,447

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

This activity is shown below on a Commissioner basis:

Activity Performance Per Commissioner	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Hywel Dda (7A2)	1,202	1,055	-147	-12%	963	92
Swansea Bay (7A3)	1,200	1,313	113	9%	1,162	151
Cardiff & Vale (7A4)	60,809	84,383	23,574	39%	82,794	1,589
Cwm Taf Morgannwg (7A5)	59,964	74,954	14,990	25%	74,013	941
Aneurin Bevan (7A6)	74,098	99,413	25,315	34%	99,839	-426
Powys (7A7)	3,619	5,676	2,057	57%	5,003	673
NHS Wales Joint Commissioning Committee	1,486	2,387	901	61%	959	1,428
Total	202,378	269,180	66,802	33%	264,733	4,447

As mentioned elsewhere in this report, Hywel Dda UHB have requested a recurrent reduction in the LTA financial value from 2026/27 given a reduction in activity where patients have been re-directed to Swansea Bay UHB as is demonstrated by the above forecast data.

WBS Position Update

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

1. Plasma for Medicines: Implementation of the Welsh Government Policy for the collection, processing and supply of plasma for the manufacture of Immunoglobulin and Albumin products;
2. Red Cell Immuno-haematology Laboratory: £0.251m for additional capacity 24/7 for the Red Cell Immuno-haematology Laboratory;
3. Haemoglobin S screening: £0.052m for implementation of Haemoglobin S (HbS) testing to comply with national guidance;

4. Blood Component Development: £0.703m for investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns;
5. Buccal Swab Pathway: £0.259m for introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel;
6. Blood Donation Team Resilience: £0.266m for additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.

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

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

As previously advised, the Trust has assumed that Welsh Government and / or Joint Commissioning Committee (JCC) will fund the Phase 2 (Option 2 Apheresis collection of Plasma) which will not be progressed until funding is approved.

Pay Highlights / Key Issues

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

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

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

Non Pay Key Issues

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

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

The remainder of the Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to support the anticipated breakeven financial position.

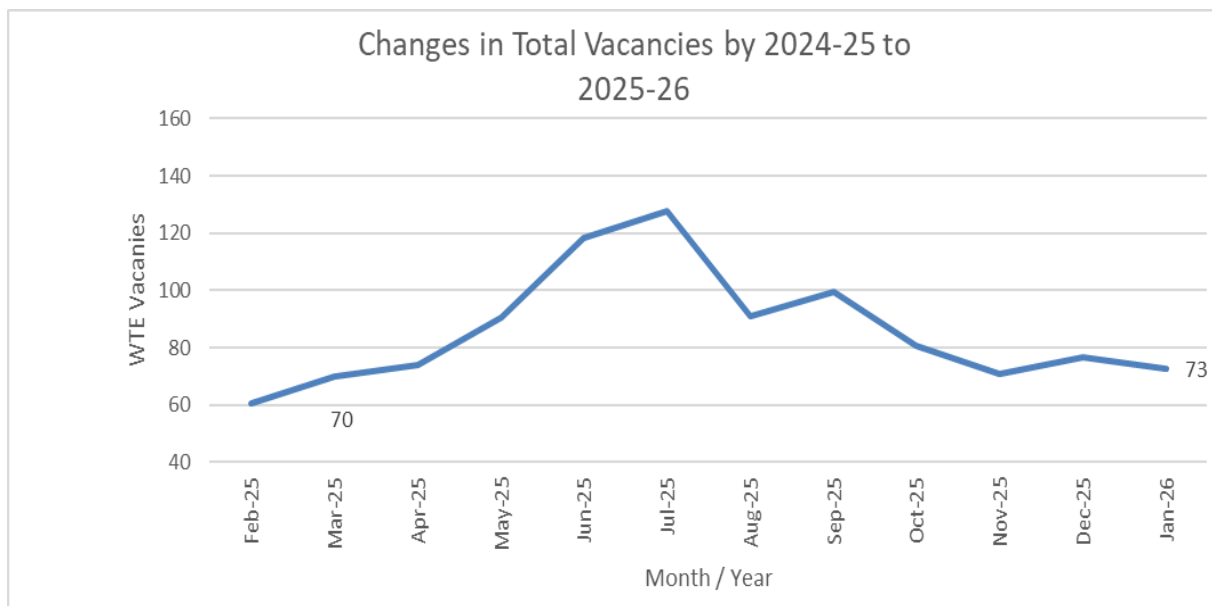
WG have advised the Trust that from 2026/27 so Trust can no longer hold an emergency reserve, and it must be used to support the underlying position.

3.1 Pay Spend Trends (Run Rate)

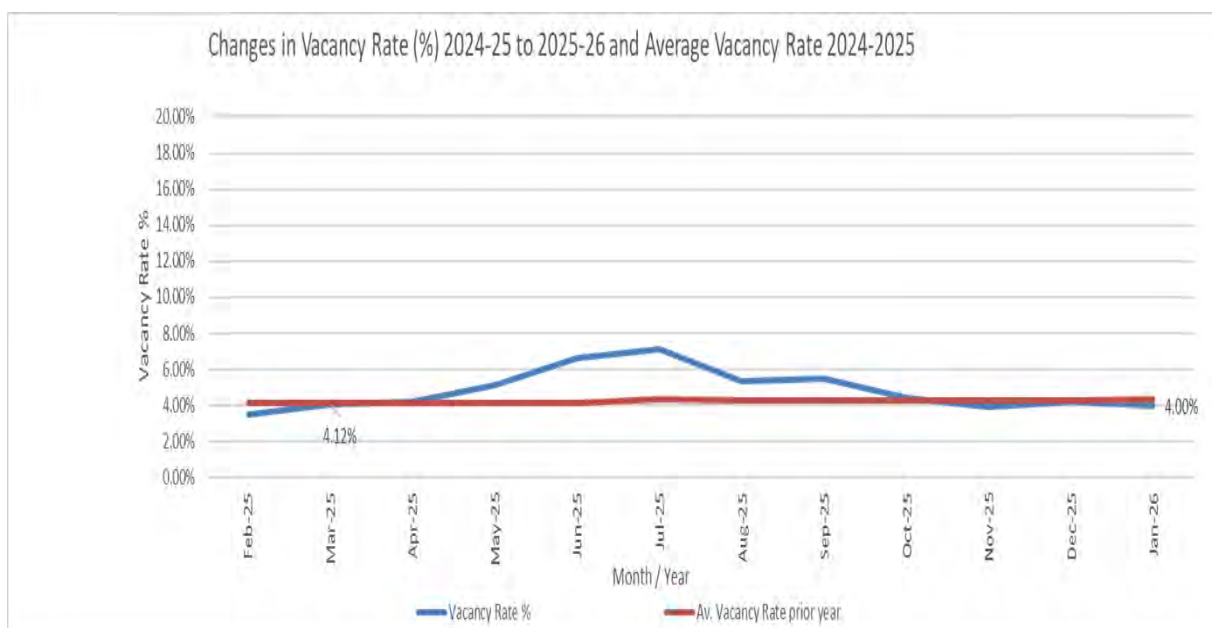
As of January 2026, the current staff in post is 1,747 WTE (December 1,743). The number of vacancies is 73 WTE (December 77), which represents a vacancy rate of 4.0% (4.2% December) against the budget of 1,820 WTE. The vacancy gap is largely being met using overtime or bank staff and is also supporting each of the division's vacancy factor savings target. In line with the WG requirement to cease the use of agency posts, currently only a few remain, and both Service Divisions are keen in future months to only utilise agency posts where options to fill via bank and fixed term contracts are not possible, and there is an unavoidable service need.

The largest number of vacancies are seen within VCS: 37 WTE. Vacancies are spread across many other services, particularly Allied Health Professionals (5 WTE), Medical (13 WTE), and Additional Clinical Services (16 WTE), Healthcare Scientists (10 WTE), offset by overestablishment in Nursing & Midwifery (12 WTE).

WBS currently are reporting 18 WTE vacancies. Healthcare Scientist posts are currently overestablished (2 WTE) while funding from related business cases to JCC has been requested. These are offset by Additional Clinical Service vacancies (19 WTE) which are currently being recruited to.



The total Trust vacancies as of January 2026 are 73 WTE (December 77 WTE): VCS (37 WTE), WBS (18 WTE), Corporate (12 WTE), RD&I (4 WTE), nVCC (0 WTE) and HTW (1 WTE).

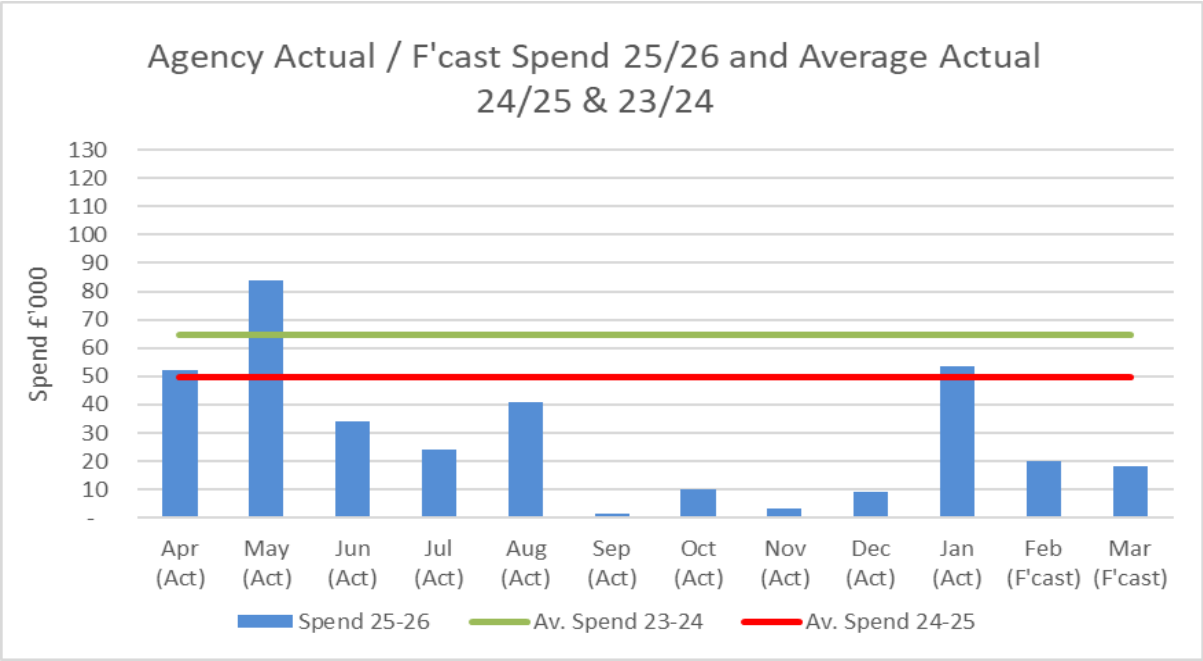


The spend on agency for January 2026 was **£0.054m** (December £0.009m) with a year end outturn forecast currently of **£0.350m** (£0.596m 2024/25).

Admin & clerical agency costs for January are higher than that forecast in month 9, and the forecast to the end of the year is also higher. This is due to 3 members of agency staff being engaged to support the Executive function of the Trust to cover vacancies and long term sickness within the Team. Payments have been backdated in January to reflect actual appointment dates of November that were not accrued into the position. Prior to these engagements, external recruitment resulted in two offers of appointments that were declined, followed by advertisements for fixed term appointments and bank appointments that resulted in no interested / appointable candidates.

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.



The largest area of agency spend relates to Admin and Clerical staff, with 3 posts supporting the Trust Executive and Governance function as described above. Allied Health Professionals also requires agency staff to support additional Capacity in Radiotherapy, and Therapies to support sickness. There continues to be some reliance on temporary staff to support vacancies, with the ambition that this will cease as posts continue to be filled. The agency expenditure forecast is therefore held broadly in line with the planning assumptions in the 2025-26 IMTP, although some areas anticipate there may be urgent service needs that will not always be met without agency / locum support.

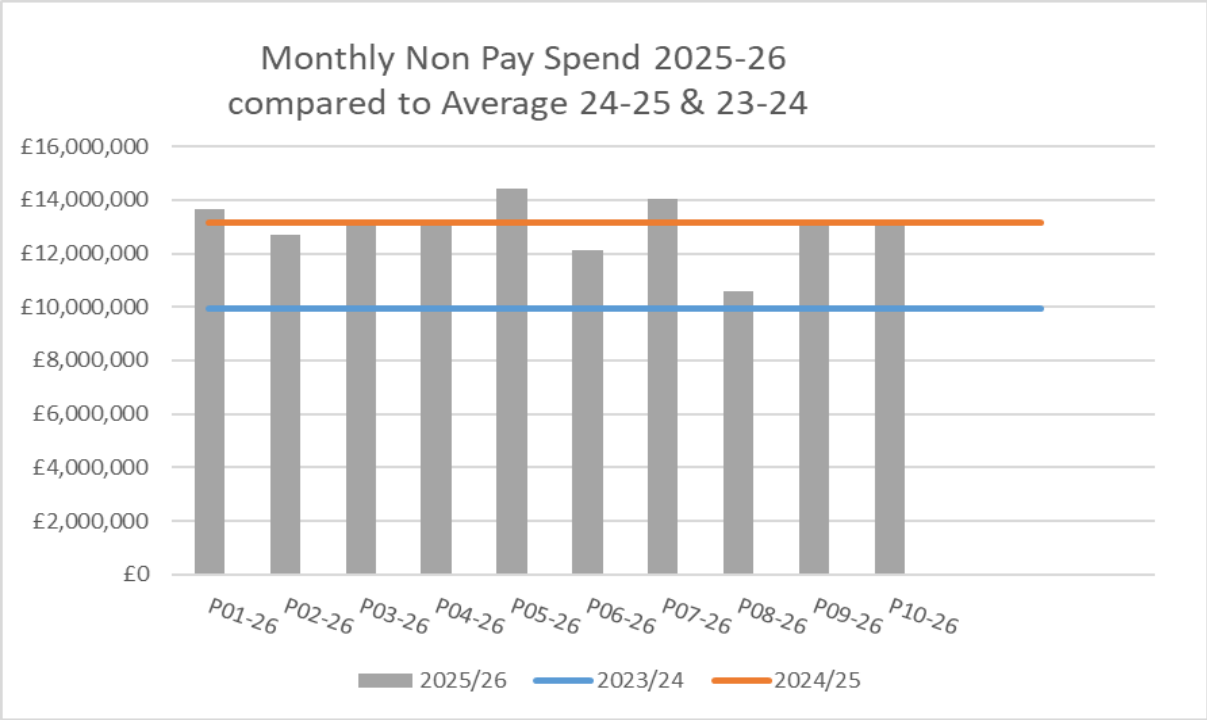
3.2 Non Pay

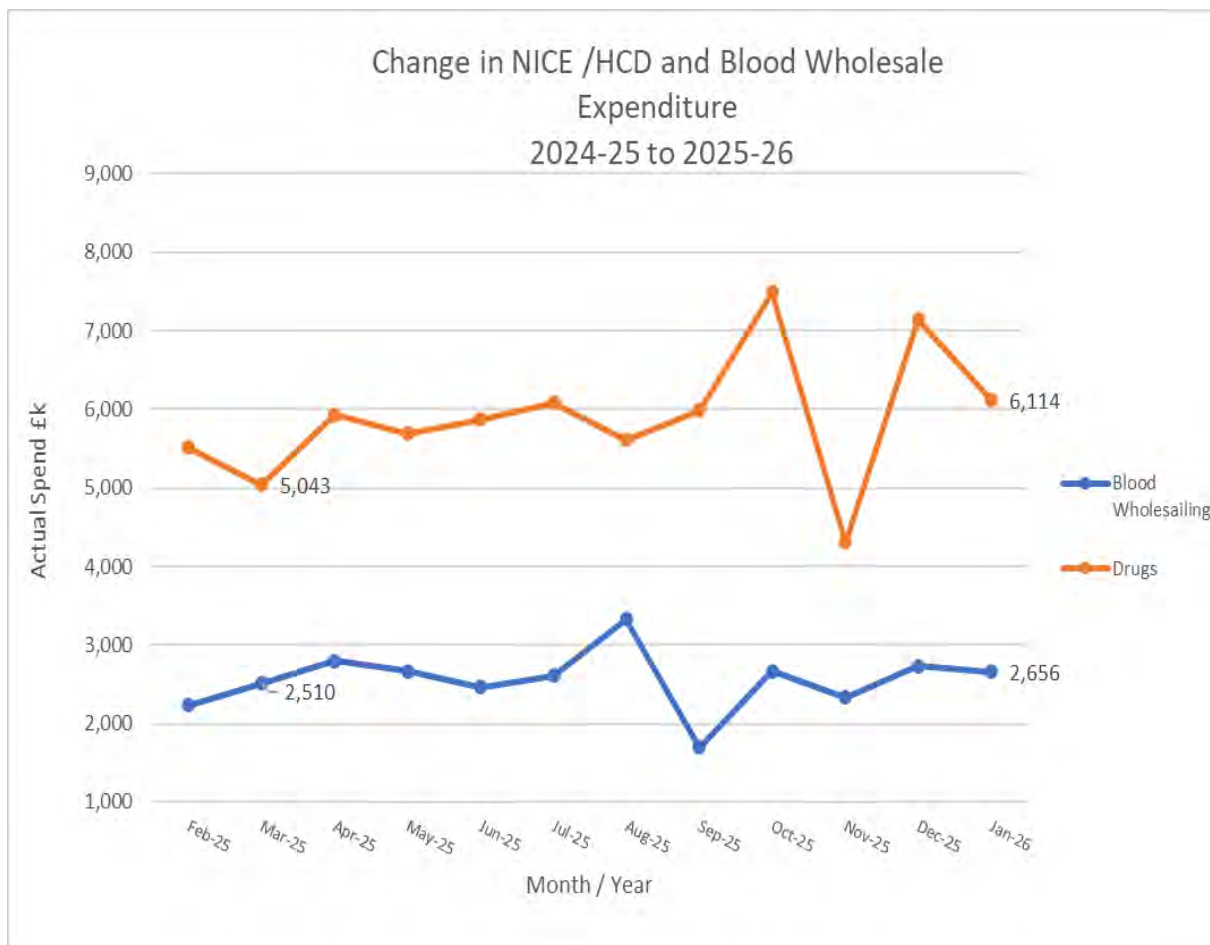
Non-Pay average spend for 2024/25 was £13.1m per month which was a £3.2m increase from the previous whole year. The largest movement was in non-cash as a result of the accelerated depreciation charge on the VCS hospital and the impairment charges associated with the nVCC Asda works (£1.8m average per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

The non-pay average monthly spend for 2025/26 to date currently stands at £13.1m. NICE and HCD drugs (£6.023m) and blood wholesale average costs to date (£2.594m) have increased which will be offset by an income increase via recharges to Health Boards. Non-Cash (Impairment

charges) are lower by (-£0.724m), mainly due to the charge incurred on the nVCC Asda works during 2024/25. 'Other' charges average costs are generally comparable at this time.

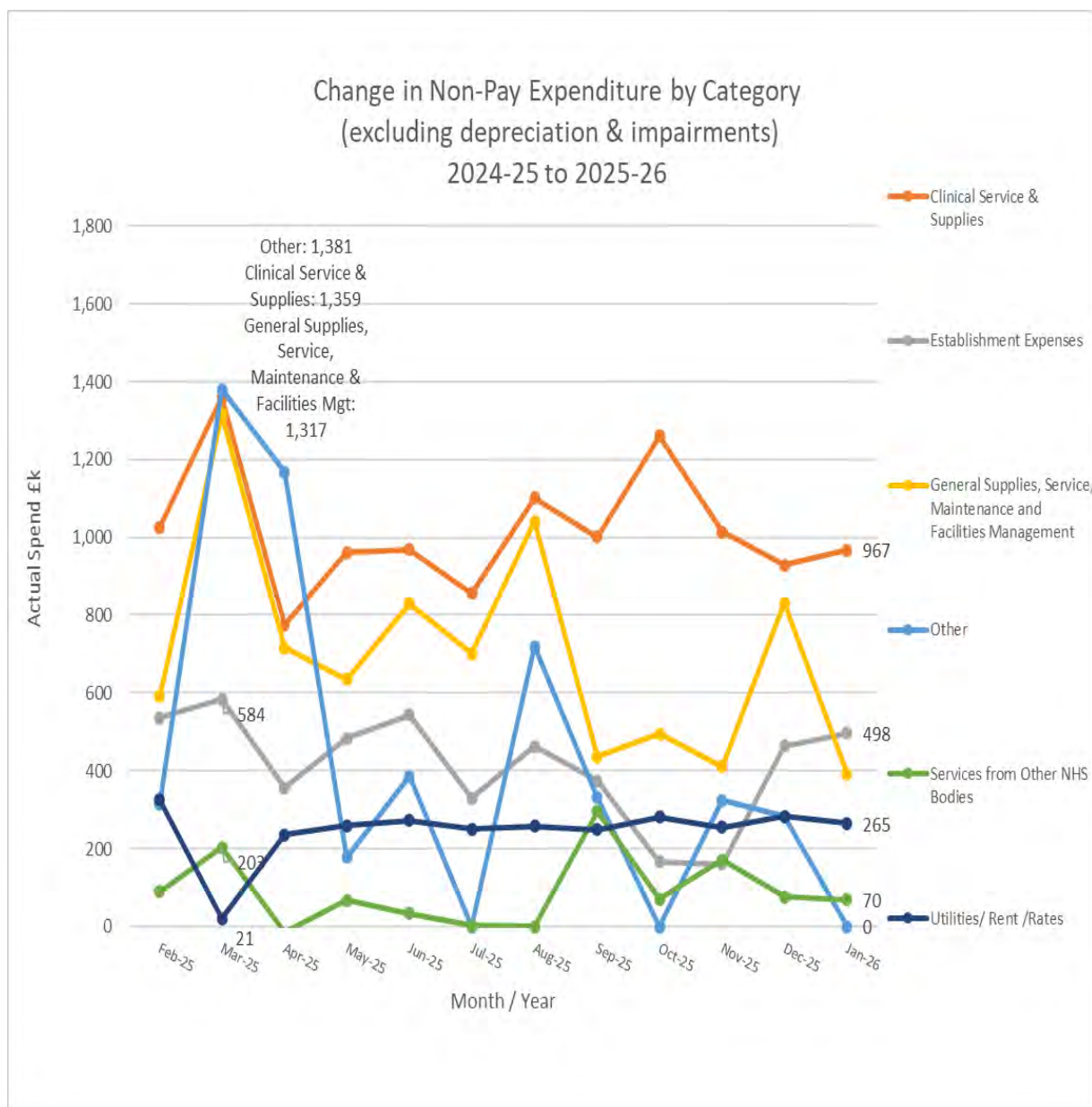
The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2025 to March 2026 compared to the average spend across the financial year 2023/24 and 2024/25.





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

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



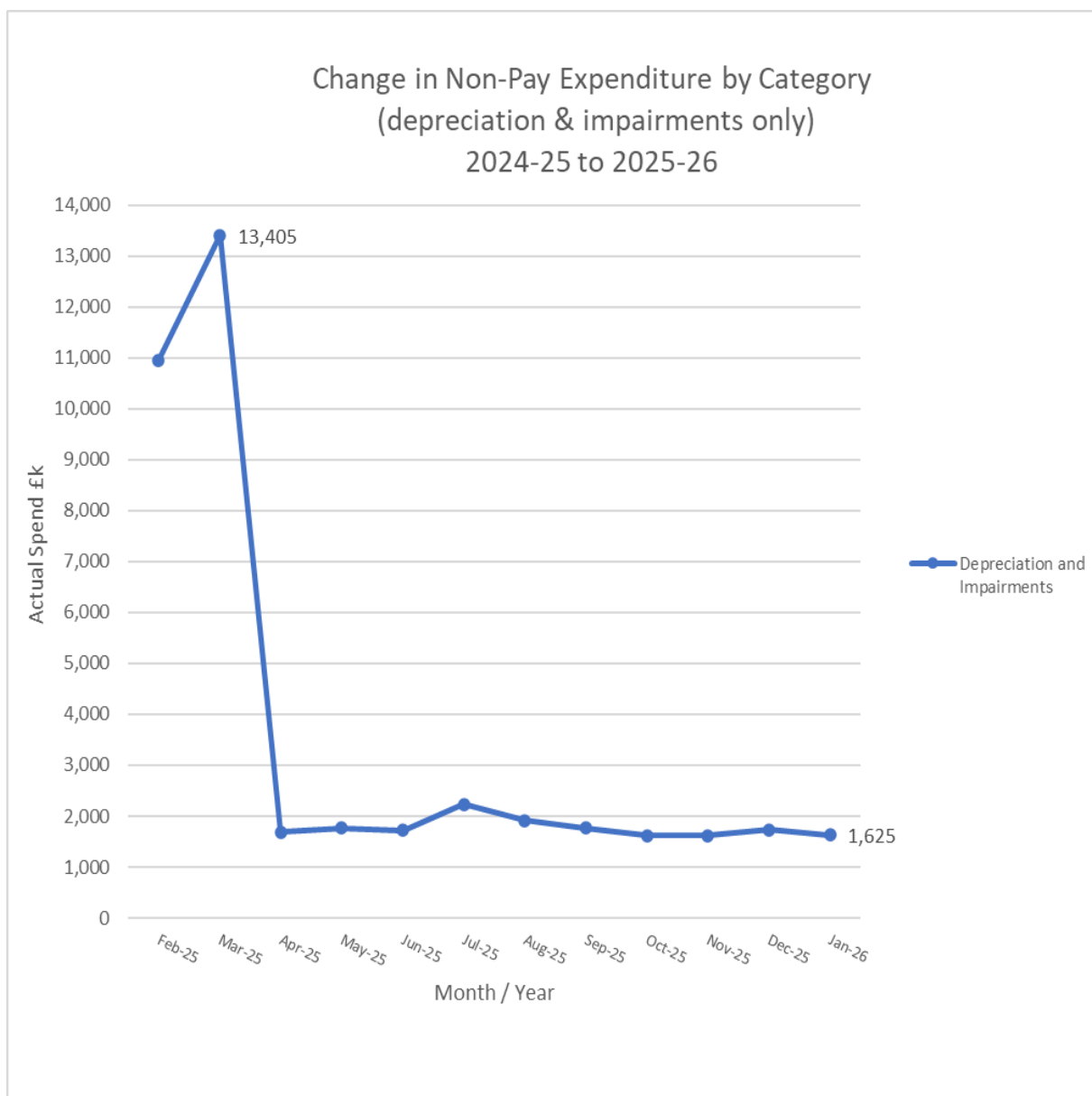
Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

The decrease in utilities / rent / rates in March was caused by an adjustment that was processed to ensure full year costs were accurately reflected and no charges for 2025-26 billed in advance of 1st April 2025 were included.

The increase in other spend in March 2025 relates to an increase in a provision for future cessium disposal costs. The reduction seen in May 2025 relates to a provision for legal costs of £1.184m which was made in error in April and has been corrected in May. A reduction is again seen in July which is due to the reimbursement of legal costs by WRP of £1.369m, with further legal costs being recognised in August, as reflected above.

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

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



The Depreciation value included in the above graph for includes £10.304m recognised for the impairment of the nVCC Enabling Works in February, and £10.593m accelerated depreciation in March relating to the building and assets of the current Velindre Cancer Centre.

4. Savings

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

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

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

All schemes were RAG rated green earlier in the year. However, some recurrent schemes are now not forecast to achieve the full value of savings planned and have therefore been replaced with other schemes. Some of the underperforming schemes were expected to deliver recurrent savings (c£0.300m) and have been replaced with non recurrent savings schemes. This has contributed to the underlying deficit the Trust is carrying forward into 2026-27 within the draft IMTP 2026-29.

Performance

The Trust savings performance as at 31st January 2026 is an achievement of £1.670m against a year to date plan of £1.854m. Current expectation is that the annual savings target will be achieved through replacement schemes where others have been underperforming.

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

The Trust is currently on track to deliver the Trust savings target, however there is some risk of full delivery against recurrent savings schemes which have been replaced by non-recurrent schemes. Whilst this will ensure the target is met for this year it has had a detrimental impact on the Trust's underlying financial position.

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

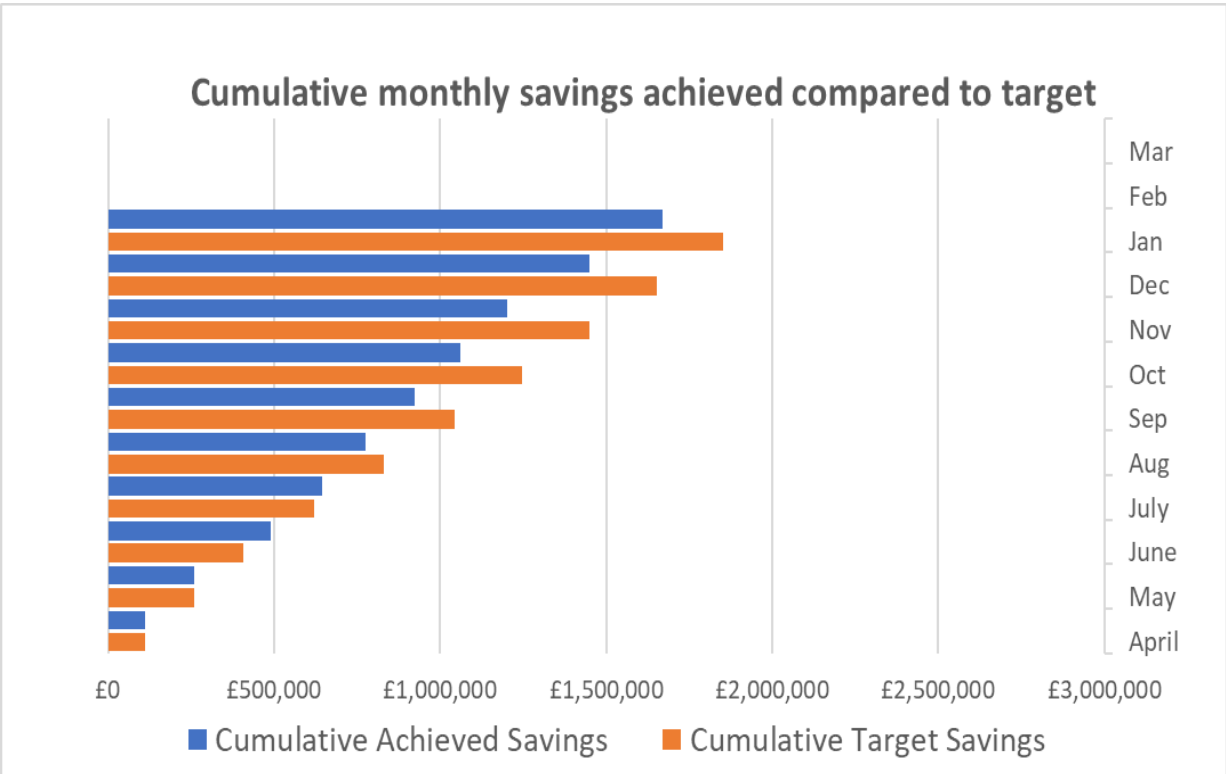
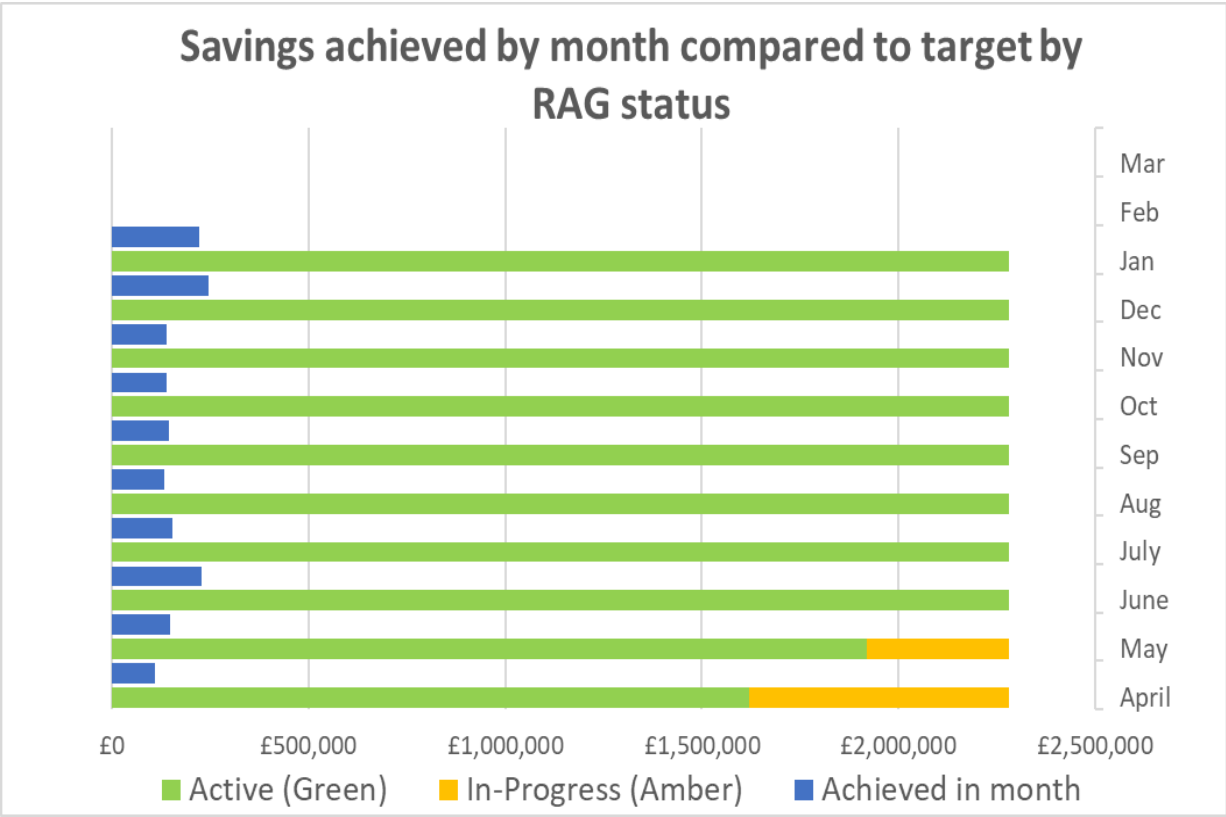
It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the savings target for 2025/26 is met.

ORIGINAL PLAN					TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS					1,043	832	712	(120)	1,043	0
							86%		100%	
WBS TOTAL SAVINGS					705	588	544	(44)	705	0
							92%		100%	
CORPORATE TOTAL SAVINGS					302	250	260	10	302	0
							104%		100%	
RD&I TOTAL SAVINGS					230	184	154	(30)	230	0
							84%		100%	
TRUST TOTAL SAVINGS					2,280	1,854	1,670	(184)	2,280	0
							90%		100%	

Scheme Type	Division	Recurrent / Non- Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services Agency Premium Reduction	VCS	NR	Green	15	12	12	0	15	0
Establishment Vacancy Control	VCS	R	Underperforming	150	125	37	(88)	37	(113)
Establishment Vacancy Control	VCS	NR	Underperforming	100	83	25	(58)	25	(75)
Procurement Supply Chain Contracting Cost Reductions	VCS	R	Replaced	50	40	0	(40)	0	(50)
Review of SLAs to mitigate / reduce service support	VCS	R	Green	30	25	25	0	30	0
3rd party SACT provision (medicines at home)	VCS	R	Green	150	113	113	0	150	0
3rd party SACT provision (medicines at home)	VCS	NR	Green	70	59	58	(1)	70	0
Establishment Vacancy Control	WBS	R	Green	100	82	83	1	100	0
Procurement Supply Chain Contracting Cost Reductions	WBS	R	Replaced	100	68	0	(68)	0	(100)
Optimised level of stock retention	WBS	NR	Green	150	150	150	0	150	0
Demand planning: collections (asphersis price saving)	WBS	R	Green	40	32	33	1	40	0
Demand planning: processing volumes	WBS	NR	Green	60	50	50	0	60	0
Process efficiencies	WBS	R	Green	30	22	30	8	30	0
Process efficiencies	WBS	NR	Green	20	14	20	6	20	0
Establishment Vacancy Control	Corporate	R	Green	50	42	42	0	50	0
Energy cost reduction	Corporate	R	Green	85	70	70	0	85	0
Establishment Vacancy Control	RD&I	R	Replaced	30	22	0	(22)	0	(30)
Establishment Vacancy Control	RD&I	NR	Replaced	50	40	0	(40)	0	(50)
Add Establishment Vacancy Control	VCS	NR	Green	128	99	22	(77)	22	(106)
Add Establishment Vacancy Control	WBS	NR	Green	55	47	45	(2)	55	(0)
Add Establishment Vacancy Control	Corporate	NR	Green	67	55	55	0	67	0
Add Establishment Vacancy Control	RD&I	NR	Replaced	30	22	0	(22)	0	(30)
3rd party SACT provision (medicines at home)	VCS	NR	Green	In yearscheme	0	52	52	106	106
Total Saving Schemes				1,560	1,272	923	(349)	1,112	(448)

Income Generation									
Private Patients Increased Fees Upon Renewed Contract	VCS	R	Green	150	118	124	6	150	0
Private Patients Income Overachievement	VCS	NR	Green	150	118	124	6	150	0
Maximising income - operational services	VCS	R	Green	50	40	0	(40)	50	0
Sale of Plasma	WBS	R	Green	50	42	50	8	50	0
Interest on bank income above budget	Corporate	NR	Green	100	83	93	10	100	0
R&D Commercial Income Generation	RD&I	R	Green	120	100	100	0	120	0
Sale of Plasma	WBS	NR	Green	100	81	82	1	100	0
Marginal activity income	VCS	NR	Green	In yearscheme	0	94	94	188	188
Marginal activity income	VCS	NR	Green	In yearscheme	0	26	26	50	50
R&D Commercial Income Generation	RD&I	NR	Green	In yearscheme	0	54	54	110	110
Sale of Plasma	WBS	NR	Green	In yearscheme	0	0	0	100	100
Total Income Generation				720	582	747	165	1,168	448

TRUST TOTAL SAVINGS					2,280	1,854	1,670	(184)	2,280	0
							90%		100%	



5. Reserves

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

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

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

6. End of Year Forecast / Risk & Opportunity Assessment

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

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

As highlighted earlier significant cost pressures and risks have materialised since the IMTP planning stage which will need to be managed or mitigated to ensure that the Trust achieves the outturn forecast position of breakeven and maintains a balanced underlying position going forward.

Further detail in relation to the financial risks currently being managed is outlined below:

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

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

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

The Trust has received confirmation from JCC that they will not fund any of the WBS Business cases which were submitted to JCC as part of the 2025/26 IMTP process. The business cases were re-submitted on 8th October 2025, for consideration as part of the 2026-27 IMTP process. If

these cases are again not supported, funding will need to be sought via Welsh Government following recommendations from the IBI report.

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

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

A risk has emerged, and crystallised in part, whereby the forecast activity income in relation to the above is not expected to match the level of investment in the Workforce. The forecast impact as at month 10 is an issue of £0.500m for 2025-26, after mitigations have been put in place, such as holding of vacancies and increased activity performance in year. A regular review of the impact and forecast position is being undertaken, with the latest expected forecast position remaining at c£0.500m shortfall against plan with £0.412m phased into the year to date position. A risk of a further £0.250m cost pressure remains.

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

It is understood that there the restructure will not result in a financial pressure in 2025/26. However, there will be an ongoing need once all posts are filled, to confirm the value and identify priority funding from 2026-27 uplift funding.

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

Opportunities

Overachievement of Bank Interest - *likelihood: low, value £0.250m*

Following a review of anticipated cash balances and potential interest rates, the forecast value of the income generated is considered realistic. There is therefore a limited opportunity for further overachievement.

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL 2025/26 £m	YTD Spend £m	Budget Remaining @M11 £m	Full Year Forecast Spend £m	Year End Variance 2025/26 £m
All Wales Capital Programme					
nVCC Enabling Works	3.683	3.129	0.554	3.726	(0.043)
nVCC Enabling Works QRA*	0.332	0.161	0.171	0.507	(0.175)
nVCC Project	6.376	4.997	1.379	6.491	(0.115)
nVCC Project QRA - Enabling Works HV Intake*	0.257	0.161	0.096	0.507	(0.250)
nVCC Project QRA - MIM	0.068	0.052	0.016	0.068	0.000
nVCC Project QRA - MIM*	0.150	0.000	0.150	0.214	(0.064)
Integrated Radiotherapy Solution (IRS)	1.400	1.283	0.117	1.352	0.048
Velindre @ Nevill Hall Radiotherapy Centre (RSC)	0.680	0.457	0.223	0.508	0.172
Whitchurch Hospital Site Disposal	0.840	0.261	0.579	0.840	0.000
Whitchurch Hospital Site Disposal - contingency*	0.300	0.000	0.300	0.020	0.280
WBS HQ Continuity Business Case OBC/FBC fees	1.000	0.768	0.232	1.000	0.000
WBS Fleet Replacement Programme	0.605	0.000	0.605	0.605	0.000
DPIF - RISP	0.214	0.000	0.214	0.214	0.000
DPIF - Blood Establishment Computer System (BECS) replacement	0.416	0.416	0.000	0.416	0.000
DPIF - Welsh Histocompatibility & Immunogenetics Service (WHAIS)	0.185	0.185	0.000	0.185	0.000
DPIF - Electronic Prescribing & Medicines Administration (EPMA)	0.086	0.000	0.086	0.086	0.000
WBS Plasma for Fractionation	0.030	0.030	0.000	0.030	0.000
Non-Radiology Ultrasound Replacement	0.048	0.000	0.048	0.048	0.000
Radiology Ultrasound Replacement	0.132	0.000	0.132	0.132	0.000
VPAG Funding - Equipment	0.037	0.000	0.037	0.037	0.000
Positron Emission Tomography (PET) Fees nVCC	0.298	0.007	0.291	0.298	0.000
Additional Digital Allocation	0.386	0.336	0.050	0.386	0.000
End of Year Funding	0.568	0.086	0.482	0.568	0.000
End of Year Equipment funding December 2025-26	0.024	0.017	0.007	0.024	0.000
End of Year Digital funding January 2025-26	1.065	0.239	0.826	1.065	0.000
Total All Wales Capital Programme	19.180	12.585	6.595	19.327	(0.147)
Discretionary Capital	2.000	1.139	0.861	2.000	0.000
	21.180	13.724	7.456	21.327	(0.147)

* QRA budget held by WG; spend will be added to CEL once confirmed & agreed by WG

The approved 2025-26 Capital Expenditure Limit (CEL) for the year ended March 2026 is currently £21.180m (2024-25 £35.076m). This includes All Wales Capital funding of £19.180m, and discretionary funding of £2.000m.

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

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

The Trust CEL has been updated to reflect the changes for 2025/26, and formal confirmation from WG Capital colleagues is awaited to confirm the re-provision of values in future years.

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital during 2025-26 to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required to complete the OBC stage of the WBS TGI scheme. WG colleagues have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m, with a total of £1.000m required in 2025/26. Welsh Government have amended the allocation for 2025/26 and confirmation as to whether the value will be reprofiled in 2026/27 is awaited.

In July 2025, WG noted their position in correspondence to the Trust, including that the current proposed costs are not considered supportable. WG also stated that as the scope of works is now expanding beyond infrastructure to include a wider lab modernisation together with the acquisition of the Wound Centre, and OBC setting out all the options would be required. How the additional revenue requirement of that option would be afforded would also need to be explained. The revised OBC will incorporate the Enabling Works and laboratory modernisation, with the appointed Supply Chain Partner leading design development. It has been agreed with WG that the Enabling Works section will be to FBC standard. The updated OBC must be submitted by the end of the 2025/26 financial year to align with WG funding timelines and strategic priorities.

The Trust has now received a revised funding award letter from DHCW relating to RISP for 2025/26, following a change in accounting treatment due to IFRS 16 which has impacted on the expenditure split between revenue and capital. This has been added to the Trust CEL.

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

In relation to the Integrated Radiotherapy Solution (IRS), the Trust received funding during 2025-26 to support the enhanced functionality and capability of two of its treatment machines. However, a request was made and agreed by WG Capital Colleagues to re-profile the funding for the enhancements on one machine into 2027-28 when the nVCC is open.

The Trust Chief Executive Office and Executive Director of Finance with the Deputy Director of Capital Estates & Facilities in WG on 19th January 2026 to discuss the IRS and on the 5th of February shared a summary case seeking approval for additional capital funding of £7m to enable Velindre to take advantage of new technology that Varian has developed since the IRS solution was tendered over 3.5 years ago.

The Trust is currently responding to questions raised by WG colleagues with expectation that a case will need to be submitted to the minister to request funding subject to WG capital colleagues supporting the request.

The discretionary allocation of £2.000m represents an increase of 4.65% on the £1.911m provided during 2024-25 which was fully spent.

The Trust's Capital Planning Group considered and approved the allocation of discretionary capital funding for 2025/26 at its meeting in May and this was approved by the Executive Management Board (EMB) on 29th May 2025. Further details on the allocation of the discretionary programme will be provided in subsequent reports.

The CEL was 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

The actual expenditure to January 2026 on the All-Wales Capital Programme schemes was £12.585m: this is broken down between spend on the nVCC schemes of £9.783m, Whitchurch Hospital Site Disposal £0.261m, Velindre@ Nevill Hall Radiotherapy Unit £0.457m, WBS HQ OBC £0.768m, BECS £0.416m, WHAIS £0.185m, WBS Plasma for Fractionation £0.030m, PET fees £0.007m, end of year funding including equipment of £0.103m and additional digital requirements £0.575m.

The spend on the Discretionary Capital programme was £1.139m. Where schemes are agreed and funding is in place, leads are encouraged to progress schemes to aid service delivery / improvements and ensure items are delivered well before the end of the financial year.

Major Schemes in Development

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

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

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

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

All Wales Approved and Unapproved Capital Schemes	2025-26	2026-27	2027/28	Further Years	Total All Wales Schemes
	£m	£m	£m	£m	£m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	25.526	56.774	6.999	0.000	89.299
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure – BJC & OBC	2.457	TBC	TBC	TBC	2.457
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913

All Wales Approved and Unapproved Capital Schemes	2025-26	2026-27	2027/28	Further Years	Total All Wales Schemes
	£m	£m	£m	£m	£m
WBS Fleet Replacement	0.364	0.738	1.851	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc)	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC
Total Unapproved Capital Schemes	6.575	2.425	4.093	0.500	13.593
Total All Wales Capital Plans	32.101	59.199	11.092	0.500	102.892

The schemes that are currently included within the draft IMTP 2026-29 are shown below:

All Wales Approved and Unapproved Capital Schemes	2026-27	2027-28	2028-29	Further Years	Total All Wales Schemes
	£m	£m	£m	£m	£m
All Wales Approved Schemes					
TCS nVCC	37.392	2.270	0.000	0.000	39.662
TCS nVCC (IRS Implementation Phase 3)	1.702	0.579	0.000	0.000	2.281
Integrated Radiotherapy Solution (IRS)	17.155	0.180	0.000	0.000	17.335
Radiotherapy Satellite Unit	0.520	0.000	0.000	0.000	0.520
EPMA (DPIF)	0.025	0.000	0.000	0.000	0.025
Talbot Green Infrastructure (WBS)	1.142	0.000	0.000	0.000	1.142
Fleet Replacement (WBS)	0.883	1.465	0.000	0.000	2.348
Total Approved Capital Schemes	58.819	4.494	0.000	0.000	63.313
All Wales Unapproved Schemes					
Whitchurch Hospital Site	0.300	0.000	0.000	0.000	0.300
nVCC – Project - Quantified Risk - MIM	3.156	0.000	0.000	0.000	3.156
nVCC – Project - Quantified Risk - Public Sector	4.829	3.085	0.000	0.000	7.914

All Wales Approved and Unapproved Capital Schemes	2026-27 £m	2027-28 £m	2028-29 £m	Further Years £m	Total All Wales Schemes £m
nVCC – Enabling works - QRA	0.506	0.000	0.000	0.000	0.506
WBS TGI Infrastructure	TBC	TBC	TBC	TBC	TBC
WBS Plasma for Fractionation	0.000	0.910	0.002	0.001	0.913
WBS BECS Blood Management System	1.840	1.187	0.000	0.000	0.000
RISP	TBC	TBC	TBC	TBC	TBC
Backlog Maintenance (WBS)	TBC	TBC	TBC	TBC	TBC
Asset Replacement (WBS)	0.250	0.000	0.530	0.000	0.780
WLIMS 2.0	TBC	TBC	TBC	TBC	0.000
WHAIS Phase 2	TBC	TBC	TBC	TBC	0.000
Digital CRM Multi Case Functions (WBMDR, AOS etc)	TBC	TBC	TBC	TBC	0.000
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	0.000
Enhanced Care Unit (VCS)	TBC	TBC	TBC	TBC	0.000
Positron Emission Tomography	TBC	TBC	TBC	TBC	0.000
Total Unapproved Capital Schemes	11.381	5.682	1.032	0.501	15.569
Total All Wales Capital Plans	70.200	10.176	1.032	0.501	78.882

These are being continually reviewed and updated prior to submission of the final IMTP.

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 25	Closing Balance End of 31 January 2026	Movement from 1st April to 31 January 2026	Forecast Closing Balance at 31 March 2026
	£'m	£'m	£'m	£'m
Non-Current Assets				
Property, plant and equipment	311.793	314.137	2.344	314.137
Intangible assets	11.160	8.776	(2.384)	8.776
Trade and other receivables	1,350.042	1,350.112	0.070	1,350.112
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,672.995	1,673.025	0.030	1,673.025
Current Assets				
Inventories	31.666	33.861	2.195	33.861
Trade and other receivables	592.821	566.173	(26.648)	599.135
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	15.206	50.869	35.663	17.907
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	639.693	650.903	11.210	650.903
TOTAL ASSETS	2,312.688	2,323.928	11.240	2,323.928
Current Liabilities				
Trade and other payables	(253.207)	(261.586)	(8.379)	(261.586)
Borrowings	(1.530)	(1.456)	0.074	(1.456)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(364.179)	(727.794)	(363.615)	(727.794)
Current Liabilities sub total	(618.916)	(990.836)	(371.920)	(990.836)
NET ASSETS LESS CURRENT LIABILITIES	1,693.772	1,333.092	(360.680)	1,333.092
Non-Current Liabilities				
Trade and other payables	(3.555)	(3.555)	0.000	(3.555)
Borrowings	(108.810)	(108.385)	0.425	(108.385)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,362.437)	(998.694)	363.743	(998.694)
Non-Current Liabilities sub total	(1,474.802)	(1,110.634)	364.17	(1,110.634)
TOTAL ASSETS EMPLOYED	218.970	222.458	3.488	222.458
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	36.469	39.926	3.46	39.926
PDC	162.684	162.685	0.001	162.685
Retained earnings	19.817	19.847	0.030	19.847
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	218.970	222.458	3.488	222.458

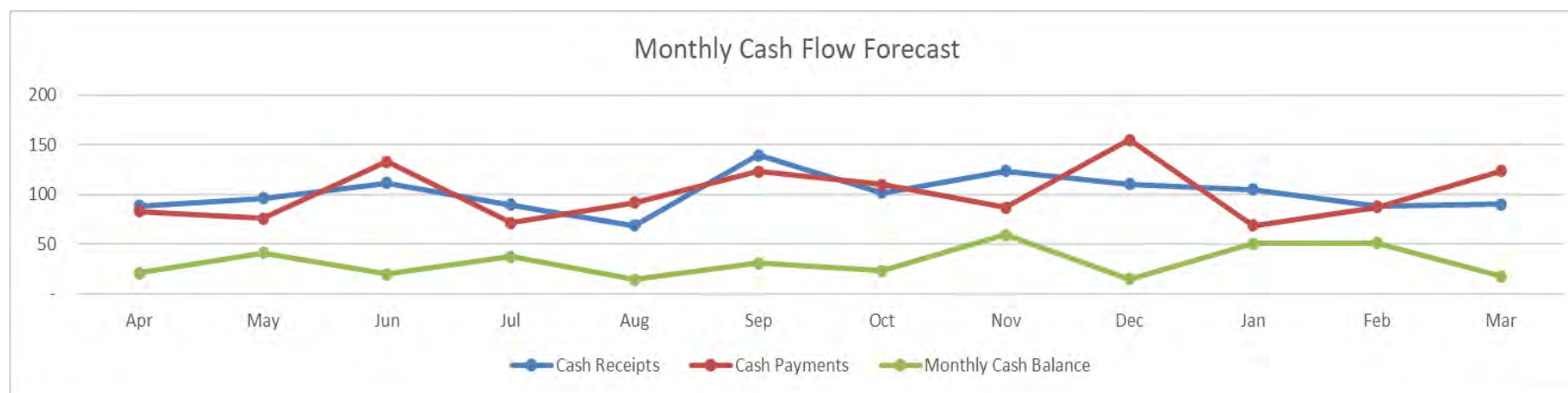
9. CASH FLOW (Includes Hosted Organisations)

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.

Year to date cash flows and those forecast to the end of the financial year are shown in table and graph format below:

	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	49.990	55.994	45.475	48.706	53.298	81.394	65.498	54.710	84.292	82.361	55.967	52.964	730.649
WG Revenue Funding	29.236	33.465	64.624	27.572	11.458	49.581	29.267	58.979	19.804	8.709	25.767	26.267	384.729
Short Term Loans													0.000
PDC												3.341	3.341
Interest Receivable	0.163	0.119	0.142	0.136	0.129	0.152	0.107	0.114	0.164	0.156	0.155	0.155	1.692
Sale of Assets													0.000
Other	9.452	6.736	1.583	13.156	3.690	8.651	7.162	9.979	6.143	13.747	5.930	7.320	93.549
TOTAL RECEIPTS	88.841	96.314	111.824	89.570	68.575	139.778	102.034	123.782	110.403	104.973	87.819	90.047	1,213.960
PAYMENTS													
Salaries and Wages	30.118	42.171	41.742	41.568	47.485	49.601	45.924	45.392	45.326	45.066	44.440	44.440	523.273
Non pay items	52.934	34.043	86.348	29.681	43.433	72.051	62.065	40.387	107.393	22.631	35.600	71.342	657.908
Short Term Loan Repayment													0.000
PDC Repayment		0.000										0.000	0.000
Capital Payment	0.000	0.000	5.038	0.387	0.890	1.481	2.165	1.282	2.430	1.376	7.255	7.750	30.054
Other items													0.000
TOTAL PAYMENTS	83.052	76.214	133.128	71.636	91.808	123.133	110.154	87.061	155.149	69.073	87.295	123.532	1,211.235
Net cash inflow/outflow	5.789	20.100	(21.304)	17.934	(23.233)	16.645	(8.120)	36.721	(44.746)	35.900	0.524	(33.486)	
Balance b/f	15.183	20.972	41.072	19.768	37.702	14.469	31.114	22.994	59.715	14.969	50.869	51.393	
Balance c/f	20.972	41.072	19.768	37.702	14.469	31.114	22.994	59.715	14.969	50.869	51.393	17.907	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
VCC	(43.321)	(44.594)	(1.274)	(51.833)	(53.107)	(1.274)
RD&I	0.182	0.167	(0.015)	0.193	0.178	(0.015)
WBS	(20.097)	(19.869)	0.228	(24.874)	(24.647)	0.228
Sub-Total Divisions	(63.235)	(64.297)	(1.061)	(76.514)	(77.576)	(1.061)
Corporate Services Directorates	(14.153)	(13.062)	1.091	(17.082)	(16.019)	1.061
Delegated Budget Position	(77.388)	(77.359)	0.029	(93.595)	(93.595)	0.000
nVCC	(0.161)	(0.162)	0.000	(0.197)	(0.197)	0.000
Health Technology Wales	(0.229)	(0.229)	0.000	(0.272)	(0.272)	0.000
Trust Income / Reserves	77.778	77.778	0.000	94.064	94.064	0.000
Trust Position	0.000	0.029	0.029	0.000	0.000	0.000

The in month position for the core Trust is an underspend of £0.002m, leading to a year to date **underspend of £0.029m**. The year end forecast is financial **breakeven**. While divisional year end forecasts are being confirmed, their positions at month 10 are now being reflected as year end projected variances. Overall, a forecast breakeven position for the Trust is currently still expected.

VCS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	81.425	82.368	0.943	98.767	99.710	0.943
Expenditure						
Staff	52.918	53.786	(0.868)	63.456	64.324	(0.868)
Non Staff	71.828	73.177	(1.349)	87.145	88.494	(1.349)
Sub Total	124.746	126.963	(2.217)	150.601	152.817	(2.217)
Total	(43.321)	(44.594)	(1.274)	(51.833)	(53.107)	(1.274)

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of January 2026 was an **overspend of (£1.274m)** with an expected outturn position currently of the same value. The forecast will be firmed up in month 11 and will need to be closely monitored as the year progresses.

Income at month 10 represents a year to date overachievement of **£0.943m** which is largely a result of overachievement of additional activity income (offset by underachievement of radiotherapy and Private Patient income).

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

A risk has emerged, and crystallised in part, whereby the forecast activity income in relation to the above is not expected to match the level of investment in the Workforce. The forecast impact as at month 10 is an issue of £0.500m for 2025-26, after mitigations have been put in place, such as holding of vacancies and increased activity performance in year. A regular review of the impact and forecast position is being undertaken, with the latest expected forecast position remaining at c£0.500m shortfall against plan with £0.412m phased into the year to date position. A further risk of £0.250m still remains at this stage.

VCS have reported a year to date overspend of **£(0.868)m** against staff. Snr Medical costs continue to be the largest pressure for VCS (resulting in an overspend of £0.640m to date), however, have significantly reduced following funding being provided during 2024-25 from the Trust Discretionary uplift in funding, agreed as a part the IMTP. NQN student streamlining has begun and is contributing to the year to date overspend by £0.238m. The vacancies have been helping to support the posts appointed at risk, and the divisional savings target and vacancy factor.

Non-Staff Expenditure at month 9 was **£(1.349)m** overspent which includes overspends of £0.403m for additional drug expenditure, £0.207m for legal costs, postage costs of £0.229m, £0.135m in respect of M&SE disposables, and £0.374m for the pathology SLA. The Division will need to ensure it understands the causes of these cost increases and put steps in place to mitigate them.

WBS

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	30.559	31.353	0.794	36.653	37.447	0.794
Expenditure						
Staff	17.086	16.980	0.105	20.760	20.655	0.105
Non Staff	33.571	34.243	(0.672)	40.768	41.440	(0.672)
Sub Total	50.656	51.223	(0.567)	61.528	62.094	(0.567)
Total	(20.097)	(19.869)	0.228	(24.874)	(24.647)	0.228

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of January 2026 was **an underspend of £0.228m** with an expected outturn position currently of the same value. The forecast will be firmed up in month 10 and will need to be closely monitored as the year progresses.

WBS recognised an overachievement of **£0.794m** on income due predominantly to an increase in activity for the bone marrow registry (£0.237m), sale of plasma (£0.091m) and exportation (£0.071m).

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

Staff underspend of **£0.105m** to date is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source, offset by some vacancies within the service, and the release of a year end accrual in respect of time off in lieu, and overtime costs. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team have created an unfunded post analysis to determine and monitor the current year and recurrent cost pressure. Some posts were recognised and funded as part of the Trust IMTP for 2025-26. Vacancies across multiple cost centres are helping to support these pay pressures.

WBS report a non-staff overspend of **(£0.672m)** as at the end of month 10. The largest cost pressure is the divisional savings target, partly offset by activity related performance.

Corporate

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	4.570	5.326	0.756	5.752	6.509	0.756
Expenditure						
Staff	14.884	13.291	1.593	18.112	16.519	1.593
Non Staff	3.840	5.098	(1.258)	4.722	6.008	(1.258)
Sub Total	18.724	18.388	0.335	22.834	22.528	0.335
Total	(14.153)	(13.062)	1.091	(17.082)	(16.019)	1.091

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of January 2026 was an **underspend of £1.091m** with an expected outturn position of £1.00m.

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. There has also been a significant recovery of previously VAT paid to HMRC, as a result of an annual review exercise.

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

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

RD&I

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	4.128	4.501	0.373	5.394	5.766	0.373
Expenditure						
Staff	3.424	3.725	(0.301)	4.390	4.690	(0.301)
Non Staff	0.522	0.609	(0.087)	0.810	0.898	(0.087)
Sub Total	3.946	4.334	(0.388)	5.200	5.588	(0.388)
Total	0.182	0.167	(0.015)	0.193	0.178	(0.015)

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of January 2026 was an **underspend of £0.015m** with an expected outturn position of the same value. This will need close monitoring as the final quarter of the year progresses.

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

nVCC – (Revenue)

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	0.039	0.036	(0.003)	0.046	0.043	(0.003)
Expenditure						
Staff	0.182	0.169	0.014	0.220	0.207	0.014
Non Staff	0.017	0.028	(0.011)	0.023	0.034	(0.011)
Sub Total	0.200	0.197	0.003	0.243	0.240	0.003
Total	(0.161)	(0.161)	0.000	(0.197)	(0.197)	0.000

nVCC Key Highlights / Issues

The reported revenue financial position for the nVCC Programme at the end of January 2026 is a breakeven position, with a year end forecast of breakeven.

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

HTW (Hosted Other)

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£m	£m	£m	£m	£m	£m
Income	1.433	1.291	(0.142)	1.723	1.581	(0.142)
Expenditure						
Staff	1.569	1.380	0.190	1.883	1.694	0.190
Non Staff	0.092	0.139	(0.048)	0.111	0.159	(0.048)
Sub Total	1.661	1.519	0.142	1.994	1.852	0.142
Total	(0.229)	(0.229)	0.000	(0.272)	(0.272)	0.000

HTW Key Highlights / Issues

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

nVCC Project Finance Report For January 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 **January 2026**.
- 1.2 The nVCC and Enabling Works Project financial position is continually monitored and updated, and an update will be provided to the nVCC Project Board and Trust Board on a monthly basis.

2. FINANCIAL SUMMARY FOR 2025-26

- 2.1 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 **January 2026** is set out below:

New Velindre Cancer Centre FINANCIAL									
	Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust								
	Budget	QRA	QRA Called	Approved to Spend (Budget plus QRA Called)	Spend to Date	Committed Funds	Projected	Forecast Spend to Complete	Unallocated Resources (Surplus)
Total Costs	54.90M	12.84M	1.32M	56.21M	13.96M	18.19M	24.00M	56.21M	11.52M

- The in-year **financial position** for **January 2026** is:
 - CAPITAL** in-year spend of **£6.774m**, with a forecast outturn of **c£8.966m** based on run-rates and financial plan.

nVCC Project Capital Budget & Spend Summary 2025-26

	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	Jan-26	Jan-26	Jan-26	Budget	Forecast	Variance
	£	£	£	£	£	£
EW FBC Project	3,199,643	3,289,793	-90,150	3,940,000	4,233,079	-293,079
nVCC FBC Project	3,484,544	3,484,479	65	4,616,000	4,732,967	-116,967
	6,684,187	6,774,272	-90,085	8,556,000	8,966,047	-410,046

- REVENUE** in-year spend of **£0.162m**, with a forecast outturn of **c£0.197m** based on run-rates and financial plan.

REVENUE

	Year to Date			Financial Year		
	Budget	Spend	Variance	Annual	Annual	Annual
	Jan-26	Jan-26	Jan-26	Budget	Forecast	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	143,954	143,954	0	174,115	174,115	0
Project Delivery Support Costs	17,316	18,054	-738	23,000	23,000	0
nVCC Revenue Total	161,270	162,007	-738	197,115	197,115	0
REVENUE TOTAL	161,270	162,007	-738	197,115	197,115	0

- Cashflow** - the actual capital run-rate reflects the planned spend; and
- Financial Risks:** The financial risks are outlined in the report.

3. FUNDING

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

- 3.1 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. Therefore, the **nVCC Project will be responsible for c£55.8m.**
- 3.2 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.

3.3 As a result of the Trust and Welsh Government reassessment of the QRA allocation, the capital funding has been **reduced to £72.805m**. It should be noted that the QRA is reviewed on a quarterly basis.

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

Total Funding

EW Project

<i>FBC Addendum</i>	£7,575,600
<i>Original FBC</i>	£0
<i>QRA</i>	£1,367,000
	£8,942,600

nVCC Project

<i>Equipment</i>	£32,540,286
<i>Transactions(Resource Costs)</i>	£14,507,885
<i>Deep Clean</i>	£272,000
<i>IRS Implementation</i>	£5,071,000
<i>QRA</i>	£11,471,460
	£63,862,631

£72,805,231

4. FINANCIAL POSITION – overall Project

4.1 The overall status of the financial position of the Project is a RAG rating of **GREEN**.

4.2 The Project overall has an agreed funding of c£56.215m. The projected spend is £56.215m leading to an breakeven position. The spend forecast is made up of actual spend of c£13.963m, contractual commitments of c£18.189m and projected spend to completion of c£24.004m. The projected spend element of c£24.004m is primarily equipment (c£23.344m).

4.3 It should be noted that as at January 2026 the Trust has commitments of c£9.0m for major medical equipment for £8.1m with purchase orders raised in September 2025 and Digitalisation of Health Records EDMS contract for £0.6m in January 2026.

- 4.4 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 £1.319m of the QRA, which represents 7.05% of the agreed reserves. In September 2025, the Trust reviewed the QRA and reduced the risk exposure by c£5.8m. Therefore, the Project retains reserves of c£11.520m.
- 4.5 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.
- 4.6 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		Jan-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	All Selected								
	7.58M	1.37M	918K	8.49M	7.15M	955K	387K	8.49M	450K
Equipment	All Selected								
	32.54M	2.58M	0	32.54M	158K	9.04M	23.34M	32.54M	2.58M
Transactions (Resource Costs)	All Selected								
	14.51M	5.18M	59K	14.57M	6.46M	8.05M	0	14.57M	5.12M
MIM (Construction Costs)									
	0	3.56M	342K	342K	195K	147K	0	342K	3.22M
Deep Clean									
	272K	156K	0	272K	0	0	272K	272K	156K

EW Project – as of January 2026

4.7 The overall financial position is an approval to spend of c£8.200m, which is set out below:

EW Project

<i>FBC Addendum</i>	£7,575,600
<i>Original FBC</i>	£0
<i>QRA Called</i>	£917,879
	£8,493,479

4.8 The overall financial position is set out below:

	FBC Funding	Costs Incurred 2024-25	Costs Incurred to Date Jan-26	Commitments Jan-26	Projected Costs Jan-26
EW Project					
Pay	£153,116	£153,116	£0	£0	£0
6MVA Supply - National Grid	£576,000	£480,000	£35,919	£96,000	£0
Supply Chain Fees	£645,800	£323,268	£114,186	£80,336	£0
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	£2,530,315	£595,588	£0
Offsite Habitat Creation (SW Corner)	£717,335	£434,292	£276,745	£108,777	£0
HV Intake Room	£627,600	£161,286	£322,756	£48,513	£0
Rural Path	£75,000	£0	£0	£0	£75,000
TCAR Habitat	£72,000	£0	£0	£0	£72,000
Revised Emergency Access	£240,000	£0	£0	£0	£240,000
Enabling Works FBC Reserves	£0	£9,921	£0	£25,404	£0
TOTAL EW PROJECT	£8,493,479	£3,862,068	£3,289,793	£954,618	£387,000
QRA funding					
HV Intake Room Drawdown	£1,367,400				£1,367,400
Asda Final Account Drawdown	-£160,800				-£160,800
Sacrificial Cable	-£368,000				-£368,000
S278 Works	-£96,000				-£96,000
Addn funding	-£293,079				-£293,079
	£449,521	£0	£0	£0	£449,521
TOTAL nVCC EW FUNDING	£8,943,000	£3,862,068	£3,289,793	£954,618	£836,521

4.9 The overall financial position of the EW Project is spend to date is c£7.152m, with commitments of c£0.955m and projected costs of c£0.387m.

4.10 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

4.11 The QRA reflects the risks being managed by the EW Project as at January 2026.

nVCC Project – as of January 2026

4.12 The overall financial position is an approval to spend of c£47.604m, which is set out below:

nVCC Project

<i>Equipment</i>	£32,540,286
<i>Transactions(Resource Costs)</i>	£14,507,885
<i>Deep Clean</i>	£272,000
<i>QRA Called</i>	£401,032
	£47,721,203

4.13 The overall financial position is set out below:

	FBC Funding	Costs Incurred 2024-25	Costs Incurred to Date Jan-26	Commitments Jan-26	Projected Costs Jan-26
nVCC MIM Activities					
Project Management Office	£3,325,884	£1,181,156	£909,679	£1,235,049	£0
Design & Construction Workstream	£2,606,271	£629,664	£761,334	£1,215,273	£0
Equipment, Commissioning and Migration Workstream	£3,722,193	£372,839	£535,110	£2,814,244	£0
Digital Workstream	£1,935,417	£113,756	£273,441	£1,548,220	£0
Engagement & Communications Workstream	£380,688	£159,689	£114,678	£106,321	£0
Commercial Activity Group	£2,242,432	£621,540	£554,487	£1,066,405	£0
Strategic Reserves			£0		£0
Project Delivery	£295,000	£117,988	£112,573	£64,439	£0
Major Medical Equipment	£10,676,400	£0	£0	£8,194,000	£2,482,400
Other Equipment	£12,385,200	£0	£53,069	£108,724	£12,223,407
IM&T infrastructure	£5,359,802	£0	£0	£0	£5,359,802
Digital	£433,415	£0	£70,425	£109,575	£253,415
Digitisation of Health Records	£3,685,469	£0	£34,728	£625,000	£3,025,741
Non Works Costs	£272,000	£0	£0	£0	£272,000
MIM Construction Costs	£342,032	£130,434	£64,955	£146,643	£0
PROW Diversions	£59,000		£0	£59,000	£0
TOTAL nVCC PROJECT	£47,721,203	£3,327,065	£3,484,479	£17,292,893	£23,616,766
QRA funding	£11,471,000				£11,471,000
Asda Traffic Management Drawdown	-£225,000				-£225,000
PROW Diversions	-£59,000				-£59,000
PA Changes	-£117,032				-£117,032
	£11,069,968	£0	£0	£0	£11,069,968
TOTAL nVCC MIM FUNDING	£58,791,171	£3,327,065	£3,484,479	£17,292,893	£34,686,734

- 4.14 The overall financial position of the nVCC Project is spend to date is c£6.812m, with commitments of c£17.293m and projected costs of c£23.617m.
- 4.15 The QRA available for the nVCC Project is c£11.070m 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

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

5. Financial Position – in year position for 2025-26

5.1 The in year financial position for **JANUARY 2026** is reporting an **overspend** position due to the additional funding required for Enabling works and nVCC that will be requested from the QRA funds available.

- **CAPITAL** in-year spend of **£6.776m**, with a forecast outturn of **c£8.967m** based on run-rates and financial plan

The detailed capital financial position is set out below:

nVCC Project Budget & Spend 2025-26						
CAPITAL	Year to Date			Financial Year		
	Budget Jan-26	Spend Jan-26	Variance Jan-26	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
Enabling Works						
Enabling Works Pay	0	0	0	0	0	0
6MVA Supply - National Grid	35,919	35,919	0	131,919	131,919	0
Supply Chain Fees	114,186	114,186	0	194,522	194,522	0
Non Works Costs	0	0	0	0	0	0
Asda Works	0	0	0	0	0	0
Walters Design & Build	9,873	9,873	0	9,873	9,873	0
S278 works on Longwood Drive	2,510,836	2,530,315	-19,479	2,801,824	3,125,903	-324,079
Offsite Habitat Creation (SW Corner)	164,705	276,745	-112,040	283,043	385,522	-102,479
HV Intake Room	364,125	322,756	41,368	452,735	371,269	81,465
TCAR Extension Planning Application	0	0	0	0	0	0
Rural Path	0	0	0	0	0	0
TCAR Habitat	0	0	0	0	0	0
Revised Emergency Access	0	0	0	0	0	0
Enabling Works FBC Reserves	0	0	0	66,085	14,072	52,013
Enabling Works Capital Total	3,199,643	3,289,793	-90,150	3,940,000	4,233,079	-293,079
New Velindre Cancer Centre						
Project Management Office	1,022,317	1,022,252	65	1,319,607	1,319,542	65
Design & Construction	761,334	761,334	0	877,106	877,106	0
MIM (Construction Costs)	64,955	64,955	0	64,955	181,987	-117,032
Equipment, Commissioning and Migration	535,110	535,110	0	764,991	764,991	0
Medical and Other Equipment Procurement	53,069	53,069	0	161,973	161,973	0
Digital	273,441	273,441	0	328,638	328,638	0
IM&T & Digital Procurement	105,154	105,154	0	265,616	265,616	0
Engagement & Communications	114,678	114,678	0	138,843	138,843	0
Commercial Activities Group	554,487	554,487	0	675,251	675,251	0
Strategic Reserves	0	0	0	19,021	19,021	0
nVCC Capital Total	3,484,544	3,484,479	65	4,616,000	4,732,967	-116,967
CAPITAL TOTAL	6,684,187	6,775,622	-91,435	8,556,000	8,967,397	-411,396

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

Work Packages are outlined below:

- **Supply Chain Fees – spend of £0.114m** - costs associated with advisory support provided by WSP (£0.110m) and Escrow fees (c£0.004m).
- **Asda Works – no spend** - costs associated with the Asda car park works costs c£0.000m. The final account is being finalised.
- **Velindre Works – spend of £0.010m** - costs associated with the D&B contract by Walters for the site works. Residual costs incurred c£0.010m.
- **S278 Works Longwood Drive – spend of £2.530m** - costs associated with the highway improvement works on Longwood Drive agreed with Cardiff County Council. Works costs c£2.488m, Water works c.£0.019m and advisory costs c£0.023m.
- **Off-site Habitat – spend of £0.277m** - costs associated with the offsite habitat creation required as part of the EPSL.
- **HV Intake Room – spend of £0.323m** - costs associated with the design and build of the HV intake room. Works costs are c£0.316m.
- **Reserves – no spend** - costs are c£0.000m – no spend to date.

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

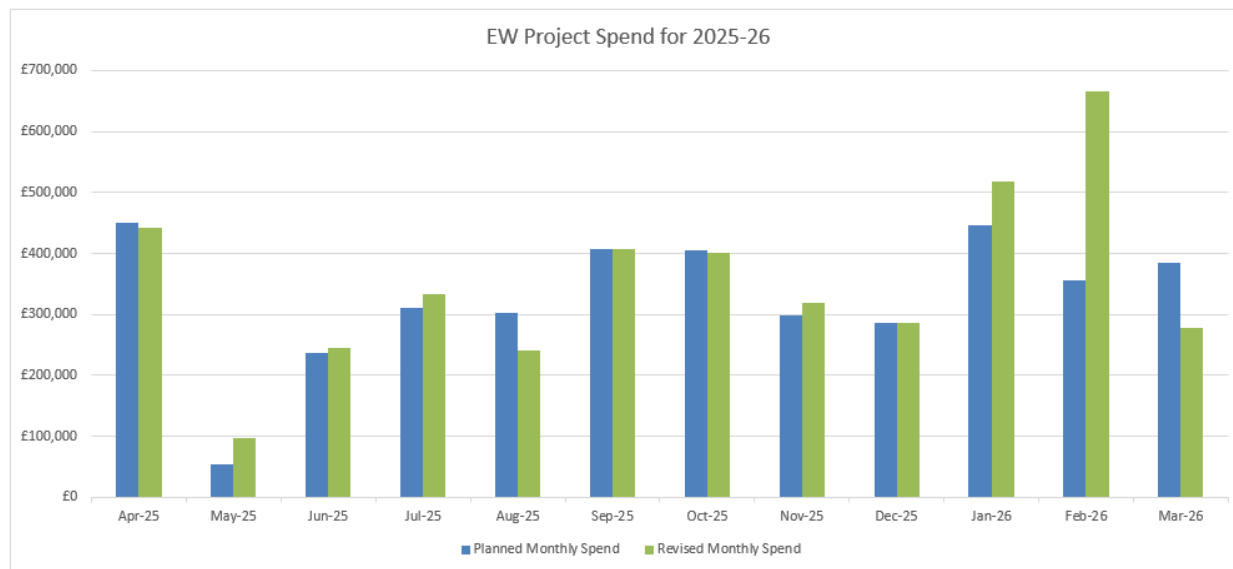
- **Staffing** - WG funded posts **spend of £2.056m**. Reflects the Project posts and a run rate of c£0.206m per month.

Work Packages are outlined below:

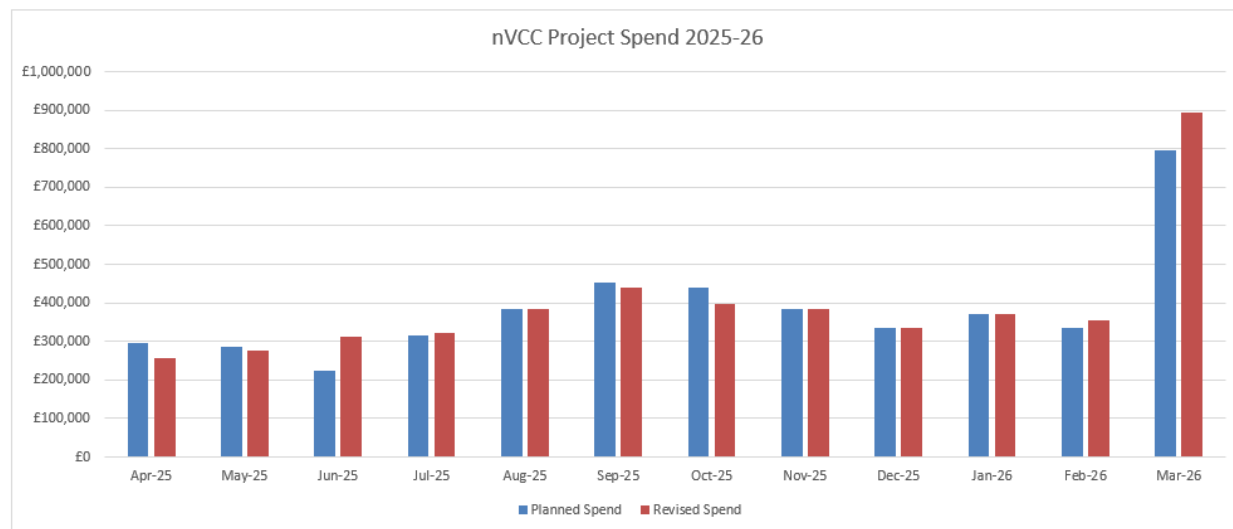
- **Project Delivery** – costs associated with the running of the Project Office and spend is **£0.113m**.
- **Capability Review – spend £0.050m**.
- **RDD Process – spend of £0.199m** for the reviewable design data process as RIBA stage design is finalized with Project Co.
- **Construction Phase – spend of £0.256m** for the services provided by the Authority Construction Surveyor.
- **MIM Construction costs – spend of £0.065** for the Asda Traffic management works and the Independent Tester costs.
- **Equipment Advisers & purchases – spend of c£0.127m** for equipment advice, Consultation site visits and Radiation dosage meters.
- **Digital and IM&T Equipment procurement – spend of c£0.124m** mainly for Switches and the Mizaic report for the Digitalisation of Health records Programme.
- **Engagement and Communications – spend of c.£0.013m** for 3D Flythrough presentations.
- **Project Management Advisers – spend of c£0.173m** for the SRO; Project Control and Risk Management support.
- **Professional Advisers – spend of £0.309m** for legal advice on the PA and changes, and range of commercial matters; commercial support.
- **Reserves – spend of £0.0.00m** – no spend to date.

5.4 Cashflow

The graph below outlines the Enabling works actual capital spend to **JANUARY 2026 is £3.290m**. The actual run-rate is **higher than** planned spend due to works happening sooner than planned on the Offsite Habitat creation with Ainsty Timber.



The graph below outlines the nVCC actual capital spend to **JANUARY 2026 is £3.484m**. The actual run-rate is **in line** with planned spend.



5.5 Capital Resource Limit - the revised CRL for the EW and nVCC Project(s) was **reviewed and agreed with WG in September 2025:**

- For **JANUARY 2026** the capital spend forecast outturn is **£8.967m**
- WG have **approved** the revised CRL for the Project(s).

5.6 The CRL position is outlined below:

EW Project

Period 2025-26	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-25	0.450	0.442	0.008
May-25	0.055	0.096	-0.041
Jun-25	0.236	0.245	-0.008
Jul-25	0.311	0.334	-0.023
Aug-25	0.302	0.241	0.062
Sep-25	0.408	0.408	0.000
Oct-25	0.405	0.401	0.004
Nov-25	0.299	0.319	-0.019
Dec-25	0.287	0.287	-0.000
Jan-26	0.446	0.517	-0.071
Feb-26	0.356	0.666	-0.310
Mar-26	0.384	0.277	0.107
TOTAL	3.940	4.233	-0.293

nVCC Project

Period 2025-26	CRL awaiting approval £m	Actual & Forecast Spend £m	Variance £m
Apr-25	0.258	0.258	0.000
May-25	0.276	0.276	0.000
Jun-25	0.314	0.314	0.000
Jul-25	0.323	0.323	0.000
Aug-25	0.383	0.383	0.000
Sep-25	0.440	0.440	0.000
Oct-25	0.399	0.399	0.000
Nov-25	0.302	0.385	-0.082
Dec-25	0.310	0.334	-0.024
Jan-26	0.325	0.371	-0.046
Feb-26	0.230	0.353	-0.124
Mar-26	1.054	0.895	0.159
TOTAL	4.616	4.733	-0.117

6. QUANTIFIED RISK ASSESSMENT (QRA)

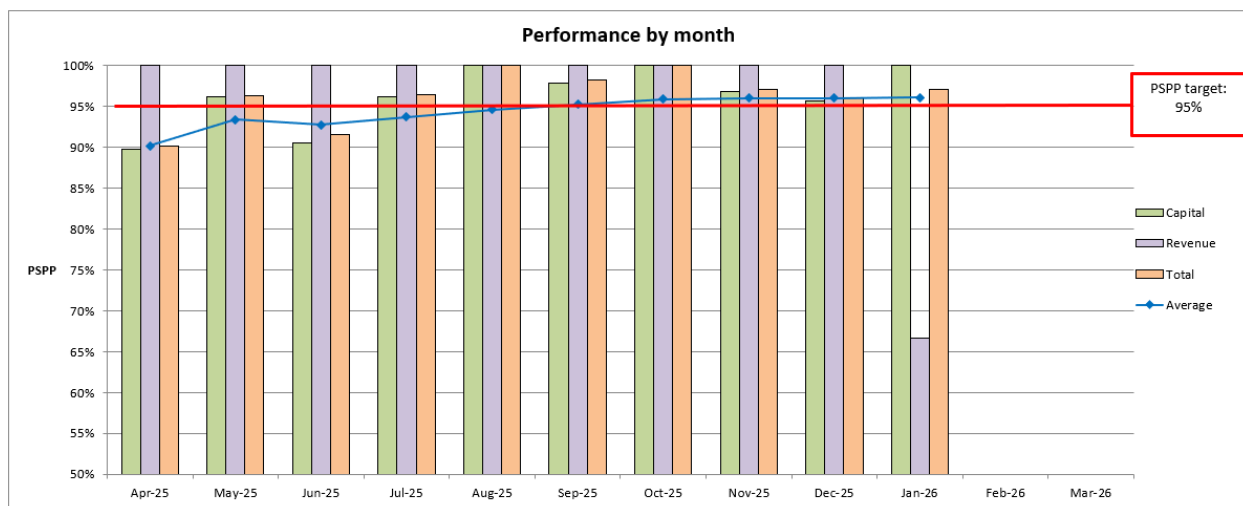
- 6.1 The **Original QRA position was £18.7m** as per the FBC and approved by Welsh Government. The revised position is now **c£12.839m** following the bi-monthly review conducted with Welsh Government. This reduction of £5.8m reflects the negating of the risks to the project, particularly in the procurement of the Category 2c equipment allocation.
- 6.2 The Project has utilised **c£1.319m** of the QRA and the funding has been provided by WG.
- 6.3 The remaining QRA is **c£11.493m with the profiling set out in the below:**

REVISED QRA (JAN 26)	2024-25	2025-26	2026-27	2027-28	TOTAL
REVISED NVCC QRA - MIM (JAN 26)			£3,188,968		£3,188,968
					£0
REVISED NVCC QRA - TRUST (JAN 26)			£4,769,800	£3,085,200	£7,855,000
					£0
REVISED EW QRA (JAN 26)			£449,521		£449,521
TOTAL QRA	£0	£0	£8,408,289	£3,085,200	£11,493,489

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

7. PUBLIC SECTOR PAYMENT POLICY

- 7.1 For **JANUARY 2026**, the PSPP performance was **97%** and the PSPP target was **achieved**. Of the 34 invoices for payment, 33 invoices were processed within the 30-day deadline.
- 7.2 The average PSPP performance to date for 2025-26 is **96%**.
- 7.3 The Project(s) PSPP monitoring report is outlined below:



8. Considerations for Board

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

9. IMPACT ASSESSMENT

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

DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Risk and Assurance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The report: • highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 and above for all other domains. • allows the Trust Board to have effective oversight and assurance of the way in which risks are being managed across the Trust. • provides the Board with a summary of activity related to the status of the risks and associated movement. • Provides an update on the sub-threshold risks in the Trust.
RECOMMENDATION / ACTIONS	The Board is asked to: • NOTE the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 on the Risk



		Register. • NOTE the update on the Datix risk system replacement. • NOTE the update on sub-threshold risks.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP		DATE
Velindre Cancer Service Divisional Team		Data shared
Welsh Blood Service Senior Leadership Team (WBS SLT)		Data Shared
Audit Committee		03.03.2026
Quality, Safety and Performance Committee		12.03.2026
Data has been validated in divisions. The Audit Committee reviewed the Trust Risk Register and noted several emerging risks, particularly around digital capacity, data systems and WBS-related operational issues, highlighting the need for deeper scrutiny at QSP and clearer assurance on mitigation plans. The Committee noted the section on the risks below TRR scoring threshold. The Quality, Safety and Performance Committee noted the Audit Committee discussion and agreed that the number of emerging risks around digital capacity, data systems and WBS operational risks should be included as an alert to the Trust Board via the highlight report. Assurance was provided by the divisional leads with regards processes to manage risk e.g. through senior leadership teams the Quality and Safety Hubs, all of which will be reflected in the new Risk Management Framework.		
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR		Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES		
1	Trust Risk Register	

1. SITUATION

This report informs the Trust Board of the status of reportable risks in line with the Trust Board approved risk appetite levels and policy. The baseline information is drawn from

Datix, with additional information provided by the Velindre Cancer Service (VCS) and the Welsh Blood Service (WBS) monthly risk analysis reports.

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

Risks reported in this paper are:

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

2. ASSESSMENT

2.1 Trust Risk Register

The Trust Risk Register is available as Appendix 1.

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

Risk 3716

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

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

Discussion at Quality, Safety and Performance Committee clarified this risk is as a result of following process in the project and carrying our risk assessments. The risk will continue to be managed through the project and will appear on the Trust Risk Register for governance reasons until reduced.

Risk 3856

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

Risk is being treated to reduce risk level.

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

Risk 3801

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

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

Risk 3643

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

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

2.3 There is one risk with a reduced current risk rating reduced below the reporting threshold since the last reporting cycle.

Risk 2774

"There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm."

Trend/Direction of Travel has decreased. HistoTrac Implemented and overall risk of using workarounds has reduced. Some remain in place until phase 2 is completed.

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

- A total of 17 risks reporting onto the public Trust Risk Register.
- Eight risks with a score of 12 or above reported in the safety/quality domain.
 - o Two on the VCS register
 - o Six on the WBS register
- Ten with a score over 15 or above reported in other domains.
 - o One on the VCS register
 - o Two on WBS register
 - o Six on the Corporate risk register.

3.0 Risk Themes

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

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

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

Overall, the risk environment remains highly influenced by capacity constraints, dependency on national digital programmes, and legacy infrastructure. While progress is being made across multiple transformation and workforce streams, the Board's continued focus on strategic mitigation, assurance, and cross-system engagement remains key.

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

Datix System Replacement

The contract with Datix 14 runs until November 2027.

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

The Trust's Task and Finish group agreed to:

- Continue to work on the specification requirements, taking into account the peer group work undertaken across NHS Wales.

- Create a plan procurement notice (PPN) as a part of the procurement process to enable engagement with potential system suppliers to develop the Trust's requirement and procurement approach and identify potential suppliers. The proposed date for this activity will be in mid-April 2026.

Risk Management Framework Review

The Trust's refreshed Risk Management Framework will be considered by the Audit Committee for onward submission to Trust Board in May. Supporting procedural documents have been reviewed by the Risk and Assurance Manager will be finalised over the coming weeks. Engagement with the Divisions to consolidate processes is underway.

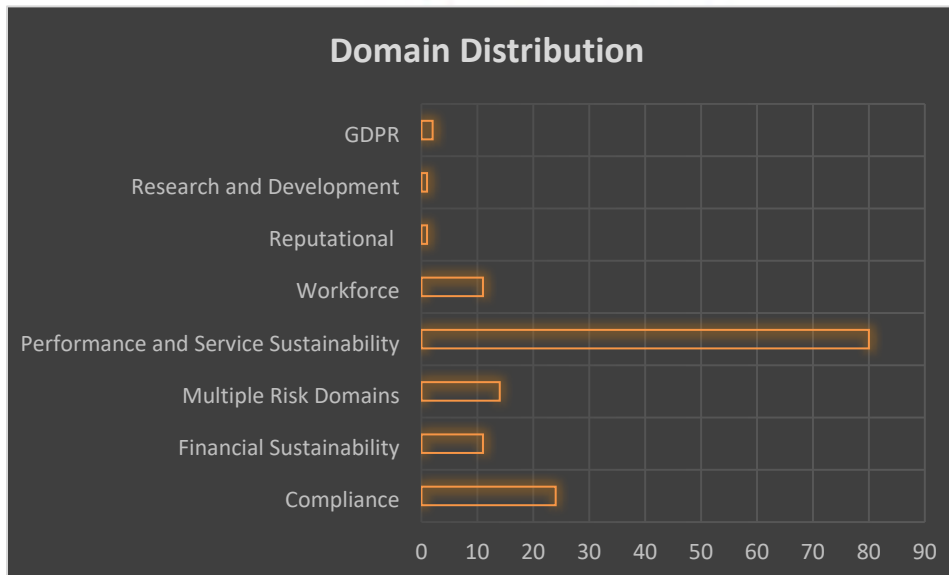
5. Sub-threshold Risk Update

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

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

In line with established governance arrangements, Quality and Safety related risks have been excluded from this review, as they are monitored and managed through the Quality and Safety Hubs, with escalation through the Integrated Quality and Safety Group as appropriate. In addition, risks associated with Welsh Blood Service (WBS) venues have been excluded, as these are recognised as tolerated risks for the duration of each venue's operational lifespan. The aim of the review is to ensure that remaining sub-threshold risks are being appropriately monitored, reviewed, and mitigated in line with the Trust's risk management policy.

The number of risks audited totalled 144. Of this total, 58 risks (40%) are at the target score and tolerated. 21 (14.5%) audited risks have an out-of-date review target – this demonstrates a reduction of 25.5% in out-of-date reviews since August 2026. The risk reviews are regularly monitored and managed with risk leads. Actions have been created and shared with risk leads to manage and update risk reviews.



Risk review dates may become overdue due to competing operational pressures, changes in ownership, or limited capacity to carry out reviews. This can impact the accuracy of the risk register by preventing timely identification of changes in risk exposure or effectiveness of controls. To address overdue risk reviews, the Risk and Assurance Manager continues to work with risk leads to implement clear review schedules, which are supported by automated reminders. Training and guidance associated to the new Risk Management Framework will reinforce the importance of reviews, while integration into governance meetings will ensure regular oversight.

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

- Clear Review Schedules – Each risk has an agreed review frequency, with automated reminders and escalation where deadlines are missed. This is also backed up with support from divisional staff and the Risk and Assurance Manager.
- Ownership and Accountability – Risk leads are responsible for timely updates, with compliance monitored through routine reporting.
- Training and Support – Risk leads receive support and guidance to reinforce the importance of timely reviews and effective risk management. Following the approval of the Risk Management Framework training will be reviewed and updated to include review of risks.
- Governance Integration – Sub-threshold risk oversight will be embedded into existing governance meetings to provide regular assurance and ensure overdue reviews are addressed.
- Monitoring and Reporting – Progress is tracked supported by the Risk and Assurance Manager for oversight.

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



6. SUMMARY OF MATTERS FOR CONSIDERATION

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

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)													
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒													
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	<table border="0"> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☒</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☒</td> </tr> <tr> <td>Efficient</td> <td>☒</td> </tr> <tr> <td>Patient Cantered</td> <td>☒</td> </tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Cantered	☒
Safe	☒												
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Cantered	☒												
	The risk register and associated risk framework are imperative to quality and safety in the organisation.												
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.												
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper. The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated												
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report. There is no												



	direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below No - Include further detail below There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL IMPLICATIONS / IMPACT LEGAL	There are no specific legal implications related to the activity outlined in this report. There are no specific legal implications related to the activity outlined in this report.

7. RISKS

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

Trust Board – Trust Risk Register
March 2026

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

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

SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING & EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service											
12+ Risks in the Quality and Safety domains											
1	3747 01.08.25	VCS	Safety	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: 30.06.2026		A Surge Capacity Action Plan will be developed to explore opportunities and implement actions at pace to support mitigation of the current and future capacity gap. This will include exploration of additional capacity across Pharmacy, nursing and pre SACT assessment in the short term. The SACT expansion business case is currently in development, and this will be updated to reflect the current growth of 14%. This will ensure sustainable additional capacity is planned for and the VCS has the appropriate workforce across all areas to deliver this capacity safely and efficiently. In addition, there will be a focus to expedite high benefit protocols which will support even balance of activity across the week to ensure optimisation of all available capacity. This will include implementation of new ways of working and transformation of the current SACT Pathway.	Update 05.02.2026 Capacity and demand being worked through to feed into business case. Implementation of SACT steering group to drive work forward.
2	3714 24.06.25	VCS	Safety	Director of Velindre Cancer	There is a risk to patient safety as a result of increased demand on the booking	16 (4x4)	15 (5x3)	6 (2x3)			25.02.2026 Reviewed risk: Ongoing capacity issues within SACT bookers, remains unresolved during

TRUST RISK REGISTER

					team leading to a delay in scheduling SACT treatments and potential breaches			Target date: 01.06.26			recruitment phase. Up to 3 week wait for booking of SACT appointment, with a approximately 150 new patients on pending list awaiting first treatment appointment. The trajectory currently shows a accumulation of patients awaiting first cycle appointments. Patient harm unquantified. Band 7 clinical support going on planned sick leave 12.03.26. Significant risk to clinical oversight. Reducing activity now being seen in SACT day case and PICC insertion list due to booking delays. Risk score increased from 12 in January.
15+ Risks in other domains											
3	3832 02.12.25	VCS	Safety	Director of Velindre Cancer Centre	There is a risk to staff safety administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure.	15 (3x5)	15 (3x5)	6 (3x2) Target date 31.03.26		1. SBAR, QIA, Risk Assessment to be presented at QSREB complete 2. Escalation to procurement for tender of products, following Board approval 3. Financial business case development 4. Education and training for CSTDs for rapid role out	12.03.2026 Confirmation of executive member support to progress to procurement and trial process to allow for development of business case to procure closed system devices. The risk score cannot reduce until closed system devices in use. Risk remains a likelihood of 5 as the risk occurs each time SACT is administered i.e. multiple times a day
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 28.03.26		1. Introduction of LIMS to mitigate the risk of manual transcription errors	16/02/2026 The risk still remains significant as the mitigating action (implementation of LIMS in Transplantation Services) is the only action that will reduce this risk score - implementation of HistoTrac remains on track for March 2026. Implementation planning for go-live currently underway.

TRUST RISK REGISTER

5	3795	WBS	Quality	Director of Welsh Blood Service	There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient.	12 (4x3)	12 (4x3)	8 (4x2) Target date 21.07.26		1. Update to report comments in progress- PAT-123 & PAT-361 in draft to inform of changes and process change requirements	16/02/2026 Risk position remains unchanged, risk reduction is reliant on implementation of replacement LIMS. Risk consideration has included current inability to work smarter due to system limitations. Further operational actions are being taken to mitigate risk where possible.
6	3716 June 2025 *New to Risk Register	WBS	Quality	Director of Welsh Blood Service	There is a risk to patient safety and GDPR as a result of reusing sample numbers leading to incorrect patient results reported.	12 (4x3)	12 (4x3)	8 (4x2) Target date: 11.06.2026	*New to Risk Register		16/02/2026 Middleware installation abandoned due to limitations within SERIF validation system, risk without mitigation to be reviewed. Risk score increased from 8 to 12 during reporting period.
7	3643 11/04/25 *New to Risk Register	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)	*New to Risk Register	1. Validation of upgrade/ Replacement 1. Unable upgrade SERIF due to age and lack of digital SME support. The system has been operating safely for over 20 years, current workarounds to remain in place. SBAR drafted to consider all replacement options and timelines.	16/02/2026 Risk position remains unchanged, risk reduction is reliant on implementation of replacement LIMS. Timelines controlled by DHCW as part of national WLIMS2.0 implementation programme...
8	3856 26/01/26 *New Risk	WBS	Quality	Director of Welsh Blood Service	There is risk to Quality as a result of the installation of data nodes to support the temperature monitoring of 2 new walk-in freezers, leading to disruption of routine services and the implementation of PFM.	16 (4x4)	12 (4x3)	4 (4x1) Target date: 31.03.2026	*New Risk		16/02/2026 Treat risk to reduce risk level On completion of identified works, installation support from our environmental monitoring provider (Contronics) to update data node number 15 from a 8 input PCB to a 16 input PCB and install the new temperature sensors in each of the new freezers. The location of these sensors will be determined by the thermal profiling exercises which will need to be undertaken once the equipment is installed.
9	3388 07/05/2024	WBS	Quality	Director of Welsh Blood Service	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16 (4x4)	16 (4x4)	2 (2x1)		1. Develop and validate interface between FEDIS and eMPI+WRRS when available	16/02/2026 Stable/No movement - work ongoing with DHCW to complete the demographic and reporting integrations (managed under PR000553). DHCW have one final issue to resolve before the project can move on from System Integration Testing phase to User Acceptance Testing phase. This

TRUST RISK REGISTER

								Target date: 22.04.26			issue has been outstanding since 20th November, with no confirmed timeline from DHCW for resolution. There will be further slippage of the project timelines, the extent of which is currently unknown until the final issue is resolved.
15+ Risks in other domains											
10	3801 November 2025 *New to Risk Register	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: 31.03.26 Target Date :20.04.26	*New to Risk Register		16/02/2026 Phase 2 Project remains in the system integration testing phase awaiting resolution of the final outstanding issue. This issue has been outstanding since 20th November, with no confirmed timeline from DHCW for resolution. Until this issue is resolved, the project progress to User Acceptance Testing and Validation (end to end testing by the lab SME).
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 30.03.26		2. Review of risk assessment required	16/02/2026 All the contingency measures i.e. hire of generator and hire of cold store have all been taken off hire and have left the service yard. No further electrical works are required at this point in time.
Corporate											
15+ Risks in other domains											
12	3634 03.04.25	Corporate	Multiple Risk Domains - Quality - Performance and Service sustainability - Workforce	Chief Digital Officer	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16 (4x4)	16 (4x4)	6 (3x2) Target date: 01.04.26		1. Agree the final plans with the service areas - expected to be complete by the end of May 2025. 2. External partner will review the roadmap. 3. Capacity demand plan will be developed to support the roadmap.	06.02.2026 The digital diagnostic outcome reported to EMB in January 2026. Digital deep dive at EMB and SDC in November.
14	3646 15.04.2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk to that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline causing an impact on realising project outcomes	20 (4x5)	20 (4x5)	6 (2x3)		1. Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0.	06.02.2026 Current proposed go live date, although unconfirmed, is at the earliest an implementation date of August 2026

TRUST RISK REGISTER

					and additional demand for further development of existing legacy systems.			Target date: 31.08.26		2. Agree the new launch date with WBS Futures Programme. 3. Mitigation plan in place with existing SERIF system.	
15	3656 24.04.25	Corporate	Performance and Service Sustainability	Director of Corporate Governance	There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services.	20 (5x4)	16 (4x4)	6 (3x2) Target date: 31.03.26		1. Annual accounts and accountability report to be approved by Trust Board. 2. Assurance mapping to be reviewed and completed by end of June 2025 3. WG review of current arrangements to be concluded by end of July 2025	16.02.2026 Annual Report presented at AGM. Assurance mapping underway in n response. Now in receipt of WG report. Approach to implementation to be confirmed.
16	3633 15.04.20 25	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trusts ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution.	15 (3x5)	12 (3x4)	6 (3x2) Target date: 28.04.26		1. Share Integration Plan with DHCW to be clear about priorities – Complete 2. Weekly escalation meetings with the DHCW Exec Director responsible to monitor assure on progress. 3. Trust to line up third party suppliers (e.g.Thermofisher) to provide their Integration at the right time.	06.02.2026 FEDIS and WHAIS interfaces are now being built by DCHW. The service would still like to accelerate the plans if possible. WHAIS is on track to go live in February 206, without the Intergration, which will need to be delivered in a subsequent phase.
17	3632 03/04/25	Corporate	Multiple risk domains -Performance and service sustainability -Quality	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of National Digital Programmes managed by Digital Health and Care Wales (DHCW) not being delivered to time/cost/quality for use by the Velindre Trust leading to disruption of the clinical model and the plan to transition services to the new Velindre Cancer Centre. The National DHCW programmes of concern for the Trust are RISP/WLIMS/EPMA.	16 (4x4)	16 (4x4)	8 (4x2) Target date: 31.03.26		Risk reviewed. Due to the change note for RISP, resetting the date of EPMA project starting.	06.02.2026 Electronic Prescribing and Medicines Administration (EPMA) remains on track. Radiotherapy Informatics System Procurement (RISP) has a no go decision for go live in January. Go live is being planned for April 2026. Welsh Laboratory Information Management System (WLIMS) is very high risk there is no national plan for the national transfusion module.

TRUST RISK REGISTER

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

ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
2774 27/10/2024	WBS	Quality/ Safety	Director of Welsh Blood Service	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16 (4x4)	8 (4x2)	4 (4x1)		13.03.2026 Trend/Direction of Travel = Decreasing. HistoTrac Implemented and overall risk of using workarounds has reduced. Some remain in place until phase 2 is completed.



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TRUST BOARD	
BOARD ASSURANCE FRAMEWORK UPDATE	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Risk and Assurance Manager
PRESENTED BY	• Non Gwilym, Interim Director of Corporate Governance • Lauren Fear, Director of Place, Portfolio and Partnerships • Nicola Williams, Director of Nursing and • Anne Carey, Chief Operating Officer • Sarah Jenkins, Director of OD and Workforce • Jacinta Abraham, Medical Director • Matthew Bunce, Director of Finance • Carl Taylor, Chief Digital Officer
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Trust Board with the latest updates to the Board Assurance Framework.
RECOMMENDATION / ACTIONS	The Board is asked to: • NOTE the status of the Board Assurance Framework which has a current assurance rating of 2.
COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	



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COMMITTEE OR GROUP		DATE
Audit Committee		03.03.2026
Quality, Safety and Performance Committee		12.03.2026
Strategic Development Committee		17.03.2026
The Audit committee noted that several BAF risks remain static and agreed that a full refresh is needed to ensure risks accurately reflect current challenges, such as digital constraints. The Committee also noted that the RD&I and University Status BAF risks were risks consistently scoring lot and they sought assurance that they were not being under-reported. Finally, the Committee agreed that the BAF will be reviewed in March 2026. The Quality, Safety and Performance Committee received assurance that risks are being actively challenged and managed through established Trust-level governance structures, including through forums such as the Health, Safety and Fire Board. Assurance mechanisms remain embedded and functioning across layers of the organisation. Digital integrations issues across clinical and operational systems were flagged. The Strategic Development Committee sought similar assurance regarding the scoring of the University Status, RDI and Governance BAF risks. Assurance was provided that a deep dive into the relevant risks on Datix had been undertaken and aligned to the scores for BAF 03 and BAF 04. The Committee queries the score of BAF 08 on the basis that the NWSSP review report was in the public domain. The Committee was informed that the risk had been reduced in December following the publication of the report and the score would be considered as the recommendations were implemented. Finally, the Committee noted the need for Executives to update the BAF regularly to ensure that the framework remained a relevant and meaningful document for managing strategic risk. All Committees approved the suggested assurance rating of 2.		
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR		2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.
APPENDICES		
1	Board Assurance Framework Overview	
2	Board Assurance Framework Dashboards	

1. SITUATION

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

2. ASSESSMENT

- 2.1 As part of the IMTP, eleven strategic risks were agreed by Trust Board in March 2025, aligned to strategic objectives.
- 2.2 Since the last Trust Board meeting, the following work has been undertaken or is in development:
- All strategic risks have been reviewed, including scrutiny of actions and assurance levels across the BAF.
 - A regular monthly review schedule is now in place with Executive Directors and wider teams.
 - A Trust Board meeting to consider the new Board Assurance Strategic Risks to be included in the 2026-2027 IMTP is scheduled for 18 March 2026.
- 2.3 Appendices show the current summary for the eleven strategic risks and the more detailed information to support, including full dashboards.

3. EXECUTIVE SUMMARIES

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

BAF01

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

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

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

BAF02

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

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

BAF03

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

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

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

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

BAF04

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

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

BAF05

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

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

BAF06

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

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

BAF07

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

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

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

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

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

BAF08

Audit Committee confirmed that the revised Risk Management Framework would be considered in May 2026 for endorsement prior to Trust Board approval.

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

External company on board to provide expert advice on a review of the Board's structure and development programme due to commence before the end of March 2026.

Structured Assessment nearing completion.

Risk score static. Will expect risk to decrease when new Risk Management Framework is approved, implementation of the NWSSP review and Board Development programme.

BAF09

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, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.

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

BAF10

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

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

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

BAF11

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

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

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

4 BOARD ASSURANCE FRAMEWORK REVIEW AND RENEW

During 2025/26, the Trust has continued to review its Board Assurance Framework (BAF) focusing on the need for it to be aligned to the organisation's strategic goals, evolving external expectations, and the scale of transformation underway across the Trust. This work has highlighted the need for both short-term refinement of the current strategic risks for inclusion in this IMTP, and a more substantial redesign of the BAF during 2026/27.

In March 2026, the Board evaluated whether the current BAF risks accurately reflect the Trust's strategic exposure, in the context of the 2026-29 IMTP. The discussion confirmed that while the existing BAF has supported assurance processes over recent years, further consideration of the strategic risks would be beneficial in the context of the Trust's current transformation agenda, particularly in relation to nVCC readiness, digital fragility and workforce sustainability. This would avoid the BAF becoming too operationally focused.

On this basis, the strategic risks have been refreshed for accuracy with a clearer articulation added where strategic risk descriptions do not adequately reflect current pressures.

The Board also recognised the need for a fundamental redesign of the BAF framework itself which will be undertaken during 2026/27, to ensure that the future BAF:

- is explicitly linked to strategic objectives
- provides a clearer "golden thread" between strategy, IMTP priorities, assurance systems and operational risk registers
- is owned and actively used by the Executive Team as a driver of strategic decision-making
- reflects the external environment post-election and evolving national leadership expectations

- is concise, genuinely strategic, and focused on the core risks that could prevent the Trust from delivering safe, sustainable and excellent services.

The Trust will undertake this redesign collaboratively through Board and Executive engagement, supported by external governance expertise. This phased approach ensures that Velindre continues to meet statutory requirements within this IMTP cycle while building a more modern, effective and strategically aligned BAF for future years.

The Board is committed to developing a BAF that is forward-looking, strategically focused and able to provide a clear, collective understanding of the risks that matter most in delivering the Trust's ambitions for patients, donors, the wider public and our people.

5 IMPACT ASSESSMENT

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



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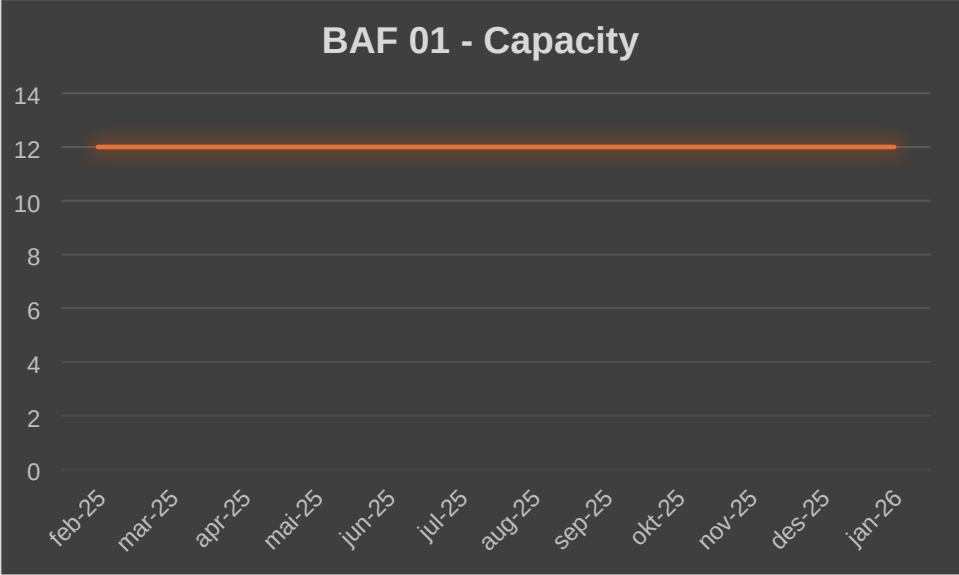
	Patient Centered ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

3 RISKS

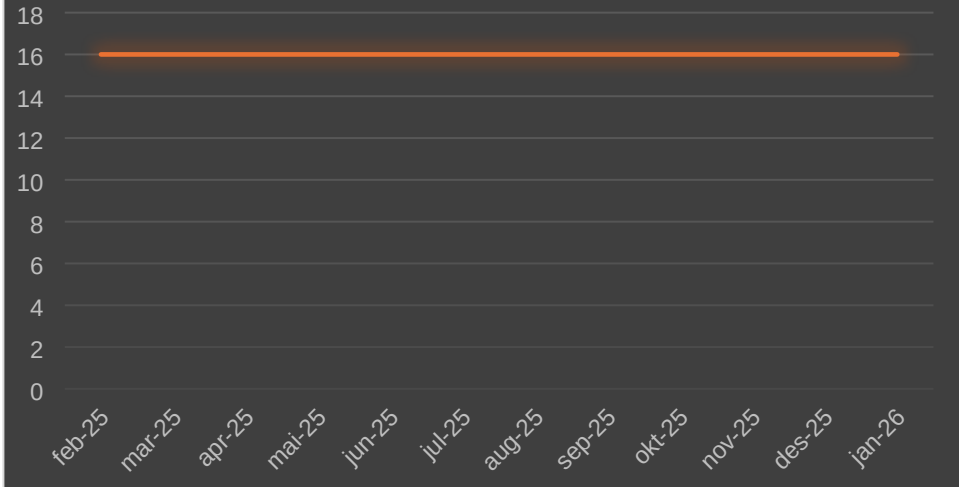
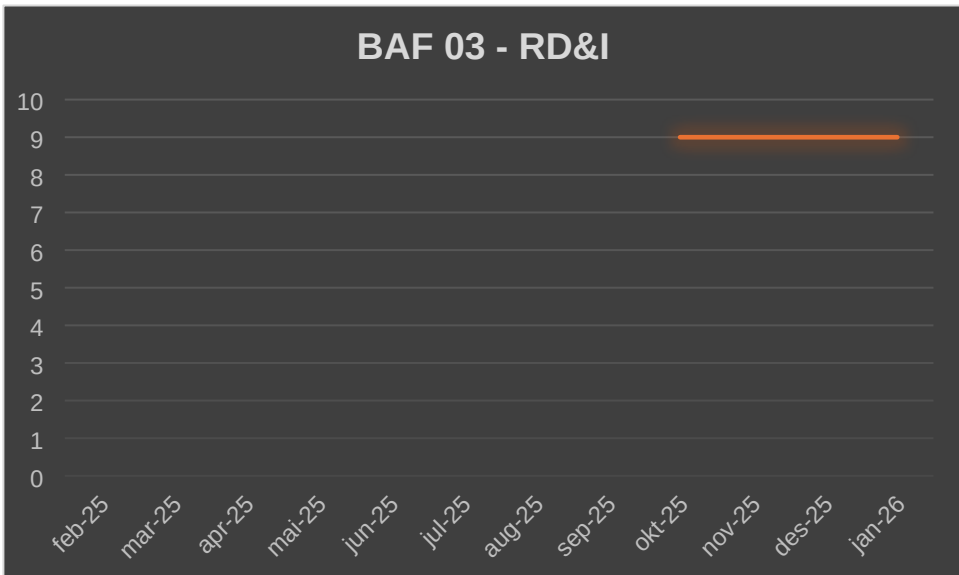
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the BAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

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

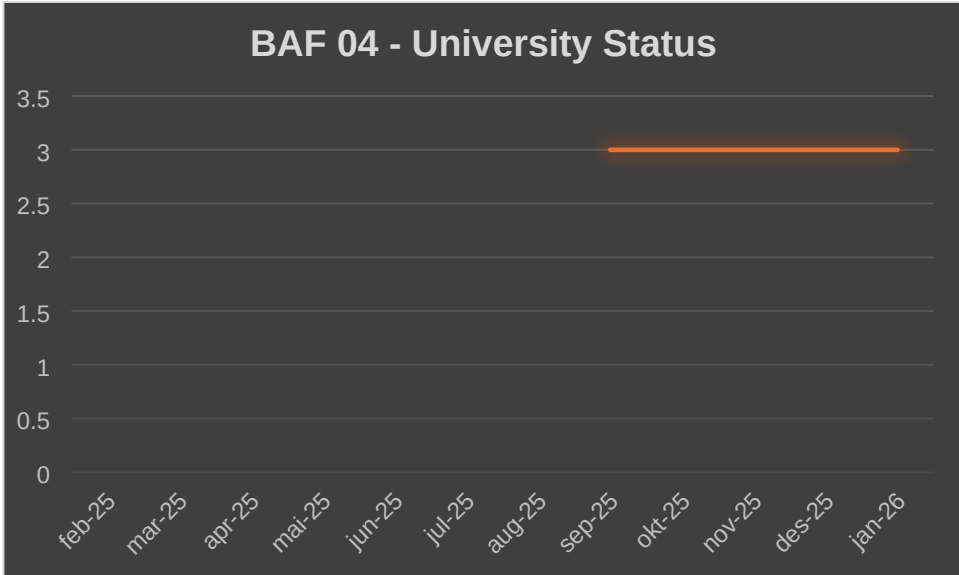
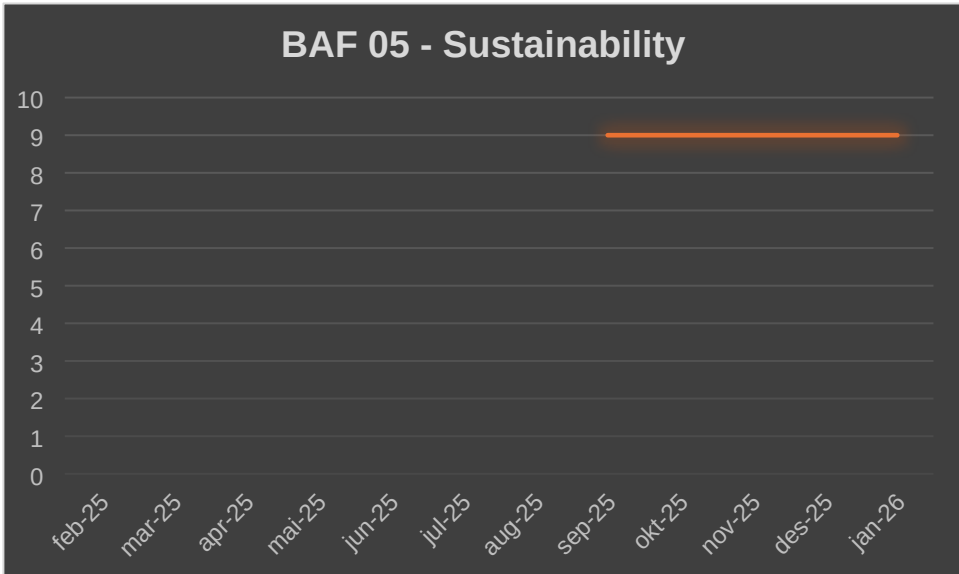
BOARD ASSURANCE FRAMEWORK

RISK ID	STRATEGIC RISK	STRATEGIC GOAL/ ENABLER	INITIAL RISK SCORE (I X L)	CURRENT RISK SCORE (I X L)	TARGET RISK SCORE (I X L) Plus expected date	CURRENT RISK TREND	ASSURANCE RATING	TRUST RISK REGISTER CORRESPONDING RISK
01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Outstanding for quality, safety and experience.	16 (4X4)	12 (4X3)	8 (4x2)	 BAF 01 - Capacity The chart displays a single horizontal line at a value of 12 on the y-axis, representing the risk score, across the entire x-axis timeline from February 2025 to January 2026. The y-axis is labeled from 0 to 14 in increments of 2. The x-axis is labeled with monthly intervals from feb-25 to jan-26. Executive Summary: WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus. Further work is needed to deliver the consistency required and to continue to build capacity. This work is being supported by increasing ability to track pathways and understand bottlenecks in pathways, for focused work. Risk score trend: The risk score has remained static since the last period. Date will be reviewed at the end of quarter 2	2	- 3418 There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care. - 3678 There is a risk to patient safety as a result of independent result entry and authorisation leading to incorrect results being reported on a patient. - 3643 There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service. - 3388 There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care. - 3634 There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully, stress and burnout for the digital team and regularly changing priorities. - 3747 There is a risk to patient safety as a result of insufficient capacity within the SACT day case service leading to delay in patients receiving SACT treatment - 3714 There is a risk to patient safety as a result of increased demand on the booking team leading to a delay in scheduling SACT treatments and potential breaches
02	There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted due to increasing demands, complexities, the need for significant service transformation and external factors.	An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations.	20 (4x5)	16 (4x4)	9 (3x3)		3	- 3418 – There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care. - 3388 - There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care. - Blood services Llantrisant. - 3832 - There is a risk to staff safety administering SACT without the use of

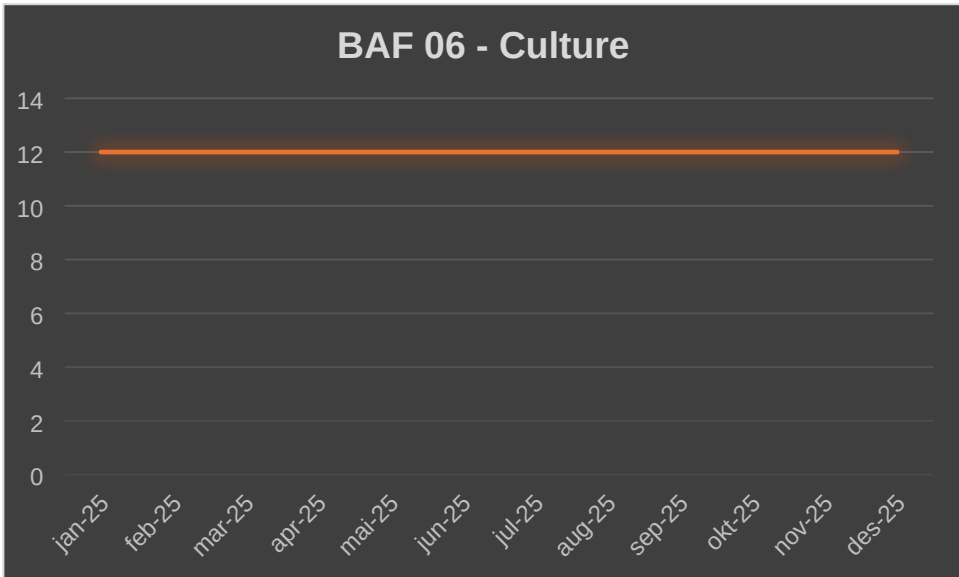
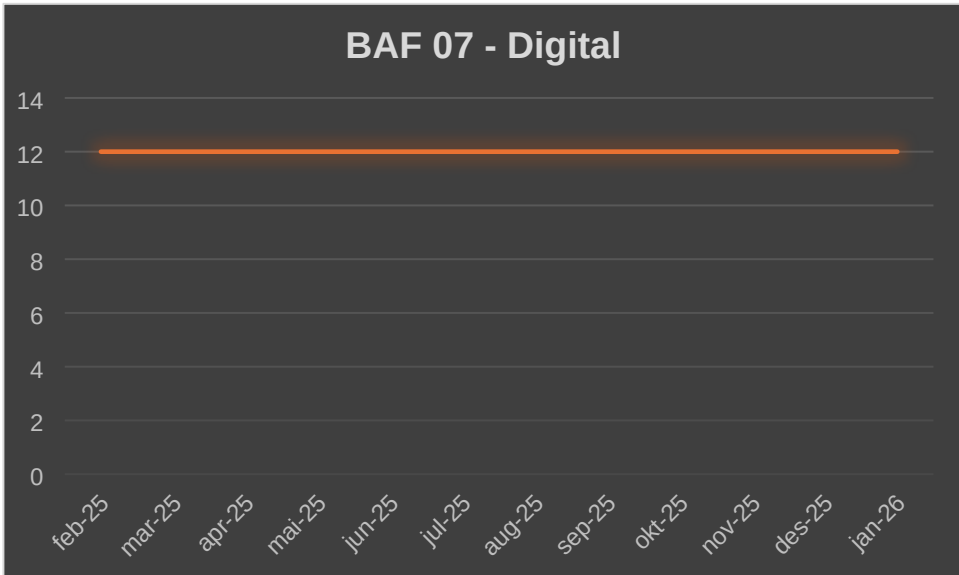
BOARD ASSURANCE FRAMEWORK

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

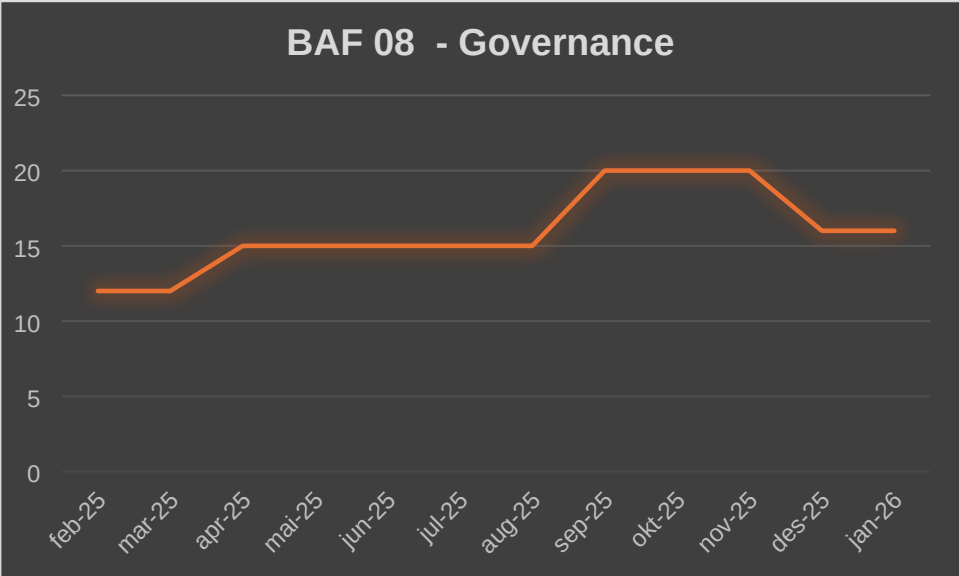
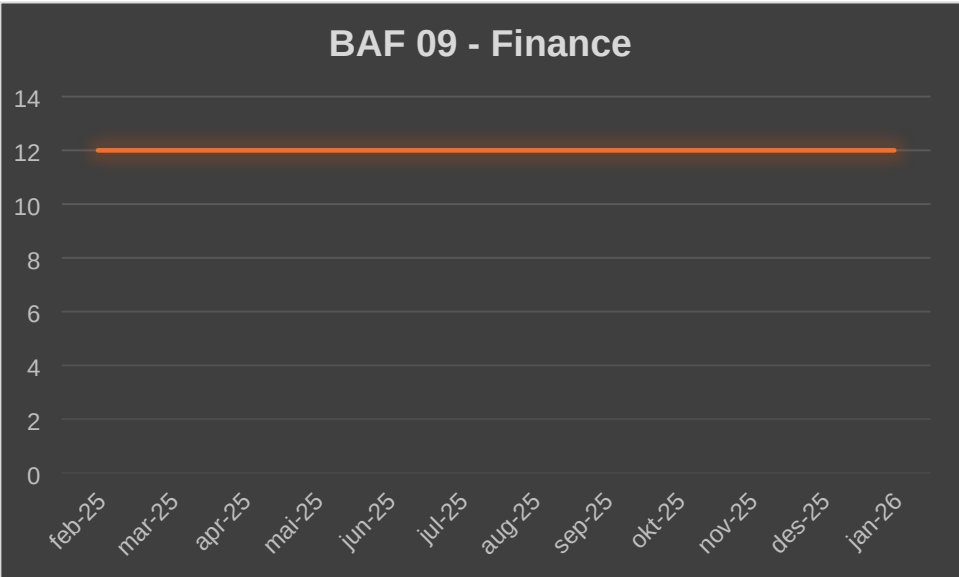
BOARD ASSURANCE FRAMEWORK

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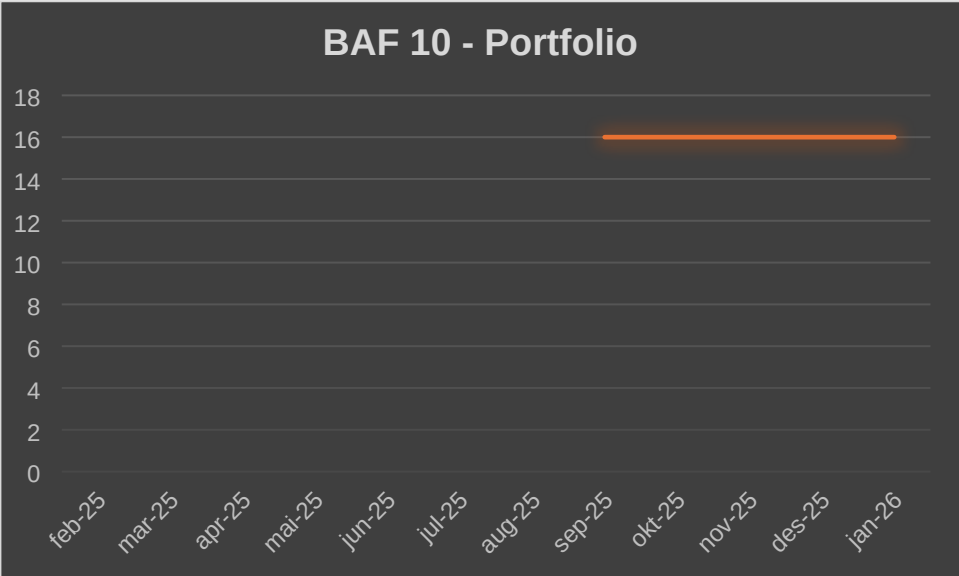
BOARD ASSURANCE FRAMEWORK

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

BOARD ASSURANCE FRAMEWORK

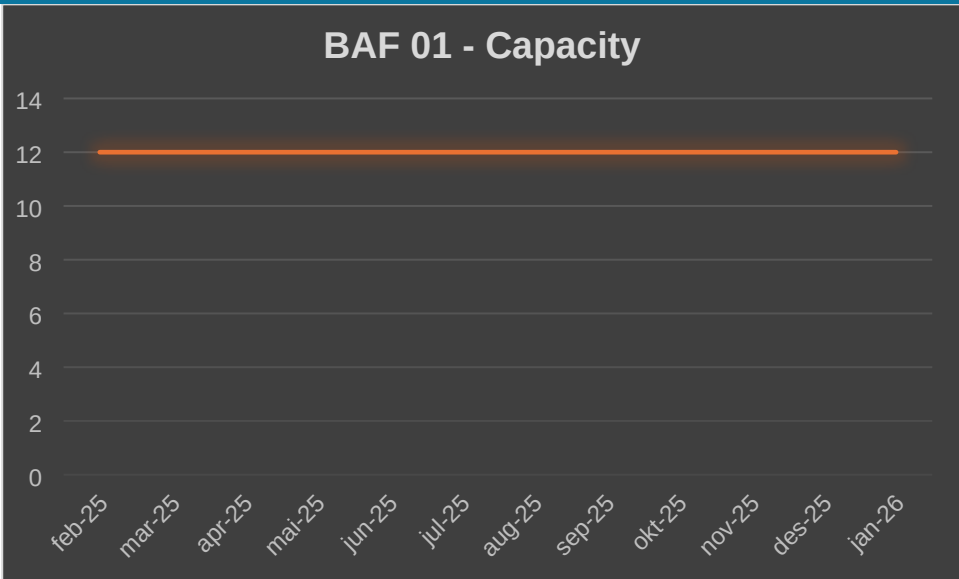
08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Governance	16 (4x4)	16 (4x4)	8 (4x2)		3	– 3656 Quality of current assurance and reporting arrangements in hosted services
					July 2026	Executive Summary: Audit Committee confirmed that the revised Risk Management Framework would be considered in May 2026 for endorsement prior to Trust Board approval. The Trust is working with Welsh Government and NWSSP regarding the next steps for the review of NWSSP Accountabilities and Governance. External company on board to provide expert advice on a review of the Board's structure and development programme due to commence before the end of March 2026. Structured Assessment nearing completion. Risk score static. Will expect risk to decrease when new Risk Management Framework is approved, implementation of the NWSSP review and Board Development programme.		
09	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Financial	16 (4x4)	12 (4x3)	8 (4x2)		4	

BOARD ASSURANCE FRAMEWORK

					April 2026	Executive Summary: There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Operational Summary Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.		
10	There is a risk that the scale and complexity of the transformation across the organisation may exceed the organisation's capacity to manage and execute effectively resulting in a failure to deliver on core strategic goals and an associated loss of benefits realisation which will impact on stakeholder confidence	Transformation Delivery	16 (4X4)	16 (4X4)	6 (3x2)	BAF 10 - Portfolio  September 2026 Executive Summary: VUNHST has a substantial programme of transformation over the next five years, totalling in excess of £500million capital funding and associated service change. Although most of the main programmes and projects have their own governance arrangements there has been no overall portfolio management. Portfolio management is currently being implemented, and this should lead to improved prioritisation, resourcing, benefit delivery and the reduction of transformation related risks at an organisational level. BAF 10 was discussed at Strategic Development Committee, the controls will be tightened and updates reflected in the next reporting cycle.	3	There are no associated risk on the Trust Risk Register
11	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape	Workforce	16 (4x4)	9 (3x3)	6 (3x2)		4	- 3634 Capacity issues for digital services - 3685 There is a risk to leadership stability and capacity due to a number of interim positions on the Executive Management Board and a key vacancy.

BOARD ASSURANCE FRAMEWORK

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

SECTION 1 – Summary								
RISK ID	01	REVIEW DATE	February 2026	Risk Title	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.		Risk Lead	Chief Operating Officer
CORE ENABLER	Service Capacity				STRATEGIC GOAL	1 - Outstanding for quality, safety and experience.		
CURRENT SCORE TREND	BAF 01 - Capacity 				CURRENT RISK SUMMARY	WBS - position is stable and has been sustained for several months. The position continues to be monitored via the Blood supply Chain Group. VCS – delivery of the patient care across SACT and Radiotherapy services requires sustained focus to deliver the consistency required and to continue to build capacity. This work is being supported by the embedding of the Cancer PTL which is increasing ability to track pathways and understand bottlenecks in pathways, for focused work. Risk score trend: The risk score has remained static since the last period.		

SECTION 2 – Risk Scores											
INHERENT RISK	IMPACT	LIKELIHOOD	TOTAL	CURRENT RISK	IMPACT	LIKELIHOOD	TOTAL	TARGET RISK	IMPACT	LIKELIHOOD	TOTAL
	4	4	16		4	3	12		4	2	8
	Inherent risk score start date		March 2025						Expected date to reach Target Risk Score		This will be reviewed at the end of Q2.

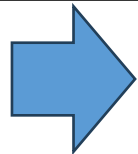
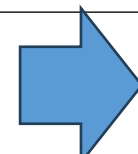
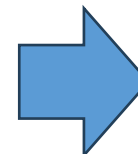
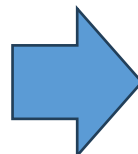
SECTION 3 – Effectiveness, Controls and Assurance			
		Overall Assurance Rating	Current Review Period
			2
			Previous Review Period
			3
		Rationale for Assurance Rating	The risk which will be discussed at Private Board
KEY CONTROLS		SOURCES OF ASSURANCE	

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
						- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreements. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director of WBS	X			Annual Service Level Agreement (SLA) engagement with each health board, including structured reviews of supply, demand, performance and blood utilisation trends. Active delivery of the Blood Health Plan for NHS Wales through the Blood Health National Oversight Group (BHNOC), including implementation of Patient Blood Management (PBM) activities, KPI monitoring, and alignment with UK and international benchmarking.	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Welsh Government Quality, Planning and Delivery Review.
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director of WBS	X			System pressures are identified early enabling timely corrective action through Department Head review and prompt escalation to Senior Leadership Team and Director. Operational oversight and reporting of BHNOC stock related KPIs.	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. Raise shortage plan at Trust Board level when relevant.	Welsh Government intervention would be invoked when necessary. National Red Cell and Platelet shortage plans.
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director of WBS	X			Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment. Managed service contracts for critical suppliers. Planned Preventative Maintenance. Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions. Blood shortage plans developed in agreement with the Health Boards.	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.

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

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

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

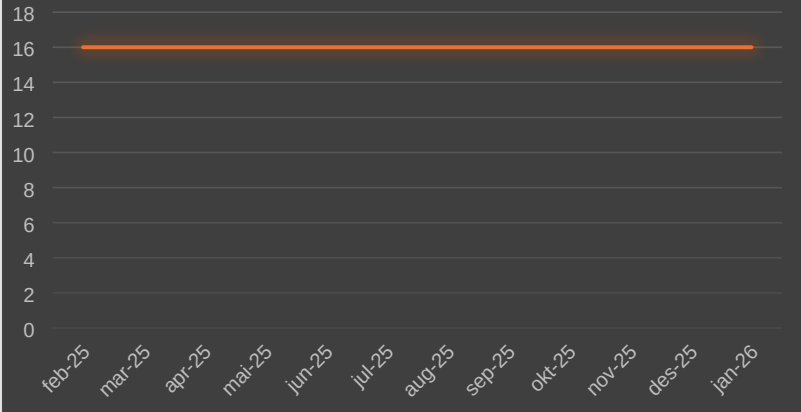
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3418 WBS	There is a risk to quality, as a result of pre- and post-examination processes, leading to a potential adverse impact on patient care.	12	
3643 WBS	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading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

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

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

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

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

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

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

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

SECTION 4 – ASSOCIATED OPERATIONAL RISK

(in line with Trust Risk appetite)

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

SECTION 5 – ACTION PLAN

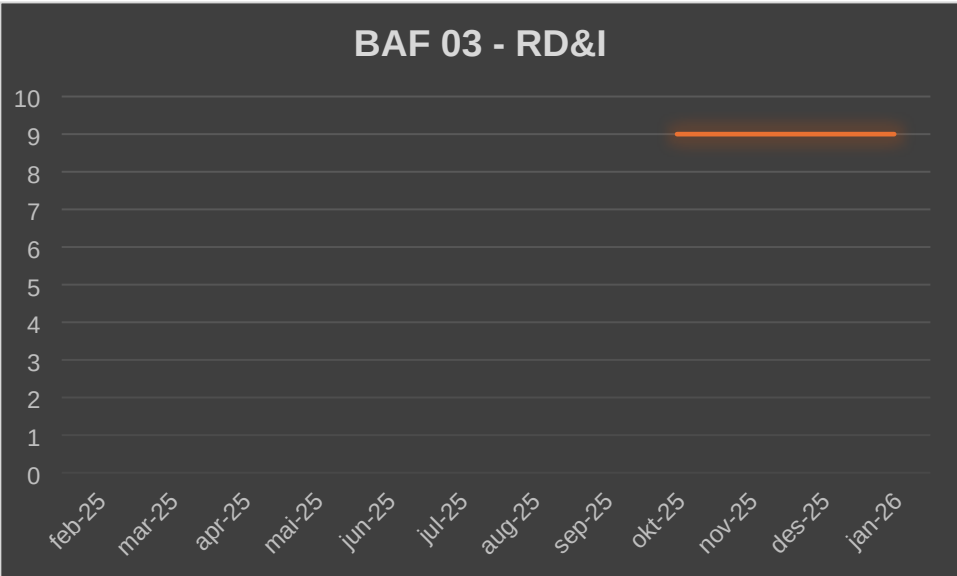
(IMTP Priority Improvement Actions and TAF Actions)

ACTION REF	ACTION	OWNE R	DUE DATE	ASSUR ANCE LEVEL	PROGRESS UPDATE	DATE OF UPDAT E	IMPACT OF CHANGE ON RISK	LEVEL/CONTROL WHEN COMPLETE DETAIL IMPACT ON ASSURANCE

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

02.07	Strengthen patient and donor experience feedback mechanisms, specifically to increase the volume of experience feedback provided to the Trust across its services and ensure that patient / donor voice features through floor to Board reporting	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	April 2026	3	Average of 16% feedback for WBS. An increase to 12% VCS patients provided feedback in Quarter 3. New national People Experience framework being implemented on target for completion by April 2026 as noted.	March 2026	Action should reduce both likelihood and impact due to enhanced listening mechanisms and opportunities for learning and improvement.	
02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	April 2026	3	Some strengthening undertaken within last 6 months. Draft clinical services priority document provided to QSP (March 26). Further work required as part of governance review	March 2026	Action should reduce both the Trust's overall health and safety risk by being assured that the appropriate quality and safety reporting mechanisms are in place.	
02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	End of March 2026	3	Learning framework in place. However, quality and safety analysis has identified repeated themes which means further strengthening and embedding required with improved ownership and accountability from service level to accountable Director. Benchmarking and Peer Review being incorporated into service redesign and performance, where possible.	March 2026	Action should reduce likelihood and impact of risk by ensuring appropriate action will be taken to avoid, in as far as possible, future incidents occurring.	
02.10	To refresh and relaunch Trust patient safety framework.	Director of Nursing, AHP and Health Science	End of Dec. 2025	4	Current framework requires review in light of structural changes and strengthening of accountabilities and responsibilities for quality and safety outcomes and experience and revised LTP regulations	March 2026	Action should reduce likelihood and impact of risk by having improved awareness, ownership and accountability at all levels.	
02/11	Implement the BCUHB Quality Dashboard and balanced score card	Chief Digital Officer	March 2026	2	Site visit held – project / implementation plan required - timescales for delivery unclear	March 2026		

Commented [NH1]: can u please put revised date of sep 26

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

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

SECTION 3 – Effectiveness, Controls and Assurance

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

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

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

KEY CONTROLS						SOURCES OF ASSURANCE				
ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE	FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE		
						- Functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight		
	Welsh Blood Service research governance	WBS Head of RD&I Services				- Strategy aligns WBS research with Trust strategy - Mitigates siloed WBS research activity - WBS Progress and Performance reported through RD&I Integrated Performance Report and monthly research reports. - Internal self-assurance. - WBS RD&I Group - RD&I Operational Management Group oversight.	Oversight through the Trust RD&I governance structures: - Executive Management Board - RD&I Sub-Committee	- Welsh Government oversight - Blood Service audits by MHRA, Human Tissue Authority		

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

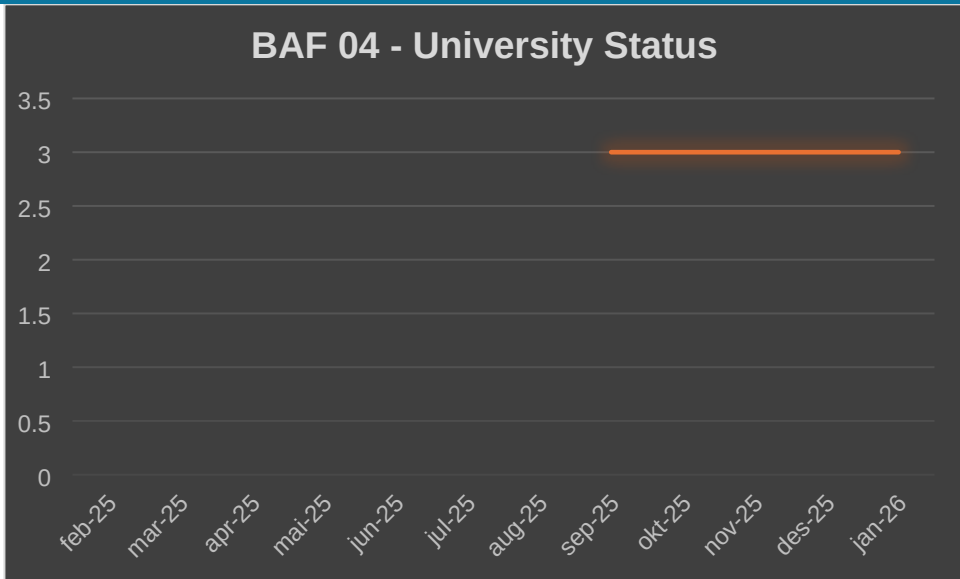
SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)				
DATIX RISK REF		CURRENT RISK RATING	RISK TREND	
	There are currently no risks on the Trust Risk Register relating to this strategic risk			

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

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

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

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

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

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

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE	SECOND LINE OF DEFENCE	THIRD LINE OF DEFENCE
							- functions that own and manage risk - Self-assurance	- Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	- Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight
C1	University Independent Board Member	Director of Corporate Governance	X				University Independent Board Member is confirmed and term of office known and understood.	Six monthly review of Board Membership undertaken by Director of Corporate Governance and Trust Board.	Audit Wales Structured Assessment.
C2	Robust collaboration with university partners, for example deed of association with the University of Wales, Trinity St Davids, Cardiff University: multi-professional research SLA; Cardiff Cancer Research Hub.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	
C3	Academic partnership arrangements across a range of universities in Wales.	Medical Director Executive Director for Nursing, Allied Health Professionals and Health Science.	X				Collaborations instigated at divisional level/EMB. All reporting into EMB for endorsement/approval, as deemed appropriate.	All collaborations reporting into the relevant Trust Committees, specifically Quality, Safety and Performance, Strategic Development and Research, Development and Innovation Committee.	

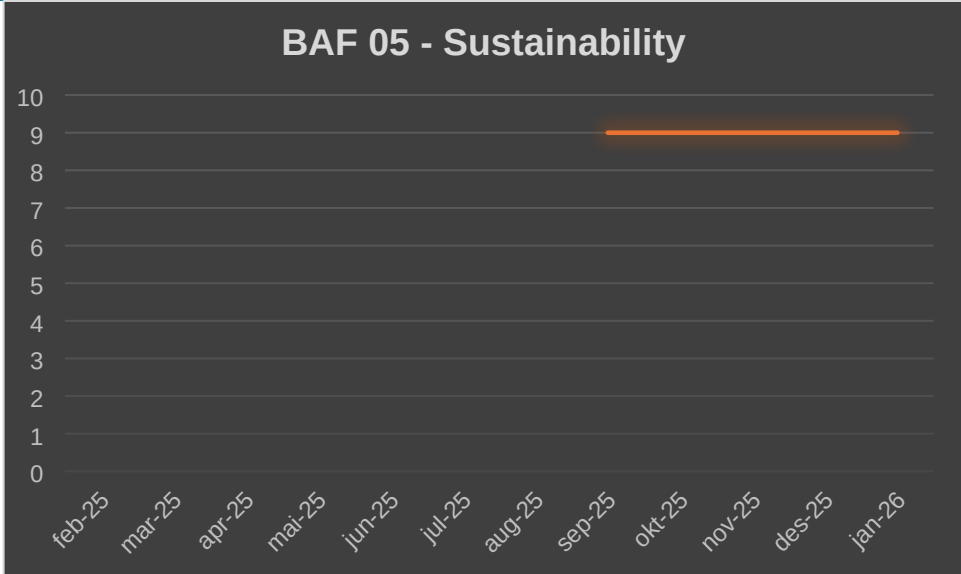
GAPS IN CONTROLS		GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
No Gaps in controls.		No gaps in assurance	-

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

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

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

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

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

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

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

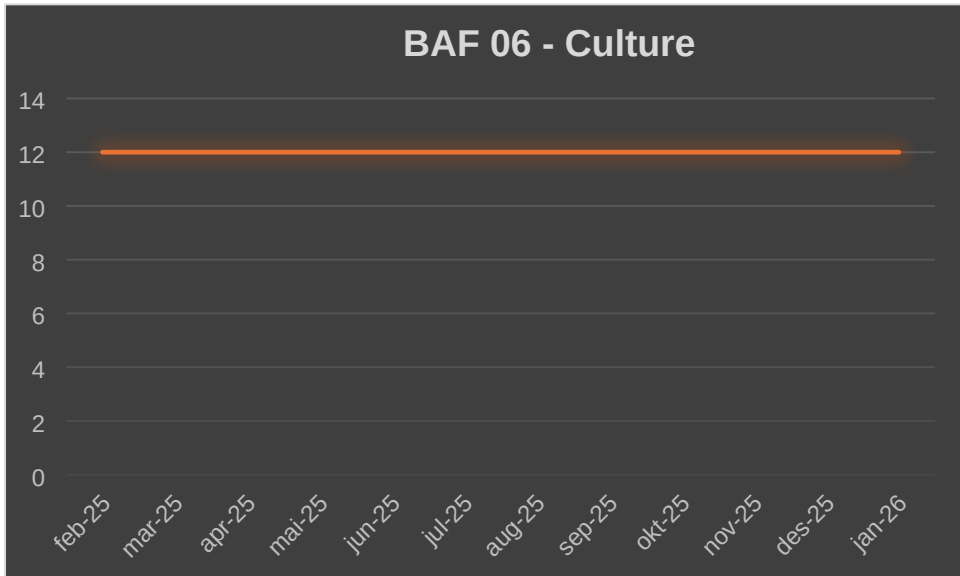
GAPS IN CONTROLS		GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Integration of sustainability into all governance and capital decision-making		Capital projects may be approved without consistent consideration of environmental impacts	5.1
Embedding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

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

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

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

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

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

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

ID	KEY CONTROLS	OWNER	PREVENTATIVE	MITIGATING	DETECTIVE		FIRST LINE OF DEFENCE - functions that own and manage risk - Self-assurance	SECOND LINE OF DEFENCE - Functions that oversee or specialise in risk management - Internal oversight/specialist control teams	THIRD LINE OF DEFENCE - Functions that provide independent assurance - Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight	
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the organisation	Director of Planning	X				Reports to EMB	Trust Board reporting on strategy and controls via cycles of business	Welsh Government reporting via JET and IMTP	
C2	Approved Education Implementation plan aligned to People Strategy to support the educational development of the Organisation to support the Trust direction	Deputy Direct of OD and People	X				People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Deputy Direct of OD and People	X				People Development and Education Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C4	Trust Values and Behaviour Framework	Deputy Direct of OD and People	X				Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C6	Health and Wellbeing infrastructure for the Trust to support physical and psychological wellbeing of staff	Deputy Direct of OD and People	X				Healthy and Engaged Steering Group	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Assistant Director of Communications	X				Reports to EMB	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Director of Planning	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C9	Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles	Chief Operating Officer	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports	
C10	Operational workforce plans developed to support agreed service models	Chief Operating Officer	X				Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	Reports to EMB, Committees and Trust Board	Internal Audit Reports	

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

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

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

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

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

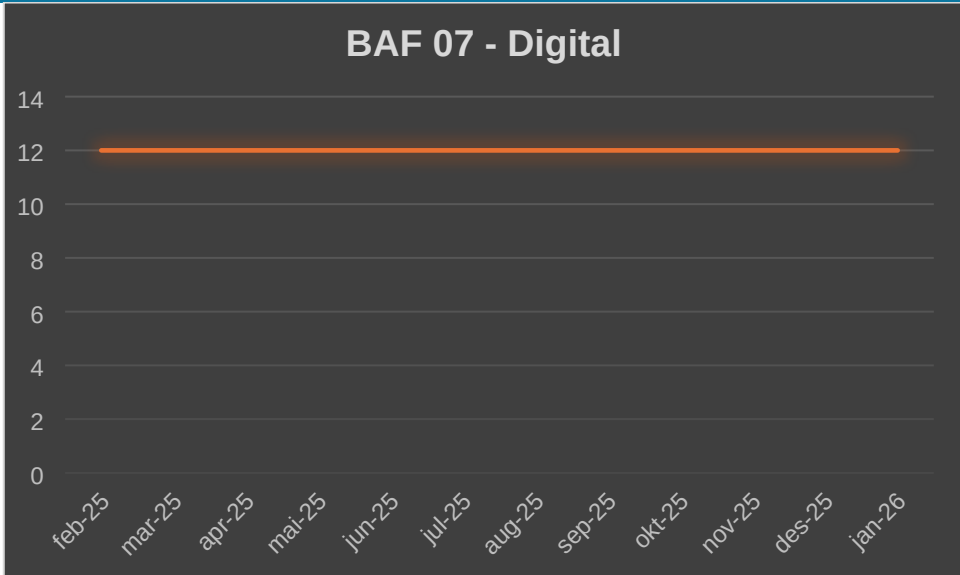
ACTION REF	ACTION	OWNER	DUE DATE	ASSURANCE LEVEL	PROGRESS UPDATE	DATE OF UPDATE	IMPACT OF CHANGE ON RISK	DETAIL IMPACT ON ASSURANCE LEVEL/CONTROL WHEN COMPLETE
06.05	Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	OD Specialist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

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

CLOSED ACTIONS

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

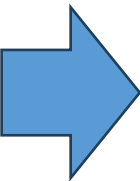
06.02	Embed the principles of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Head of Workforce	Apr 25		06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session, a meeting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

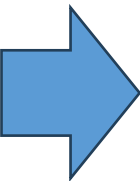
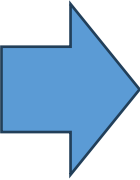
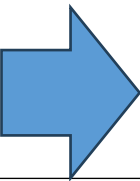
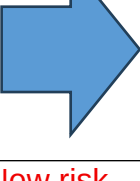
SECTION 1 – Summary													
RISK ID	07	REVIEW DATE	February 2026	Risk Title	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and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

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

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

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

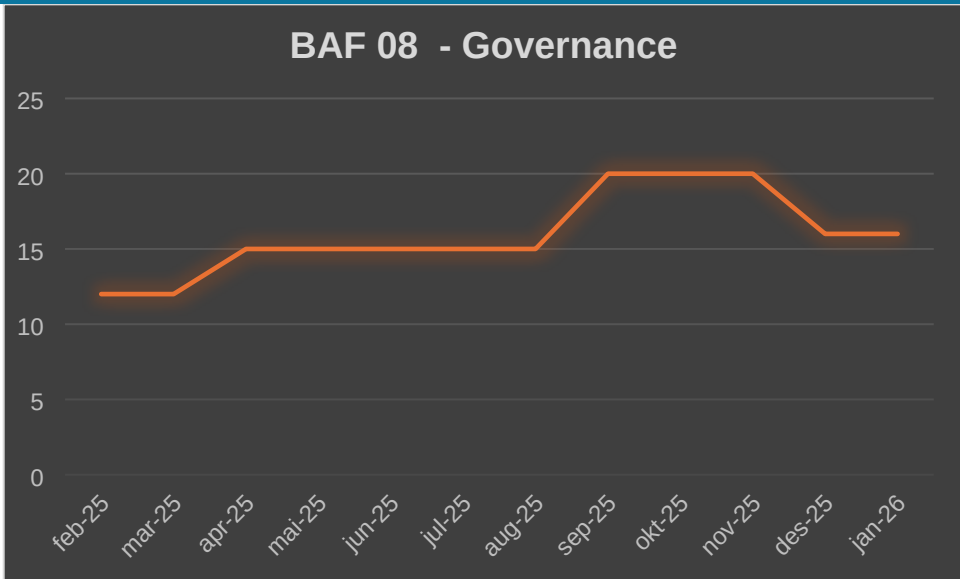
SECTION 4 – ASSOCIATED OPERATIONAL RISK (in line with Trust Risk appetite)			
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3634 Corporate	There is a risk to Quality, Performance and Service Sustainability, and Workforce domains as a result of demand for work on new digital services exceeding the capacity of the Trust digital team and the Trust's capacity to take on the business changes management leading to priority service initiatives enabled by digital not being delivered successfully , stress and burnout for the digital team and regularly changing priorities.	16	

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

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

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

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

SECTION 1 – Summary																				
RISK ID	08	REVIEW DATE	March 2026	Risk Title	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.					Risk Lead	Director of Corporate Governance									
CORE ENABLER	Organisational and Clinical Governance				STRATEGIC GOAL	1 - Outstanding for quality, safety and experience														
CURRENT SCORE TREND	BAF 08 - Governance 				CURRENT RISK SUMMARY	Audit Committee confirmed that the revised Risk Management Framework would be considered in May 2026 for endorsement prior to Trust Board approval. The Trust is working with Welsh Government and NWSSP regarding the next steps for the review of NWSSP Accountabilities and Governance. External company on board to provide expert advice on a review of the Board's structure and development programme due to commence before the end of March 2026. Structured Assessment nearing completion. Risk score static. Will expect risk to decrease when new Risk Management Framework is approved, implementation of the NWSSP review and Board Development programme.														
SECTION 2 – Risk Scores																				
INHERENT RISK	IMPACT		LIKELIHOOD		TOTAL		CURRENT RISK	IMPACT		LIKELIHOOD		TOTAL		TARGET RISK	IMPACT		LIKELIHOOD		TOTAL	
	5		4		20			4		4		16			3		2		6	
Inherent risk score start date			March 2025									Expected date to reach Target Risk Score: July 2026								
SECTION 3 – Effectiveness, Controls and Assurance																				
								Overall Assurance Rating	Current Review Period		3									
									Previous Review Period		3									
								Rationale for Assurance Rating	Increased assurance rating due to receipt of WG report on NWSSP hosting arrangements, confirmed plan for review of Risk Policy and clear plans for Board Development programme and review of committee structure. Expect score to decrease when activities have been delivered. Impact to be measured via a mix of quantitative and qualitative metrics.											
KEY CONTROLS						SOURCES OF ASSURCE														

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

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

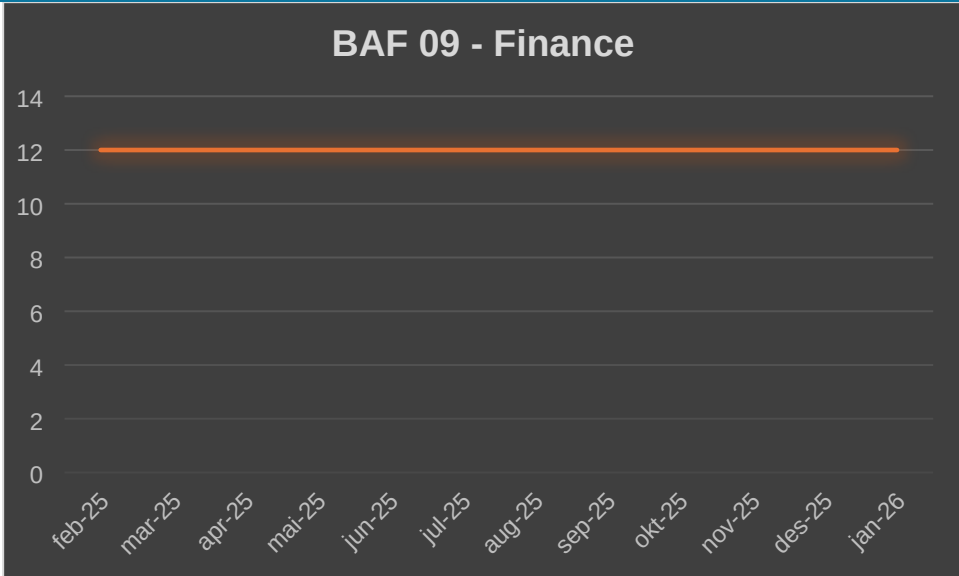
DATIX RISK REF		CURRENT RISK RATING	RISK TREND
3656	There is a risk to the quality of clinical and corporate governance caused by a lack of assurance and effective reporting of hosted units' custom and practice with regard to: - Employment issues - Health and Safety issues - Medical licences - Scope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

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

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

08.04	Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high-quality services today and shaping our services for the future	Director of Corporate Governance	March 2026	2	GAR Group met in October 2025 to consider next steps for GAR. EMB considered: 1. Minutes principles 2. Template for Committee and Board Papers 3. Ways of Working – a guide to engaging and managing VUNHST Board and Committee business	March 2026	• When delivered, the Corporate Governance Manual will provide a means for ongoing reference and information on how Trust governance works and the standards set. • The review of the Trust's current governance structures will take into account changes to the Trust's work programme since the last review in 2020, to ensure we are fit for the future. • Work to review the current hosting arrangements underway and will consider Welsh Government review (July 2025).	A structure fit for the future, clearly articulated in a Corporate Governance Manual that is visible to the organisation and adhered to, as evidenced by KPIs.
08.05	Review Terms of Reference for all Board Committees capturing all requirements in relation to Duty of Quality.	Director of Corporate Governance	March 2026	3	To be completed by end of December 2025.	March 2026	Board assured that scope of Committees' work referencing requirements of Duty of Quality effectively.	All ToR up to date and consistent in their interpretation of the Duty of Quality and its impact on Board Committee work.
08.06	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	April 2026	5	Initial discussions resulting in changes of requirement re: Duty of Quality reporting in Board/Committee paper template. Assurance level awareness training complete. Board training 23 October 2025.	March 2026	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.
08.08	Prepare paperwork outlining concerns and solutions to improve hosted services governance in advance of distribution of WG review	Director of Corporate Governance	July 2026	2	Implementation group established February 2026. Trust task and finish group to be established in support.	March 2026	None – but it will allow us to respond quickly to the WG report. Urgent issues will require escalating.	Clarity on priorities to refresh governance of hosted services.

08.09	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	March 2026	4	Duty of Quality session scheduled for Board Development February 2026	January 2026	Board assured that Trust business is compliant with the Duty of Quality statutory requirements.	All staff aware of purpose, driver and process for completing Quality Impact Assessments. Duty of Quality embedded in Board decision making process.
08.10	New Board Development Programme delivered	Director of Corporate Governance	March 2026	3	Specification for external expert advice completed December 2025. New provider to commence work in March 2026.	March 2026	Board culture and ways of working reviewed and improved to deliver in accordance with organisational need.	Board effectiveness measured via quantitative and qualitative measures.
CLOSED ACTIONS								
08.07	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies.	Director of Corporate Governance	Nov-25	5	First phase complete. Awareness raising exercise underway.	Oct 2025	Risk of non-compliance with national policies reduced. Policy updates timely.	All staff to be aware of latest policy updates and assured that information presented is up to date. Annual reporting into QSP.

SECTION 1 – Summary						
RISK ID	09	REVIEW DATE	February .2026	Risk Title	A strategic risk emerges if the Trust does not secure sufficient funding for the provision of it services or does not maximises its use of finite resources, which could negatively impact on the care that our patients and donors receive	
				Risk Lead	Director of Finance	
CORE ENABLER	Financial Sustainability and Long-Term Value				STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe
CURRENT SCORE TREND	BAF 09 - Finance 				CURRENT RISK SUMMARY	Executive Summary There are a range of factors that impact on the finance sustainability and long-term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Operational Summary Risk score trend: The risk score has remained static since the last period, however, given the significant emerging cost pressures the risk score may need review in future months in the context of the underlying financial position which is being considered as part of the IMTP development.

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

SECTION 3 – Effectiveness, Controls and Assurance

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

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

KEY CONTROLS			SOURCES OF ASSURANCE			
ID	KEY CONTROLS	OWNER				THIRD LINE OF DEFENCE
			PREVENTATIVE	MITIGATING	DETECTIVE	
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting Head of Finance Business Partner Budget Holders			X	Internal Audit / External Audit
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance Head of Finance Business Partnering			X	Internal Audit / External Audit
FSLTV3	Divisional Performance Review	Deputy Director of Finance Head of Finance Business Partnering			X	Internal Audit / External Audit
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	Internal Audit / External Audit
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	Welsh Government / NHS Executive (FP&D) / External Audit
FSLTV6	Monthly Finance and Performance Meetings	Executive Director of Finance		X		Internal Audit / External Audit

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

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

GAPS IN CONTROLS

GAPS IN ASSURANCE

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

Scheme of Delegation and Governance Framework for All Major Programmes	Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives	F6 (Controls); F4 (Assurance)
There is a need to be able to evidence use of medicines are providing the best value for patients	Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS.	F2
There are issues with the processes around LTA activity capture and mapping to currencies with some activity currently not being identified and charged to commissioners. Additional system and process controls have been established which has in part mitigated data issues, however, weakness remains, specifically in relation to the Radiotherapy IRS implementation which is being addressed with Service and Business Intelligence.	LTA Activity performance monitoring review has concluded providing assurance and ensuring that controls are in place, however the review process will continue as part of routine practice. An exercise is currently underway to review the contract model to ensure we are recovering the income for cost of service.	F7

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

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

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

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

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

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

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

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

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

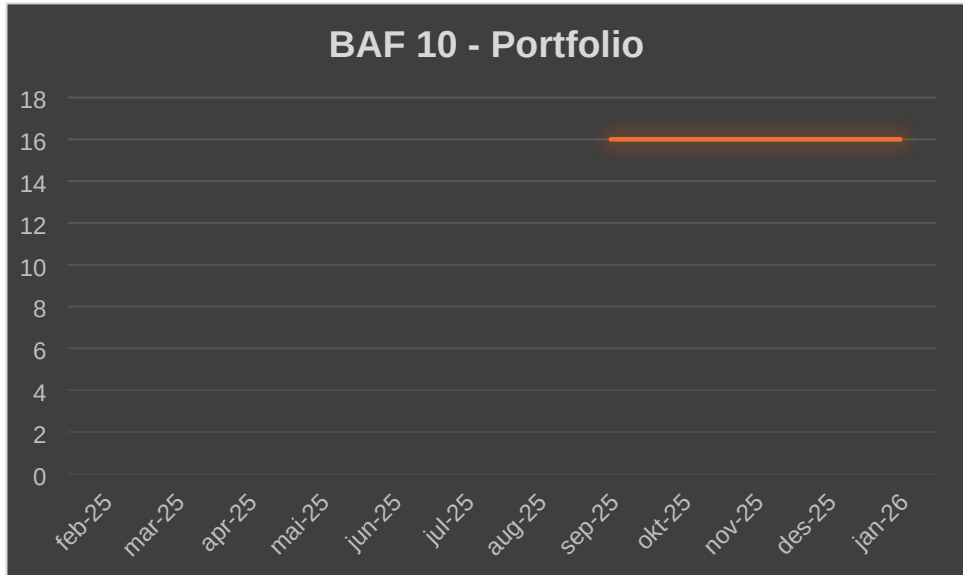
					A revised charging tariff had been agreed with an implementation date of 1 st July 2025 with further rates from 1 st November 2025. Contract negotiations are actively underway with those insurers that have specific queries and those involving payment of old debts.			
09.06	Develop Scheme of Delegation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

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

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

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

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

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

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

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

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

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

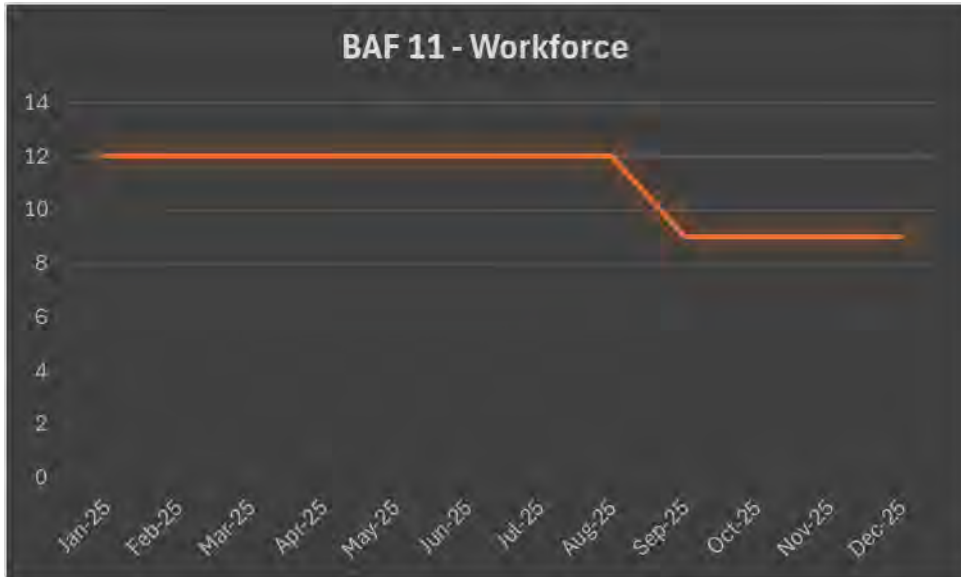
SECTION 4 – ASSOCIATED OPERATIONAL RISK
(in line with Trust Risk appetite)

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

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

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

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

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

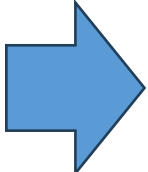
SECTION 2 – Risk Scores											
INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL
	4	4	16		3	3	9		2	3	6
Inherent risk score start date		March 2025						Expected date to reach Target Risk Score		Current work programme to March 2029	

SECTION 3 – Effectiveness, Controls and Assurance

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

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

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

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

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

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

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

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

11.6	Develop and provide Welsh Language education and learning opportunities for staff at all levels within the Trust.	Assistant Director of Workforce Planning	September 2026	3	26.02.2026 Successful appointments made across Nursing and HCSW roles and within WBS. Bank capacity is improving in priority areas, helping to support short-notice cover and reduce agency dependency. Action plan for phase 2 of bank development underway.	February 2026	Providing dedicated skills development in Welsh Language will ensure the Trust is able to provide our services bilingually improving the quality, safety and dignity of care provided.	
	Establish a talent management process that identifies high potential at all levels within the organisation.	Assistant Director of Workforce Planning	April 2027		26.06.2026 Structured interviews with Trust Leaders at various level in progress. Final self-assessment and action plan to be completed by April 2026	February 2026	Having a talent management process will enable the Trust to identify and support high potential people and prepare future leaders early, reducing risks on succession planning.	
	Develop a network of management coaches across the Trust in partnership with local education providers.	Assistant Director of Workforce Planning	November 2026		26.02.2026 Funding secured from Bridgend College to deliver Chartered Institute of Management Certificate in Coaching & Mentoring.18 learners subscribed for cohort one and further cohorts scheduled.	February 2026	Embedding coaching into the organisation promotes a learning culture where reflection, feedback, and growth are valued and encouraged and managers feel supported to foster positive team environments, contributing to overall workforce stability.	
CLOSED ACTIONS								
11.2	Embed workforce planning into monthly Divisional Senior Leadership Workforce reporting. Moved to C10 – Feb 2026	Assistant Director of Workforce Planning	Complete	3	Additional Resource for Workforce Planning through IMTP not supported. Alternative plan to embed workforce planning though the wider team undertaken instead. Monthly meetings underway with ongoing dedicated support for recruitment, development, retention and people analytics.	December 2025	Having workforce planning embedded into monthly management meetings with Advisors and BP's ensures alignment between operational performance and effective people management and ensures early intervention to support the development of the workforce at micro and meso levels within the Trust.	Assurance Level 6 - this is now part of BAU within the Trust and sustained improvements are being made as detailed in the workforce metrics reported within the Supply and Shape Assurance Paper to Quality, Safety and Performance Committee.

11.3	Implementation of the Attraction and Resourcing Project Moved to C11 – Feb 2026	Assistant Director of Workforce Planning	Complete	4	Initial implementation completed. Financial agreement for ongoing resource agreed as part of the IMTP. Project to become part of BAU for POD.	December 2025	The Trust will be able to reach a wider audience outside of current NHS job boards, improve employer branding and support targeted recruitment campaigns. This in turn will improve the workforce metrics across the Trust, growing our workforce and reducing turnover as we become an employer of choice.	Assurance Level 4 - Robust plan in place with actions and deliverables reported through Supply and Shape Assurance Paper to Quality, Safety and Performance Committee

TRUST BOARD	
Embedding the Donor & Patient Voice Across Velindre University NHS Trust Delivery Plan	
DATE OF MEETING	26 th March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
PRESENTED BY	Chris Kelly, Interim Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
EXECUTIVE SUMMARY	This paper presents a Trust-wide delivery plan to strengthen and embed the donor, patient and carer voice across Velindre University NHS Trust. Building on existing strengths, the plan aligns with the People's Experience Framework and addresses the need for more consistent, organisation-wide learning from experience.
RECOMMENDATION / ACTIONS	The Trust Board are asked to APPROVE the Trust Embedding the Donor, Patient & Carer Voice Delivery Plan to help actively shape the proposals to have the donor and patient voice embedded across all parts of the Trust.
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	26/01/2026
Quality, Safety & Performance Committee	13/01/2026
Trust Board	29/01/2026
Quality, Safety & Performance Committee	12/03/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Draft proposals have been provided to EMB, QSP & Trust Board - members feedback and discussion points have been used to develop this final proposal.	

Quality, Safety & Performance Committee endorsed the delivery plan.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	
1	Embedding the Donor, Patient & Carer Voice across Velindre University NHS Trust Improvement Plan
2	https://www.gov.wales/sites/default/files/publications/2025-04/peoples-experience-framework-2025-survey.pdf

1. Background

Significant work has been undertaken in recent years to capture and utilise experiential feedback from patients and donors. This feedback is routinely reported and shared with staff at all levels and is used to inform service improvement and change. The implementation of the CIVICA system has strengthened electronic capture and supported an increase in the volume and accessibility of feedback.

In parallel, patient and donor engagement strategies and plans have been developed across both divisions. An established patient group operates within Velindre Cancer Service, and a donor group is currently being established within the Welsh Blood Service. Notwithstanding this progress, it is recognised that further work is required to significantly strengthen and embed the voice of our population, patients and donors across all areas of the Trust.

Following previous discussions at Quality, Safety & Performance Committee and Trust Board, a Trust-wide improvement plan has been developed (**Appendix 1: Embedding the Donor, Patient and Carer Voice across Velindre University NHS Trust Delivery Plan**).

The improvement plan has been developed in alignment with the National People's Experience Framework self-assessment tool. A key enhancement within this framework is the Local Self-Assessment Tool, which enables organisations to assess their level of maturity, identify areas for development, and establish ambitious improvement plans supported by continuous learning. This ensures comprehensive coverage of all aspects of the people's experience. <https://www.gov.wales/sites/default/files/publications/2025-04/peoples-experience-framework-2025-survey.pdf>

The baseline Trust self-assessment against the People's Experience Framework was undertaken collaboratively. High-level findings indicate that the Trust has strong foundations across leadership, feedback collection, learning from experience, analysis and triangulation, and transparent reporting. However, the assessment also identified that significant organisation-wide collaborative working is required to achieve full compliance with the framework. This requirement is reflected within the Trust IMTP quality priorities for 2025/2026.

	Criteria	Self-assessment April 2025
1	Leadership	Trust Board approved the People's Experiences strategy in place emphasising continuous improvement, and ongoing learning.
2	Capacity & Capability to effectively collect feedback	A variety of feedback and engagement methods are in place and actively promoted and widely disseminated across the Trust.
3	Using peoples feedback to drive quality improvement and learning	The Trust actively and consistently seeks people's experiences, and works to ensure that learning from this is embedded
4	Analysis & Triangulation	The Trust has a systematic method for reviewing, analysing, triangulating and learning from people's feedback and experiences – the results are presented within publicly accessible reports
5	Reporting and publication	The Trust publishes data and reports in a transparent and accessible way, including the annual Duty of Quality report

Key:

RED - No / insufficient evidence.

AMBER - Evidence available but may need further development.

GREEN - Sufficient relevant evidence

The plan will also be monitored and reported utilising the Trust 7 levels of assurance to ensure that key risks are being effectively managed and that actions are working in practice.

2. Next Steps

The delivery plan following approval, progress will be monitored through established quality and safety governance routes, including the Trust regulatory tracker and IMTP monitoring arrangements.

3. Impact Assessment

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below

If yes - please select all relevant goals: - Outstanding for quality, safety and experience ☒ - An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ - A beacon for research, development and innovation in our stated areas of priority ☒ - An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ - A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	07 - Patient Outcomes
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	Not required at this stage
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
None identified	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	Not required at this stage but will be required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Appendix 1

Strengthening the Donor, Patient and Carer Voice across Velindre University NHS Trust Delivery Plan

1. Donor, Patient & Carer Voice Vision

“The voices of donors, patients, families, donors and carers are at the heart of everything we do. People with lived experience are true partners—shaping decisions, improving services, influencing culture and driving meaningful change at every level. Through compassionate listening, co-production, inclusivity and transparent learning, every voice is heard, every experience matters, and every improvement reflects what matters most.”

2. Core Principles

- **Partnership, not consultation:** Patients, donors, families and carers are *equal partners* in design, delivery, evaluation and governance.
- **Co-production as the default:** From strategy to pathway redesign, engagement begins at idea stage and continues through evaluation.
- **Do no harm in engagement:** Trauma-informed, psychologically safe approaches for both contributors and staff.
- **Equity, diversity & inclusion:** Proactively remove barriers (access, language, digital, disability) and ensure representative participation.
- **Accessibility & clarity:** Information is understandable, bilingual where appropriate, and provided in accessible formats.
- **Multiple ways to speak up:** Surveys, stories, panels, drop-ins, digital tools and community outreach—so every voice can be heard and is fed through governance route.

- **Evidence + stories together:** Quantitative data (PREMs/PROMs) is interpreted alongside lived experience; both inform decisions.
- **Transparency & accountability:** We publish “You said, we did” outcomes and explain the “why” when we can’t implement feedback.
- **Learning system mindset:** Feedback → analysis → action → review is a standard cycle in QI, education and governance.
- **Good governance:** The D/PCPB/Velindre Voices have clear routes into WBS & VCS SLT, EMB and Board committees; patient voice is visible in all key decisions.
- **Privacy & consent:** Engagement follows IG/ethics standards; contributors control how their stories are used and credited.
- **Continuous improvement:** We regularly review methods, outcomes and inclusivity, adapting our approach as needs evolve.

3. Measuring Delivery

Measures will be reported through organisation – service delivery to Board (as relevant)

The People Experience Framework already defines *what good looks like* through five criteria. These should become your core success domains:

1. **Leadership**
2. **Capacity & capability to collect feedback**
3. **Analysis & triangulation**
4. **Using feedback to drive improvement**
5. **Reporting & publication**

Success is measured by **progress against each criterion**, rather than by isolated metrics. We will utilise the People Experience Framework to measure success by:

- Treating it as a **maturity and assurance framework**
- Measuring progress across leadership, capability, analysis, improvement and reporting
- Using evidence, dashboards and stories together
- Demonstrating impact through governance and “You said, we did” learning

4. Delivery Plan

Self-assessment domain 1 - Leadership

	Safety action description (SMART)	Target completion date	action owner	Action Taken	Relevant Evidence
1.	To review and amend the People's Experience Standard in co-production with both Divisions and patient, donor and advocate engagement.	June 2026	Trust Head of Quality, Safety and Assurance		
2.	Enhance evidence of Listening, reporting and acting upon feedback, e.g. We Asked, You Said, We Did, in Board Reports.	July 2026	Three Integrated Quality Hubs		
3.	Lived experience of people along with associated learning and actions are shared internally and externally,	July 2026	Nominated Executive Lead for		

	including Leadership boards.		People's Experience		
4.	Review the Patient and Carer Partnership Board Terms of Reference and operating arrangements.	August 2026	Head of Patient Engagement		
5.	Introduce a WBS co-design forum to enable donors and advocates to provide feedback and insight on a particular subject when called upon.	September 2026	Head of Donor Engagement		

Self-assessment domain 2 – Capacity and capability to effectively collect feedback

	Safety action description (SMART)	Target completion date	action owner	Action Taken	Relevant Evidence
1.	To consider opportunities to increase capability and capacity to collect feedback.	September 2026	Three Integrated Quality Hubs		
2.	Develop dashboards to demonstrate increased capacity and capability to collect feedback overtime.	July 2026	Trust Head of Quality, Safety and Assurance		
3.	Utilise the digitals stories toolkit across the Trust to	September 2026	Three Integrated Quality Hubs		

	reinforce using stories to improve quality.				
4.	Create a repository for people's stories across the Trust.	September 2026	Communications Team		
5.	Establish infrastructure to support the collection of feedback and insight from hard-to-reach groups and people with protected characteristics.	July 2026	Trust Head of Quality, Safety and Assurance		
6.	Evaluate and implement easy-read options on Civica to make feedback forms and reports more accessible to all service users, including those with literacy challenges.	July 2026	Trust Head of Quality, Safety and Assurance		
6.	Review and update the Velindre University NHS Trust Patient Engagement Strategy for Velindre Cancer Services.	August 2026	Head of Patient Engagement		

Self-assessment domain 3 – Analysis and Triangulation

	Safety action description (SMART)	Target completion date	action owner	Action Taken	Relevant Evidence

1.	To review Terms of Reference within the Quality and Safety meeting Governance Structure to ensure Patient and Donor voices are reported to build on what is doing well and to identify where improvement can be made.	September 2026	Three Integrated Quality Hubs		
2.	Development of dashboards to enhance real time data analysis.	September 2026	Trust Head of Quality, Safety and Assurance		
3.	To develop key performance indicators for People's Experience Surveys.	September 2026	Trust Head of Quality, Safety and Assurance		
4.	Produce a bi-annual equality monitoring analysis report, from the People's experience framework.	April 2026	Trust Head of Quality, Safety and Assurance		

Self-assessment domain 4 – Using peoples feedback to drive quality improvement and learning

	Safety action description (SMART)	Target completion date	action owner	Action Taken	Relevant Evidence
1.	Strengthen the public facing internet pages to ensure there is process in place that the public are informed of how their experience and feedback has influenced change.	May 2026	Head of Quality, Safety and Assurance and Communications team		
2.	Review how Civica reports are shared and utilised by individual service areas.	May 2026	Three Integrated Quality Hubs		

Self-assessment domain 5 – Reporting and Publication

	Safety action description (SMART)	Target completion date	action owner	Action Taken	Relevant Evidence
1.	Ensure that People's Experience is the key component of the Duty of Quality report.	April 2026	Head of Quality, Safety and Assurance		
2.	Liaise with the donor and patient groups to ensure the Duty of Quality report	March 2026	Head of Quality,		

	is presented in an agreed style and format.		Safety and Assurance		
3.	Review the Trust communications channels with Llais and Public Service Ombudsman to ensure feedback received is incorporated and considered.	June 2026	Head of Quality, Safety and Assurance		

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

5. Approval & Review

The plan will be monitored at divisional quality meetings and updates provided through the Trust Integrated Quality & Safety Group and then through the agreed governance structure.

TRUST BOARD	
Organisational Culture: Milestones	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist Sarah Jenkins, Executive Director of People and Organisational Development
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development
EXECUTIVE SUMMARY	This paper sets out a milestone plan for the culture and leadership programme which shows the key actions in three phases between March 2026 to May 2029. The Board is asked to approve the milestone approach and the 5 specific recommendations in order to bring the programme to life.
RECOMMENDATION / ACTIONS	For discussion and approval

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Team agreement	23.2.26
Informal engagement with most members of Trust Board to help co-create	Various

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The content of the slides at Appendix 1 were agreed by the Executive Team on 23 February 2026 as milestones and phases for delivering the Culture and Leadership Milestones.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as ‘ ASSURANCE ’, this section must be completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance
	<i>These ratings were agreed at QSP on 11.9.25</i>
	Compassionate Leadership3
	Psychological and Physical Wellbeing3
	Diversity and Inclusion3
	Values and Behaviours3
	Employee Voice2

APPENDICES	
1	Better Together - Culture & Leadership Milestone Plan

1. SITUATION

- 1.1 In December 2025 a Cultural Baseline was shared with the Trust Board and an agreement reached to commission programmes for further development, including a workstream on Culture and Leadership.
- 1.2 A tender has been published for the Culture and Leadership programme with a closing date of 27 March 2026 with a target commencement date of 1 June 2026. It is the intention this work will be integrated within and enable the change being managed across the organisation. It will help support provide the right interventions and tools to empower the right behaviours and leadership we need to help us succeed in delivery.
- 1.3 This paper supplies details of the principal activities and outline milestones in this work.

2. MILESTONE PLAN

- 2.1 The slides attached at Appendix 1 set out three parts to the milestone plan:
- Staff engagement approach and principles
 - High level timeline
 - Phases and milestones
- 2.2 The high level timeline sets out three phases for the work:

	Actions	Time allocation	Dates
Phase 1	Mobilise and Discover	0-90 days	March to May 2026
Phase 2	Design and Deliver	3-12 months	June 2026 to May 2027
Phase 3	Embed and Sustain	12-36 months	June 2027 to May 2029

The Culture and Leadership Programme that has been put out to tender will focus on Phase 2, but will also support the finalisation of Phase 1 and the establishment of healthy practices for Phase 3.

- 2.3 Milestones have been indicated for each of the three phases. Some of the specific programmes, such as Civility Saves Lives and Radical Candour are

suggested as potential vehicles for working with staff to enable positive behaviour and the growth of a positive culture. This will all be co-designed with staff.

- 2.4 The actions in Phase 1 have been started. For example, the priorities for the Culture and Leadership milestone approach are being developed and agreed through this paper and the prior Cultural Baseline paper. We will be working with the leadership teams within our services to agree how the work is integrated within our normal ways of working.
- 2.5 Phase 2 focuses on the activities that more directly involve staff. This will be the highest profile and most motivating phase of the programme. It will offer opportunities for staff to contribute, for example in developing the Behavioural Framework and developing resources, potentially on the lines of a Culture Charter. But this will be informed by what we agree with our staff.
- 2.6 The final phase is where we embed the new Behaviour Framework and supporting resources into business as usual. This will require a high level of commitment from everyone in the Trust, with a clear need for the Board to continue to endorse and model positive behaviours.

3. MEASURES

- 3.1 There are five metrics embedded into the Performance Management Framework taken from the NHS Staff Survey which measure the key aspects of culture. As this measure is a snapshot of staff perceptions once a year. In addition, Divisions will be equipped to interrogate their staff survey results and where helpful deploy short pulse surveys to assist in improving staff experience based on any local plans they create with staff.

4. STAFF ENGAGEMENT

- 4.1 The engagement of staff is intrinsic to culture development. It is imperative that the culture work is co-designed with staff so that it is meaningful and relevant. This includes working in partnership with staff representatives and trades union colleagues. Secondly, visible leadership will be instrumental in successful engagement; this means Board members participating in walkabouts in the service and supporting any engagement sessions. Our role is to empower and support on the ground leadership, not to do it for them. Further details of some of the other pertinent activities is reflected in the attached appendix.

5. ORGANISATIONAL DEVELOPMENT RESOURCE

- 5.1 The current programme is being delivered through a combination of Trust staff and commissioned external support. As the programme grows, it will be essential that people across the organisation are involved in different developments and activities. Resources may need to be re-directed internally to support the full actualisation of the plan.

6. ROLE MODELLING

- 6.1 The role of the organisation's leadership team is critical in developing a positive culture. This Milestone Plan highlights the processes of walk abouts and Ask Me Anything. To make this a reality, all Board members will need to actively commit to role modelling positive behaviours and to visibly live the Trust values of Caring, Respectful and Accountable.

7. SUMMARY OF MATTERS FOR CONSIDERATION

- 7.1 The Trust Board is asked to:
1. Approve the three-year cultural milestone approach.
 2. Agree culture measures - annual staff survey with further agreed measures in phase 1 to be agreed.
 3. Sponsor the Staff Engagement principles.
 4. Acknowledge the need to review resources for Organisational Development support, external assessment and People and Organisational Development infrastructure and approach to ensure we are focused on the right things.
 5. Commit to change by modelling positive behaviours in every interaction. Being *Caring, Respectful and Accountable* without exception.

8. IMPACT ASSESSMENT

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

If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐													
RELATED STRATEGIC RISK - BOARD ASSURANCE FRAMEWORK (BAF) For more information: STRATEGIC RISK DESCRIPTIONS	Choose an item Risk 06 – Organisational Culture												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below <table border="0"> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☐</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☐</td> </tr> <tr> <td>Efficient</td> <td>☐</td> </tr> <tr> <td>Patient Centred</td> <td>☐</td> </tr> </table>	Safe	☒	Timely	☐	Effective	☒	Equitable	☐	Efficient	☐	Patient Centred	☐
	Safe	☒											
	Timely	☐											
Effective	☒												
Equitable	☐												
Efficient	☐												
Patient Centred	☐												
The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). <i>[Please include narrative to explain the selected domain in no more than 3 succinct points].</i> Click or tap here to enter text													
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to</i>	Choose an item												

consider the impact of that decision on the Health and Care Quality Standards.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Choose an item
	[Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Choose an item
EQUALITY IMPACT ASSESSMENT	Choose an item

<i>For more information:</i> https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	<i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text
	<i>[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].</i>

9. RISKS

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

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

Our Velindre/Better Together – our culture & leadership

Enabling a culture of care,
compassion and inclusivity in
Velindre University NHS Trust



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



Gwasanaeth Gwaed Cymru
Welsh Blood Service



Technoleg Iechyd Cymru
Health Technology Wales



Gwasanaeth Cancer Felindre
Velindre Cancer Service



Advanced
Therapies
Wales

Therapiau
Datblygiedig
Cymru



Ymddiriedolaeth
Prifysgol Felindre
Velindre University
NHS Trust

Agenda

1. Where are we now?
2. Where do we want to be from a culture and leadership perspective?
3. How will we get there? *Our Cultural Milestones*
4. How will we support this?



Where are we now?

**Reminding us of how our culture
feels from our Staff, our Patient &
Donor experience**





Educational opportunities
Statutory and Mandatory
We have good team working
People see us a place to work
Our vacancy rates remain low
People are engaged
People feel trusted to do their job

We fill most roles
Excellence
Proud
Strategic intention
Valued
We have a Social Media presence

Key things this helped us to understand from our staff?



TRUST/SPEAKING
UP SAFELY



WE NEED TO
LISTEN TO
UNDERSTAND AND
THEN ACT



COMPASSIONATE
LEADERSHIP



EMPOWER OUR
STAFF TO FOCUS
ON IMPROVEMENT



TOO MANY
PRIORITIES



WE LIVE OUR
VALUES

Hot off the press – Our Staff Survey Results 2025

Positivity scores by survey theme: 2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups

With green and pink bars indicating scores above and below the benchmark*



Positivity score	59.3%	71.3%	67.9%	70.7%	78.0%	67.9%	73.3%	65.6%	64.7%	66.3%
Benchmark*	53.7%	59.7%	57.7%	65.6%	69.6%	63.1%	68.7%	60.8%	56.5%	61.2%
Highest performing org.	60.2%	71.3%	67.9%	70.8%	78.0%	67.9%	74.3%	68.5%	64.7%	68.8%
Lowest performing org.	50.1%	57.7%	55.3%	63.9%	67.6%	59.8%	67.4%	58.7%	53.6%	59.3%

Staff Survey Results 2025 – *How our results compare to 2024*

	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*

Green is higher than benchmark, pink is lower
Health Board Benchmark shown by *



3.1 VELINDRE CANCER SERVICE – PATIENT

Heat map for the National Patient Experience Survey at VCS

Figure 6

971 patients provided feedback through the Patient Experience Survey.

	Responses	3 - Was the time you waited:	4 - Did you feel well cared for?	5 - Were you treated with dignity and respect?	7 - Were you able to communicate in your preferred language?	8 - Did you feel that you were listened to?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Were things explained to you in a way you could understand?	11 - How would you rate your overall experience?	Overall
Service		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Clinical Trials	9	83	96	100	100	100	96	100	97	97
Medicine	6	83	100	100	100	100	100	100	100	98
Nuclear Medicine	3	75	100	100	100	100	100	100	100	97
Nursing	227	89	98	100	99	97	96	97	96	97
Outpatients	173	76	89	94	98	93	93	93	91	91
Palliative care	1	100	67	33	67	67	33	33	50	56
Radiology	8	100	92	100	100	96	92	92	91	95
Radiotherapy	108	94	97	98	100	99	97	98	98	98
Radiotherapy/Brachytherapy	1	100	67	-	-	-	-	-	-	83
SACT	435	92	97	99	98	96	94	95	96	96
	Overall	89	96	98	99	96	95	95	95	95
	Benchmarks	85	85	85	85	85	85	85	85	

3.1 VELINDRE CANCER SERVICE – PATIENT EXPERIENCE CONT.

95% were
happy with
their
experience

11%
**Felt the
time they
waited was
longer than
expected**

96%
Were
overall
satisfied
with their
care

**98% felt they
were treated
with dignity
and respect**

1022 patients in total completed a feedback survey - 13% increase from Q2 2025/26

5%
**Felt their care
was not
always
explained in a
way they
understood**





3.3 WELSH BLOOD SERVICE – DONOR

The Welsh Blood Service values all donor feedback received in helping to understand both successes and further opportunities to improve. We capture, analyse and trend our donor experience feedback, and share it, along with actions taken in response, with our donors, their families and staff in line with the requirements of the Duty of Quality. These are the results of the Civica Surveys and digital on-session feedback forms., including the new Patient Experience Survey (figure 8).

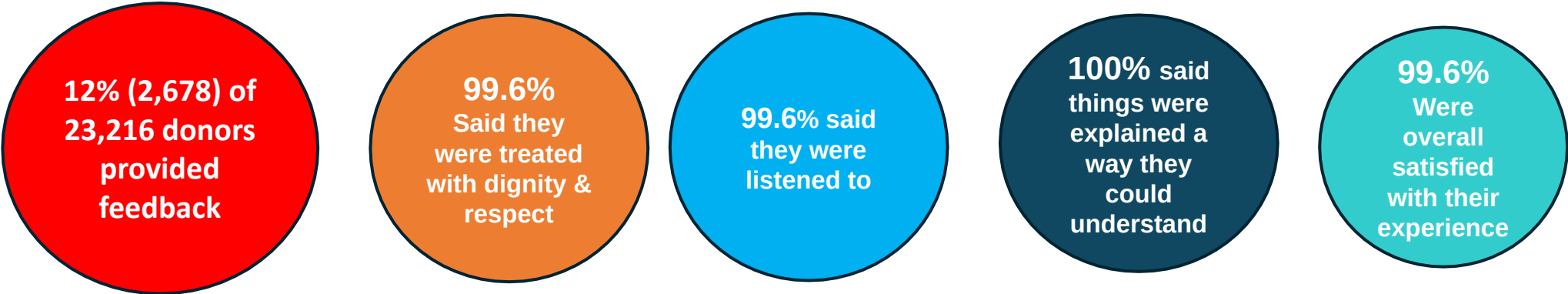
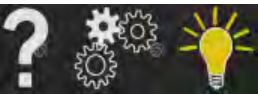


Figure 8

Responses		2 - Was the time you waited:	3 - Did you feel well cared for?	4 - Were you treated with dignity and respect?	6 - Were you able to communicate in your preferred language?	7 - Did you feel that you were listened to?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Were things explained to you in a way you could understand?	10 - How would you rate your overall experience?	Overall
Service Group		Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	Welsh Blood Service People's Experience Survey (PES)	
WBS		2684	96	99	99	98	99	99	99	98
Overall			96	99	99	98	99	99	99	98
Benchmarks			85	85	85	85	85	85	85	10



3.3 WELSH BLOOD SERVICE – DONOR EXPERIENCE CONT.



Welsh Blood Service Wall of Thanks

East B - All staff incredibly friendly and made me feel at ease as it was my first time. I will be back

Reception - Michelle Katrina and Susan are three of the most kind ladies and nothing is too much trouble for them, thank you so much!

West team - Treated by very professional staff very friendly puts you at ease every time

East A - The staff are always so professional, caring and attentive to individuals needs. Amazing people doing an awesome job

East C - Always look forward to giving blood because the nurses and staff are all so friendly

Bangor - Cefais gyfarthrebu drwy'r Gymraeg tra roeddwn gyda chi-pwysig iawn i fi fel Cymro

Wrexham - Very personable staff, processes explained very clearly. Staff conducted themselves very professionally

Platelets - It is always a smooth process, I always feel safe and valued

We are making a start – Our Governance and Leadership work

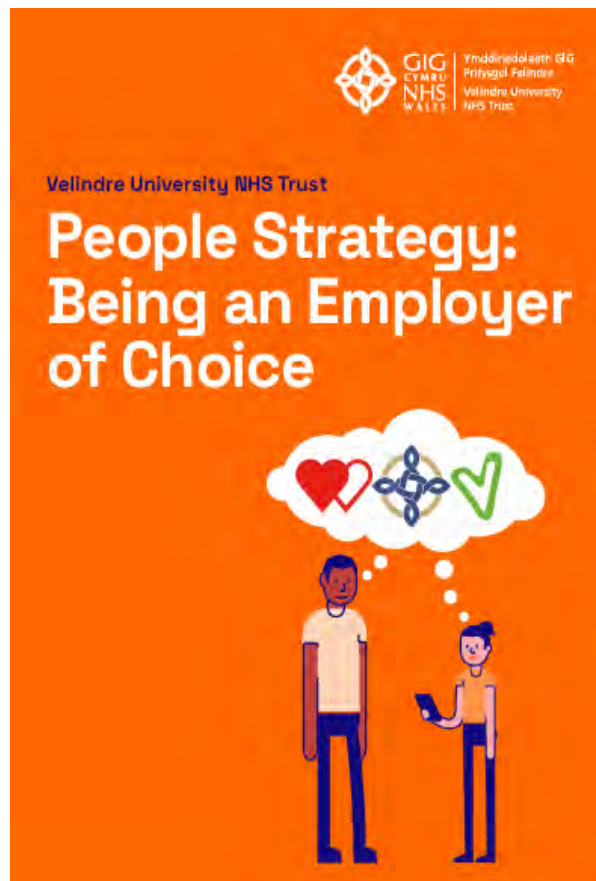
- Governance & Board leadership
- Line of Sight
- Culture is about – “*how it feels to work here*”. (Impacts - People, Systems & Processes)
- *Top Down* (Board Leadership Development and Governance) meets *Bottom Up* approach (co-created with our staff and Trade Unions)
- What we decide here will significantly impact *how it feels for our staff* on a day to day basis e.g. if we want to empower staff – we need to consider freedom to act and minimal bureaucracy



Where do we want to be?

Our aspirational culture from our People Strategy

Our People Strategy – *a culture of care, compassion and inclusivity*



Does this feel right? –

We want to reset this with our staff to
ensure as we move into our future –
we co create an environment that we
all want to work in

How will we get there?

Our cultural milestone plan



Leaders create culture.
Culture drives behavior.
Behavior produces results.

Urban Meyer

***“If you want culture change, don’t
have a culture change programme.”***



Cultural Journey

Better Together - What will we do together



Staff engagement approach and principles

- **Co-design:** partner with our staff, stakeholders and TU and networks involved from outset. Service led.
- **Independent view** – to help us check and challenge we have understood our staff
- **Multiple channels:** Ask me anything (Teams), Team Brief, huddles, intranet, QR codes, town halls, story capture.
- **Inclusive & accessible:** plain language, alt text, captions, materials in Welsh and English.
- **Continuous listening:** pulse + appropriate deep dive schedule; feedback loops 'You Said – We Did'.
- **Visible leadership:** Structured Board walk arounds and 'Ask Me Anything' Executive sessions;
- **Measure impact:** we will agree how we measure progress as part of the Discovery phase 1

High level timeline and approach



	Actions	Time allocation	Dates
Phase 1	Mobilise and Discover	0-90 days	May to July 2026 (OD Partner being commissioned from June)
Phase 2	Design and Deliver	3-12 months	August 2026 to June 2027
Phase 3	Embed and Sustain	12-36 months	July 2027 to June 2029

Phase 1 – Mobilise & Discover (0 – 90 days)

Connecting our staff to our purpose (what am I for?):

Actions: We will bring to life Destination 2033, re-set the People Strategy and focus on our 5-year WBS and Cancer plans. We need to align all together to help bring it to life for our staff

Outcomes: This will help us agree together our common purpose, and set the context for the culture we want to create

Impact: will provide clarity of connection and expectations

Co-creating with our staff our “To be” culture:

Actions: We will engage directly with staff through a variety of mechanisms based on existing structures to focus on what is most important for our staff and will help them to do their jobs. Empowering local leadership to lead this. What we learn will be fed into our governance review.

Outcomes: This will help us agree together the culture we want and will help us create a co-created Charter or Compact on our mutual obligations to each other (to ensure we empower each other).

Listening and acting.

Impact: will provide clarity of connection and expectations for all. Mutuality of Obligation to impact and show the right behaviours

Discovery – Independent check and challenge:

Actions: Work with our new commissioned OD partner from June 2026 to establish if Discovery work representative of what we need to focus on. Complete any further Discovery work required based on advice and review Milestone approach to ensure right approach

Outcomes: External validation of our approach

Impact: Building trust and establishing credibility we have understood staff feedback messages and mechanisms from the Cultural Baseline

Phase 1 – Mobilise & Discover (0 – 90 days)

Adopt and communicate:

Actions: Engage with our staff about what we have heard, and what we will focus on regarding Culture and Leadership. Confirm we commit to co creation with staff & TU partners

Outcome: Ensure staff are connected and engaged

Impact: Building trust and demonstrating we are listening and acting

Listen actively to our staff and acting – Staff Survey 2025 results:

Actions: Engagement with staff on Staff Survey results with opportunity to commit to 3 key organisational priorities as an organisation, with local plans to be developed. Intelligence and results will be used to help inform the creation of a Behaviour Framework, to define the standards of behaviour needed.

Outcomes: Co-created staff survey action plan that also helps us feed into a Behaviour Framework

Impact: Staff feel listened to, increase the importance of our annual staff survey as a tool to measure staff voice and engagement, help define the behaviours we all want to see and co-own that they are live and important

Phase 1 – Mobilise & Discover (0 – 90 days)

Speaking up Safely Maturity

Actions: Continue raising awareness of mechanisms to speak up, enable opportunities for our IM for Speaking up to connect directly with staff further, agree commissioning of an advisory audit on speaking up safely infrastructure to ensure we are providing the right things, commence the Board visibility programme (Working Together)

Outcome: Continue to build a safe space for our staff to speak up and the right opportunities to do so

Impact: Recognising this is about ongoing leadership and staff relationships. It is a long-term challenge – but we would want to see an improvement in our staff survey result in 2026 on this measure.

How will we know we are making progress - methods of measurement

Action: we will agree methods of measurement of success – to help us know what good looks like. For example, we will explore measurements of use of pulse surveys and other workforce metrics. We will also explore team tools for measurement.

Outcome: Enables one reporting mechanism to assess the journey

Impact: Should help us not react to one measure in isolation. Culture is complex and no one measure is finite in suggesting action or inaction required.

Phase 2 – Design & Deliver

(3 – 12 months)

Enabling the right behaviours – How will we behave?

Action: Launch our new behaviour framework. Work with our OD partner to create interventions to support behaviour change, co-create toolkits to support teams and individuals (for example Civility Saves Lives/Radical Candour campaign). Enhance 5 minute improvements across whole organisation

Outcome: Launched Behaviour Framework and support toolkits

Impact: 24/7 access to empower leaders and teams to embed behaviour change

Review existing People and OD offering – stop, start, continue

Action: Implement recommendations of advisory audit on speaking up safely and any recommendations from our OD Partner to change.

Outcome: We have the right infrastructure in place

Impact: supporting the right options for speaking up and people support

Implement methods of measurement of success

Action: finalise live workforce dashboard for launch and agree reporting structure respecting monthly reporting not appropriate for Culture assessments. Celebrate successes as we go along

Outcome: Agreed reporting structure

Impact: Understanding the culture journey trend

Re-launch compassionate/inclusive leadership

Action: relaunch Inspire programme with commitment to new behaviours

Outcome: An aligned programme to help our managers grow and develop with the expected behaviours

Impact: We ensure our leaders and managers lead by example

Phase 3 – Embed & Sustain (12-36 Months)

Embed People Charter/Compact and Refreshed People Strategy into all people processes.

Lead by example the Board to role model and practice through the governance review the right behaviours

Embed behaviours and service improvement programmes and open learning in day-to-day working

Strengthen Speak-Up maturity and thematic action tracking

Celebrate our Successes through tracking our measures of success

How will we support this?



Governance, Risks & suggested Mitigations

Oversight: Board owns outcomes; need to agree cycle of business to ensure we have appropriate time to get things done. Recognising the review of our governance may lead to different reporting.

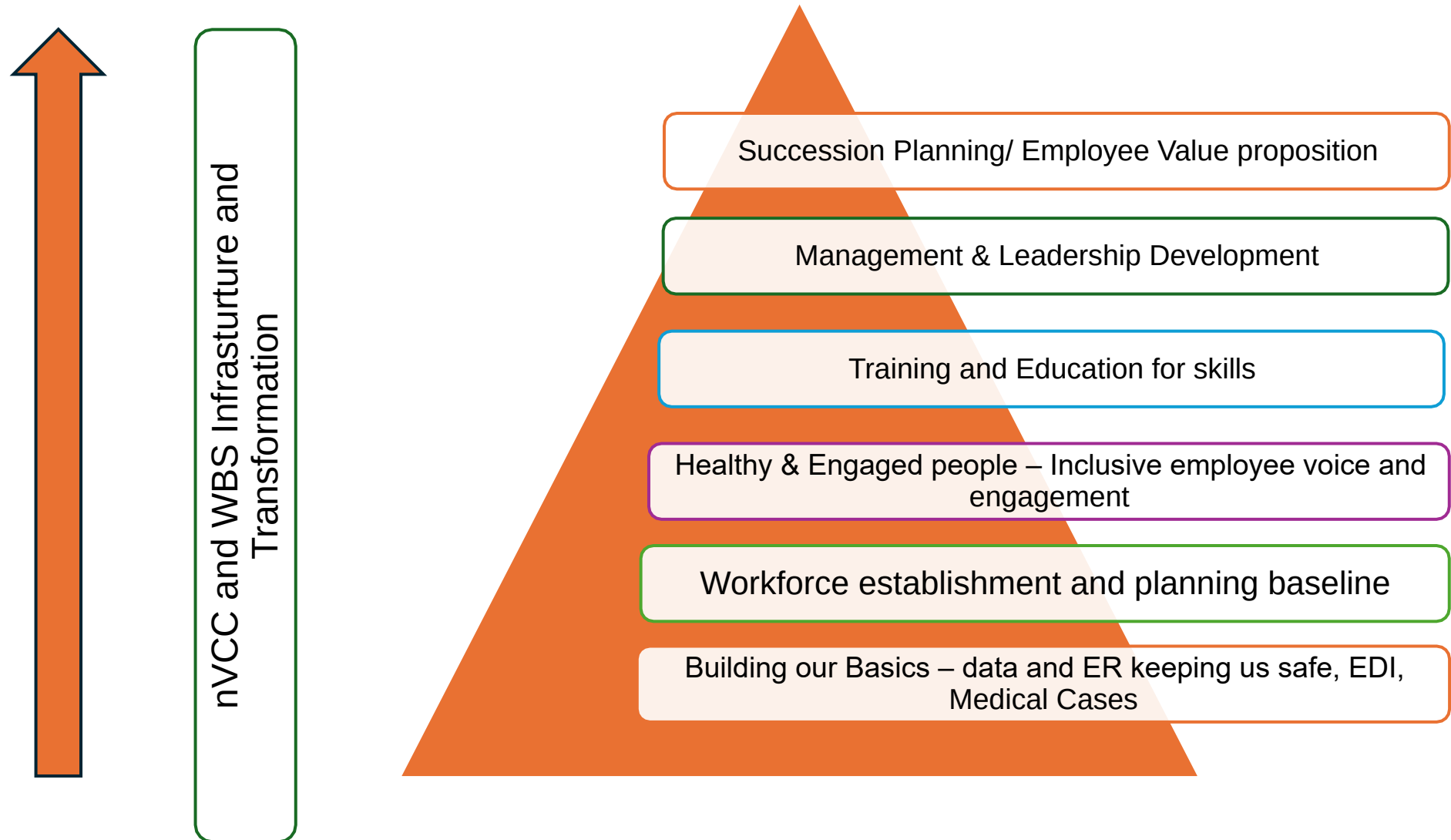
Risk themes: capacity, change fatigue, integration to existing transformation programmes of work, data quality, inconsistency across sites (how we embrace difference).

Mitigations: phasing, Champion network in every area, open data standards, Board sponsorship & visibility, *“do what we say we are going to do”*, benefits tracking through annual staff survey and local pulse.

Decision points: approve milestones, principles for engagement, metrics & dashboard (PMF), progress updates on milestones and what we are learning/adapting to change and embed.



People Strategy – Recognising the work we are already doing



Next Steps and Ask of the Board



Approve the three-year milestone plan



Agree culture measures – annual staff survey focus (local operational pulse), as we shape a wider group of measures in phase 1 for reporting



Sponsor the Staff Engagement Principles



Acknowledge the need to review what we stop start and continue, to ensure the right impact



Leadership - commit to change by modelling positive behaviours in every interaction. Being *Caring, Respectful and Accountable* without exception.

TRUST BOARD	
Culture and Inclusion Report	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist, Sarah Jenkins, Executive Director of People and Organisation Development (Interim)
PRESENTED BY	Sarah Jenkins, Interim Executive Director of People and Organisational Development
APPROVED BY	Sarah Jenkins, Interim Executive Director of People and Organisational Development
EXECUTIVE SUMMARY	This paper gives an update on progress in our Culture & Inclusion work. The Appendices detail the improvement in the measurement of staff experience, the increase in the staff survey response rate and the positive advisory review of the wellbeing service. The dominant matter for culture and inclusion is securing agreement by the Board to a way forward in driving cultural development to create a high performing organisation where staff feel energised and rewarded. To agree the further work required focusing on Governance, Culture & Leadership.

RECOMMENDATION / ACTIONS	To TAKE ASSURANCE on the details provided and discussed in detail at QSP and SDC: and AGREE the further work required on Governance, Culture & Leadership.	
GOVERNANCE ROUTE		
List the Name(s) of Committee / Group who have previously received and considered this report:	Date	
EMB	22.12.25	
QSP	13.01.26	
SDC	20.01.26	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS		
Executive Management Board supported the paper as a summary of the current position of the culture within the Trust and the key issues requiring attention for the development of a positive culture in line with the agreed People Strategy. Roles and responsibilities have been set out in this paper which are critical in making the changes required. Support was given for a programme of work to consider governance, culture and leadership.		
QSP supported the paper as a summary of the current position of the culture within the Trust and the key issues requiring attention for the development of a positive culture in line with the agreed People Strategy. During the discussion the following key queries were identified for clarity: 1. Recognition of the key areas for improvement as set out in the report of: Speaking up Safely and How we Manage Change. 2. Supporting Managers on how to manage change (ensuring we tailor the support provided) – assurance was provided by confirming actions being undertaken through coaching, intranet toolkits and digital learning long term approach. 3. Managing poor behaviour – views were expressed about being more proactive with this and the importance of Board sponsorship for messaging around this. 4. Recognition that other initiatives and culture work undertaken in the past – a desire to ensure staff engagement and co-creation of the actions and solutions. So a need to review this with staff through the Healthy and Engaged Working group to ensure this. 5. Exploring pulse engagement measurements with staff in between the annual staff survey to have a 6 month temperate check.		
SDC also supported the paper as a summary of the current position of the culture within the Trust and the key issues requiring attention for the development of a positive culture in line with the agreed People Strategy. Recognising the discussions that took place at QSP, the discussion the following key areas were considered for clarity: 1. The work being undertaken on Diversity & Inclusion networks. The Assurance assessment for Diversity & Inclusion remained at 3 following a discussion around this. 2. For consideration to be given for future committees for deep dive focus areas that can be provided for further assurance. Support was given for a programme of work to consider governance, culture and leadership.		

5 7 LEVELS OF ASSURANCE		
If the purpose of the report is selected as ‘ ASSURANCE ’, this section must be completed.		
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance	
	Compassionate Leadership	3
	Psychological and Physical Wellbeing	3
	Diversity and Inclusion	3
	Values and Behaviours	3
	Employee Voice	2
APPENDICES		
1	Culture & Inclusion Report	
2	Cultural Baseline November 2025	

1. SITUATION

The Purpose of this paper is to provide assurance to the Trust Board around the programme of work focused on culture. The Cultural Baseline created in November 2025, has helped us better understand our current culture. This has been used to develop an action plan which will be shaped with our staff, and to ensure we continue to work on creating a culture of 'true inclusivity, fairness and equity across the workforce (People Strategy)'.

2. BACKGROUND

2.1 Recognising receipt of anonymous letters relating to processes of change within our Velindre Cancer Services, steps were taken by the Trust Board to support a Neutral Assessment process by Resolution @ Work. This was discussed at the recent Cabinet Secretary Public Accountability Meeting and a programme of staff engagement due to be underway.

In addition to this work, a discovery piece of work was completed to create our Cultural Baseline. This allowed us to review and reflect staff views from different sources, to help us get a fuller picture of the culture within the Trust as a whole.

The feedback and recommendations from both, as well as any new insights from our 2025 staff survey, will also be integrated into this work to ensure we have a co-owned and effective action plan to work on together.

2.2. Cultural & Inclusion Reporting

A Culture & Inclusion Report (Appendix 1) is regularly considered at the Quality Safety and Performance Committee (QSP), and the Strategic Development Committee (SDC). The most recent report included a comprehensive Discovery Cultural Baseline report (appendix 2) which was provided for assurance to reflect a better understanding of the Culture of the organisation. The work is supported through the *Healthy and Engaged People Steering Group* to ensure all we do is co-created with our staff and managers.

3. ASSESSMENT OF PROGRESS

3.1 The Trust Board are asked to acknowledge the assurance taken from discussions at the QSP and SDC as indicated in Appendix 1 which are summarised below:

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

3.2 Cultural Baseline – Priority factors

Based on evidence and feedback, the following factors are recommended for priority action to create an effective organisational culture:

- 1. Speaking Up Safely; and
- 2. How we manage change well

These will guide Culture and Inclusion activity over the next 12 months and form a part of the wider work on Governance, Culture and Leadership.

3.3 Measuring Impact

Since December 2025, we have adopted a new approach to measuring people data, focused on providing meaningful insight and narrative on impact rather than simply reporting metrics. This work will progress incrementally towards a digital People Dashboard, over the next 12 months. Immediate Enhancements – are included within the Culture & Inclusion Report (Appendix 1). This has immediately strengthened our reporting. The approach combines data with

storytelling, enabling shared learning and highlighting the real impact on staff experience.

4. SUMMARY OF MATTERS FOR CONSIDERATION

- 4.1** Significant discussions and work have taken place around Culture and Leadership at Board development and Committee level. It has allowed to understand the key priority areas that work will be focused on.
- 4.2** The Trust are asked to agree the further work needed. The outputs of this will be a focus on a Board Development Programme to ensure leadership by example and work around Governance, Culture & Leadership to help embed across the organisation. Work will be done with our staff to ensure the right actions are taken.
- 4.3** The People and OD indicators in the Performance Management Framework have been refreshed to ensure a reliable set of metrics are tracked to reflect progress with culture and inclusion. In time, this will be supplemented by a Digital Dashboard which will include a basket of Staff Experience indicators.

5. IMPACT ASSESSMENT

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

For more information: <u>STRATEGIC RISK DESCRIPTIONS</u>	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐
	Click or tap here to enter text
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, ☒	

encouraging people to participate in the arts, and sports and recreation. • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Culture & Leadership expertise is being commissioned to support the programme of work. A procurement exercise is being completed and initial work has been procured around Board Leadership and Governance impacting culture.
EQUALITY IMPACT ASSESSMENT For more information: https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.asp <u>X</u>	Not yet completed - Include further detail below why <i>EIA will be completed when action plan proposed to ensure impact assessed.</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	As described in Board Assurance Framework Risk 06.
WHAT IS THE CURRENT RISK SCORE	12

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Creating a positive working environment, which is characterised by effective values and behaviours, systems and processes, to enable the Trust to meet or exceed service expectations.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	31.3.27
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY & PERFORMANCE COMMITTEE	
Culture and Inclusion Report	
DATE OF MEETING	15 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist, Sarah Jenkins, Executive Director of People and Organisation Development (Interim)
PRESENTED BY	Sarah Jenkins, interim Executive Director of People and Organisational Development
APPROVED BY	Sarah Jenkins, Interim Executive Director of People and Organisational Development
EXECUTIVE SUMMARY	This paper gives an update on progress in the five sections of the culture framework. It reports on improvement in the measurement of staff experience, the increase in the staff survey response rate and the positive advisory review of the wellbeing service. The dominant matter for culture and inclusion is securing agreement by the Board to a way forward in driving cultural development to create a high performing organisation where staff feel energised and rewarded.

RECOMMENDATION / ACTIONS		To NOTE for onward submission to Strategic Development Committee and Trust Board.	
GOVERNANCE ROUTE			
List the Name(s) of Committee / Group who have previously received and considered this report:			Date
EMB			22.12.25
To go to SDC			20.01.26
To go to Trust Board			29.01.26
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive Management Board supported the paper as a summary of the current position of the culture within the Trust and the key issues requiring attention for the development of a positive culture in line with the agreed People Strategy. Roles and responsibilities have been set out in this paper which are critical in making the changes required.			
7 LEVELS OF ASSURANCE			
If the purpose of the report is selected as ' ASSURANCE ', this section must be completed.			
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR		Select Current Level of Assurance	
		Compassionate Leadership	3
		Psychological and Physical Wellbeing	3
		Diversity and Inclusion	3
		Values and Behaviours	3
		Employee Voice	2
APPENDICES			
1	Cultural Baseline November 2025		

1. SITUATION

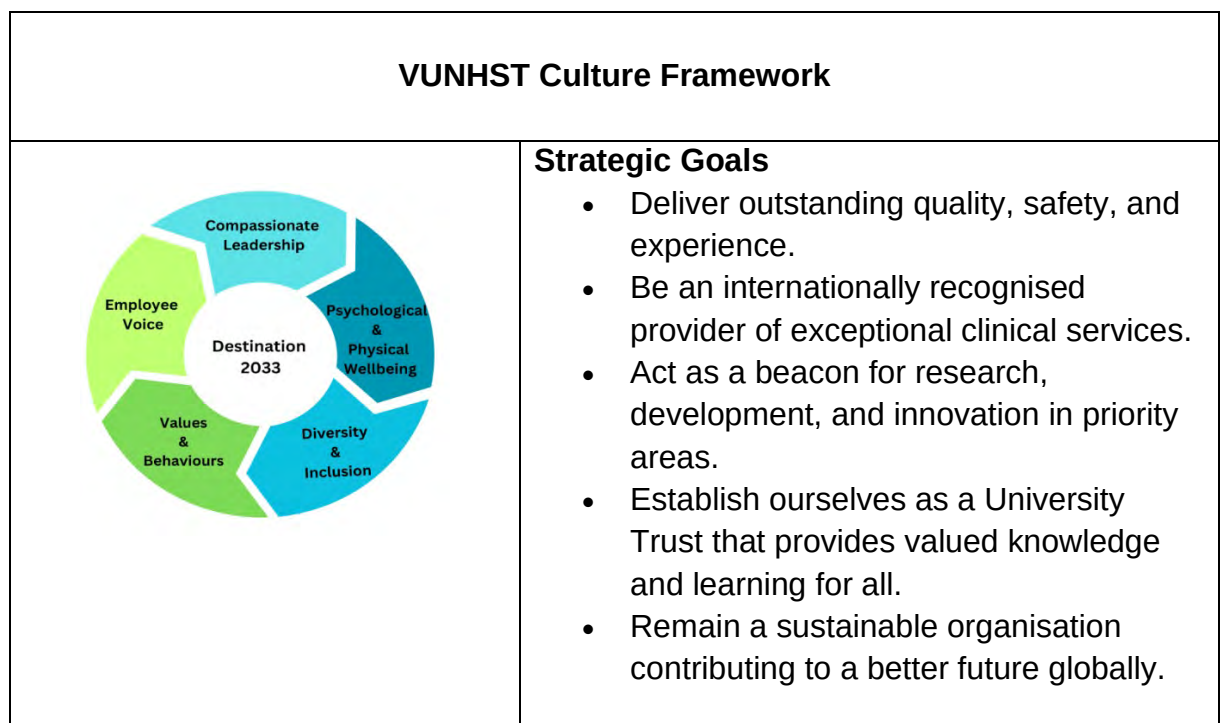
1.1 The People Strategy sets out a vision of having:

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

This paper provides a report on progress towards achieving this vision. The work is supported through the *Healthy and Engaged People Steering Group* to ensure all we do is co-created with our staff and managers.

2. BACKGROUND

- 2.1 The Trust has developed and approved a **Culture Framework** to provide structure and direction for this work. It comprises five interconnected areas with key actions under each. A positive culture depends on the consistent interplay of these strands, so issues must not be addressed in isolation.



2.2. Framework Evolution

As Board discussions on culture and leadership progress, the framework may evolve. For now, it provides a useful structure for modelling actions and considering how we measure impact.

2.3 Cultural Baseline

A cultural baseline exercise was completed in November 2025 (Appendix 1) and shared with the Trust Board during a Development Session. This baseline reflects staff feedback and draws on:

- People metrics and staff survey results
- Insights from management and leadership development programmes
- Exit interviews and external platforms such as Glassdoor

The upcoming 2025 Staff Survey results will be used to validate and update this discovery work.

2.4 Priority Factors

Based on evidence and feedback, the following factors must be prioritised to create an effective organisational culture:

1. Trust and Speaking Up Safely
2. Listening to Understand, Then Acting
3. Compassionate Leadership
4. Empowering Staff to Drive Improvement
5. Strengthening Assurance
6. Reducing Competing Priorities

These will guide Culture and Inclusion activity over the next 12 months.

2.5 Measuring Progress

In July 2025, the Healthy and Engaged Steering Group agreed a set of measures from the NHS Staff Survey to track progress against three focus areas identified from the 2024 survey. The 2025 scores will be added once results are available in January 2026.

Topic		2023 actual	2024 actual	2025 target	2025 Actuals due Jan 2026
PADR	Theme - we are continuously learning and improving	69.20%	70.20%	71%	
PADR	Q19a -In the last 12 months have you had a PADR?	82.10%	78.90%	83%	
PADR	Q19b - If yes, to what extent did it help me improve how I do my job?	66%	63%	67%	
PADR	Q19c - It helped me agree clear objectives for my work.	82.20%	82%	83%	
Team Time	Theme - we are compassionate and inclusive	76%	77.90%	79%	
Team Time	Sub theme -Inclusion	75.10%	74.90%	76%	
Team Time	Q1h - I feel valued by my team	69.60%	73.10%	74%	
Team Time	Q15c - The people I work with are understanding and kind to one another	76.10%	74.80%	76%	
Team Time	Q15d - The people I work with are polite and treat each other with respect	78%	74.30%	79%	
Psychological Safety	Theme - We are able to speak up	70.20%	72.10%	73%	
Psychological Safety	Sub theme - Autonomy and Control	74.30%	76.80%	78%	
Psychological Safety	Sub theme - Raising Concerns	66.20%	67.30%	68%	
Psychological Safety	Sub theme - Negative experiences*	85.50%	88.10%	89%	

2.6 Five core measures have already been extracted from the NHS Staff Survey for monitoring based on last years results. To help us measure our progress with these they will now form a part of the Performance Management Framework.

1. Staff Survey Response Rate
2. Staff Engagement Index
3. Theme – we are able to speak up
4. Theme – we are compassionate and inclusive
5. Theme – we are continuously learning and improving

2.7 Roles and Responsibilities

Culture and leadership are both a collective and individual responsibility. Every interaction—whether from a leader, a team, or a colleague—shapes how people feel at work and impacts the quality of care and donor support we provide. When considering culture, we must look at people, systems, and processes, recognising that multiple factors influence outcomes. Clarity on roles and responsibilities is essential for effectiveness and assurance.

Role of the Board

The Board sets the tone for the organisation, modelling values and behaviours that promote a compassionate, inclusive, and high-performing culture. Through visible leadership, clear strategic direction, and robust governance, the Board fosters openness, learning, and accountability—supporting staff to deliver safe, high-quality care. Listening to staff and service users, and using assurance information effectively, ensures culture and leadership remain aligned with the Trust values and long-term ambitions.

Role of the Executive Team

The Executive Team translates the Board's vision into everyday practice, providing visible and inclusive leadership across all services. By engaging staff and partners, making consistent decisions, and addressing concerns promptly, the Executive creates a culture of safety, collaboration, and improvement. Empowering leaders at all levels and using data and feedback to drive change ensures sustainable, high-quality services.

Role of People & OD

The People & OD function provides the frameworks, systems, and support that enable a positive, values-driven culture. This includes leadership development, performance management, staff engagement, workforce planning, and career pathways. POD ensures the organisation has the capability and infrastructure to sustain effective leadership, promote wellbeing, and deliver continuous improvement aligned with our priorities.

Role of Leaders and Managers

Leaders and managers shape culture through everyday behaviours. By modelling our Trust values, communicating effectively, and engaging staff, they create safe,

inclusive environments. Supporting wellbeing, encouraging learning, and addressing issues fairly enables teams to deliver high-quality, person-centred care and services.

Role of Staff

Every member of staff contributes to culture by living our Trust values in their daily work. Through professionalism, teamwork, and open communication, staff help create respectful, inclusive environments. Speaking up, supporting colleagues, and engaging in improvement strengthens leadership at all levels and ensures compassionate care for patients, donors, and service users.

3. ASSESSMENT OF PROGRESS

3.1 Compassionate Leadership – Assurance Level 3

This work reflects key themes from our cultural baseline:

1. Trust and Speaking Up Safely
2. Listening to Understand, Then Acting
3. Compassionate Leadership
4. Empowering Staff to Drive Improvement
5. Managing Competing Priorities

Progress to Date: Significant progress has been made in embedding Compassionate Leadership principles into day-to-day management and training. These principles, set out in our Compassionate Leadership Pledge, now form part of core management training and leadership development. Most managers have completed modules under Fundamentals of Management (FOM) or participated in Inspire and bespoke development sessions.

Fundamentals of Management, launched in 2025, is tracked via ESR. Compliance has improved across all modules since July 2025, though face-to-face modules—Respect and Resolution and Communicating in Difficult Situations—remain slower to complete. Additional dates for 2026 have been scheduled to ensure all managers complete the seven modules.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
FOMS - Managing attendance at work	70%	71%	74%	74%	78%
FOMS - Recruitment and selection	53%	55%	59%	60%	68%
FOMS - Respect and resolution	15%	20%	26%	33%	39%
FOMS - Communicating in difficult situations	8%	14%	19%	22%	28%
FOMS - Effective PADR	63%	64%	66%	69%	72%
FOMS - Stress Awareness	33%	36%	44%	48%	58%
FOMS - Safeguarding	11%	16%	21%	29%	42%

Embedding these principles in practice will determine whether staff experience a positive impact. To support this, we must ensure managers have time to attend training and that completion is reflected in PADRs. We are also exploring a digital learning platform to provide 24/7 access to bite-sized learning; a proposal is under consideration.

Outstanding Work: Four key actions remain from the last Culture and Inclusion paper:

Action	Progress	Next Steps
Embed Compassionate Leadership principles in the staff engagement framework	Principles included in draft framework	Finalise and implement by end of Q4 2025
Use Nurturing & Kindness indicators for Board development	Indicators shared with Executive Director of POD	Incorporate into Board Development programme
Roll out training and briefings on new Values & Behaviours	Cultural baseline completed; capacity needs identified	Confirm scope and commission Trust-wide programme
Update leadership development to reflect shared decision-making	Awaiting national Management Competency Framework	Embed additional content on innovation and patient outcomes

National Context: In 2024, the NHS Wales Chief Executive encouraged senior leaders to use *Nurturing Kindness and Inclusion behavioural indicators* from the

NHS Wales Success Profile as a tool for self-reflection and development. These indicators will inform our Board development approach.

Nurturing kindness and inclusion - this is about taking personal responsibility for embedding an inclusive and compassionate culture where staff, partners and citizens are valued for their uniqueness and the differences between individuals are celebrated.	
16.	Genuine, able to connect with people at a personal level, and interested in the lives and aspirations that extend beyond their day-to-day work.
17.	Brave and uncompromising in tackling discrimination, bullying or prejudice, whether within their own Health Board, local system or at a national level.
18.	Champions and models the benefits of inclusion and diversity for all aspects of team, organisational and system effectiveness.
19.	Builds trust and creates psychological safety through expressing personal vulnerability, sharing their shortcomings, and demonstrating forgiveness.
20.	Works proactively with their Chair and Board members to shape a culture that values empathy and support as much as candor and a willingness to challenge.

Embedding Compassionate Leadership and Next Steps: Alongside the outstanding actions noted above, we acknowledge the wider Board-level discussions on culture. These discussions have led to the decision to commission an external partner to support the Board in strengthening Governance, Culture, and Leadership, as well as developing a comprehensive Board Development Plan.

Compassionate Leadership will remain a cornerstone of creating a positive cultural experience for staff. Leadership impacts every level—from Board to Ward—so these principles will be embedded within PADRs and integrated into the Performance Management Framework.

Our latest data shows PADR compliance has reached the organisational target of 86.9% (November 2025). However, true impact will be measured through staff feedback. We will look for improvements in survey scores on whether PADRs help staff improve their work and set meaningful objectives—both key indicators of compassionate leadership in practice.

3.2 Psychological and Physical Wellbeing – Assurance Level 3

This work reflects key cultural themes:

1. Trust and Speaking Up Safely
2. Listening to Understand, Then Acting
3. Compassionate Leadership
4. Managing Competing Priorities

Progress and Assurance - In November 2025, the Trust received an Advisory Review Report from NWSSP Audit and Assurance Service (Appendix 2), which concluded:

“Substantial progress has been made over the past year in enhancing staff wellbeing and strengthening organisational culture.”

The review identified 12 areas of good practice (Appendix A). Additional management considerations are being incorporated into the Wellbeing Action Plan for 2026–27.

Key Risk - The main risk to sustaining the current wellbeing service is the temporary nature of its funding.

- Wellbeing Project Coordinator funded until July 2026
 - Clinical Psychologist for Staff and Teams funded until September 2026
- Both posts are currently supported through charitable funds. A business case and options appraisal are being developed to secure continued funding, recognising that this service impacts not only psychological and physical wellbeing but also other key cultural measures outlined in this paper.

Current Position - Sickness absence levels show an improving trend, although some hotspot areas remain. Managers are responsible for ensuring staff are managed compassionately in line with the Managing Attendance at Work policy, which now embeds Compassionate Leadership principles across NHS Wales.

3.3 Diversity and Inclusion – Assurance Level 3

Since the last Culture and Inclusion report, the Trust has strengthened staff engagement in diversity and inclusion initiatives. Over 2025, six Staff Networks have been fully established, with a combined membership of 45 colleagues:

- Carers'
- Disability
- LGBTQ+
- Race
- Rhwydwaith Iaith Gymraeg
- Women's

Two Leadership for Staff Networks sessions have been delivered, attended by 13 participants, focusing on the purpose of networks, how they amplify staff voice, and the role of allyship. To build on this, a Teams group has been launched to

connect members, share ideas, and provide peer support. **Next steps** include working with network Chairs to strengthen their leadership role and drive meaningful discussion and change.

Current priorities include developing an annual programme of diversity activities for 2026–27, including a Women's Day event on 8 March 2026. Network Chairs will report progress through the Healthy and Engaged Steering Group.

External Engagement: In October 2025, the Trust contributed to a Welsh Government evidence session on the BSL (Wales) Bill, providing feedback on potential implementation challenges within healthcare settings from both workforce and service user perspectives.

Divisional Progress: Both VCS and WBS continue to deliver against their Strategic Equality Plan action plans (update due after 31 December 2025). This includes preparing to implement the All-Wales Standards for Accessible Communication and Information (issued September 2025), ensuring services are accessible for individuals with communication or information needs related to impairment, disability, literacy, or language.

Next Steps: We will continue to improve how we measure the impact of diversity and inclusion work by incorporating appropriate indicators into the Performance Management Framework.

3.4 Values and Behaviours – Assurance Level 3

This reflects on the following themes from our cultural baseline and is a critical component when we consider roles and responsibilities set out above:

1. Trust/Speaking Up Safely
2. We need to listen to understand then act
3. Compassionate Leadership

The Trust Values of Caring, Respectful and Accountable are embedded into all employee policies, induction, leadership and management development and forms the foundation of the annual Employee Excellence Awards. It is also integrated within our POD infrastructure of support. Our values were co-created with our staff and are embedded within the organisation.

However, the Cultural baseline assessment referenced above has helped us understand that there is more work for us to do on demonstrating the right behaviours and for leaders at all levels to be champions and ambassadors of this. There is an opportunity for the Board to embrace this.

As part of the work which is being commissioned by the Board on Culture & Leadership, we will work with the provider to reshape our behaviour framework and to ensure it is embedded in the behaviour at every level and all areas of the Trust within a culture of healthy & positive performance management.

3.5 Employee Voice – Assurance Level 2

Our cultural baseline highlights two critical themes:

- 1. Trust and Speaking Up Safely**
- 2. Listening to Understand, Then Acting**

We have a range of mechanisms for staff to raise their voice safely and confidently, including the annual NHS Staff Survey, the Working in Confidence platform, Freedom to Speak Up routes, employee relations data, and local engagement through management and divisional structures. These provide choice and opportunity for staff to be heard.

However, recent anonymous letters remind us that infrastructure alone is not enough. The challenge lies in embedding these mechanisms so staff feel confident to use them and trust that we will act appropriately on what is heard—even if that means explaining why certain actions cannot be taken. Success depends on every leader understanding that listening and responding is everyone's responsibility.

To strengthen this, we will invite divisional leadership teams to participate in the Performance Management Framework, providing a spotlight on their service and sharing how they lead and support their staff. This will help bring good practice to life and foster shared learning.

Progress and Next Steps:

- Staff Survey Engagement: The 2025 NHS Staff Survey response rate rose to 40% (up from 34% in 2024). Analysis suggests this improvement reflects managers actively engaging with teams on previous results and agreeing actions to improve the working experience.
- Six-Point Engagement Framework: The People and OD function has adopted a simple, structured approach to strengthen two-way communication and personal connectedness. This framework, shaped by Compassionate Leadership principles, will be embedded into wider Trust communication through the Healthy & Engaged Steering Group. It focuses on:
 - o Building supportive, effective teams
 - o Creating environments for collective leadership
 - o Promoting equality, inclusion, and diversity
 - o Enabling continuous improvement and innovation
 - o Aligning direction and commitment
 - o Fostering safe, trusting, and engaging cultures

This framework will guide leadership in ensuring all aspects of engagement are addressed—not just a select few—creating a consistent and compassionate approach to staff voice.

	Definition	Examples
Inform	Our ability to share information effectively and efficiently with one another on an ongoing basis.	Intranets – news and resources Training, briefings and policies Line Manager's briefing
Involve	Interaction with staff to provide opportunities for listening, discussion and problem solving. This is also how we address leadership visibility.	Staff Survey completion Staff Survey discussion in team Bright Ideas scheme Executive Director and Senior Leader walkabouts
Empower	Provide opportunities for staff to contribute to organisational improvement and innovation.	Staff Survey discussion in team and Division 5 minute improvements
Raise and Resolve	Provide the means for staff to anonymously raise problems, concerns or ideas with	Speaking Up Safely resources including Independent Member Champion Work in Confidence platform

	management with no fear of repercussions.	People and Relationships team advice and support Datix
Reward	Rewarding a job well done is key. Staff are motivated by a workplace atmosphere of mutual respect. Reward can go a long way toward building employee self-motivation.	Employee Excellence Awards – nominations and awards Wall of Thanks and other intranet items
Measure	Embed a culture of ongoing measurement so that we can assess the motivation and satisfaction rates of employees to ensure staff are happy at work.	NHS Staff Survey theme - We are able to speak up

We continue to circulate monthly reminders to staff about the options available to Speak Up Safely, and both VCS and WBS have recently reinforced these messages. However, these mechanisms are only effective within a climate of trust and psychological safety. We recognise there is still more to do to embed this culture so staff feel confident to use these channels. This will form a key part of our wider cultural work and remains a core leadership responsibility.

To strengthen engagement, the Executive Team is developing an Executive Engagement Plan to ensure visibility and connection to our strategy—responding directly to staff feedback. We have also committed to focusing on three priority areas for action once the latest staff survey results are available. Both Divisions have been asked to do the same and are supportive. This approach will enable us to deliver a clear message:

“You said, so we will do—together.”

This is critical to building trust, encouraging staff voice, and demonstrating leadership accountability.

4. MEASURING IMPACT

Since December 2025, we have adopted a new approach to measuring people data, focused on providing meaningful insight and narrative on impact rather than simply reporting metrics. This work will progress incrementally towards a **digital People Dashboard**, which will:

- Offer comprehensive oversight of workforce indicators.
- Enable managers to drill down into data to support effective decision-making.
- Integrate with the Organisation Quality Dashboard for a holistic view of performance.

Each level of the organisation will receive the appropriate information to fulfil its responsibilities. We are currently working scoping the work to agree milestones and build the solution.

Immediate Enhancements - While the dashboard is in development, we have strengthened our Performance Management Framework to provide a more complete picture of workforce experience and impact. This now includes:

- **Heatmaps** by service/division for key workforce metrics.
- **Staff survey measures** aligned to themes identified by our people as most important.
- A **“Spotlight On” feature**, inviting divisional leadership to share how they are supporting staff and embedding good practice.

This approach combines data with storytelling, enabling shared learning and highlighting the real impact on staff experience.

Next Steps - As part of the Board-led cultural and leadership programme, we will co-create a method for measuring **staff engagement and impact** during the year. This will ensure our approach reflects what matters most to our colleagues and supports a culture where everyone feels valued and heard.

5. SUMMARY OF MATTERS FOR CONSIDERATION

- 5.1** Significant discussions have taken place since the previous Culture and Inclusion paper on how to develop a positive culture in the Trust. A Board Development session in November 2025 paved the way for the refinement of a business case for additional capacity and expertise in working with staff in working with our values and ensure that the moments that matter at work are dealt with compassionately and effectively. The outputs of this will be a focus on a Board Development Programme to ensure leadership by example and work around Governance, Culture & Leadership to help embed across the organisation.
- 5.2** Reflecting an understanding the different roles and responsibilities in this area is critical to ensuring effective and impactful decisions are made.
- 5.3** The People and OD indicators in the Performance Management Framework have been refreshed to ensure a reliable set of metrics are tracked to reflect progress with culture and inclusion. In time, this will be supplemented by a Quality Dashboard which will include a basket of Staff Experience indicators.

- 5.4** Compassionate Leadership is well embedded in our leadership and management development offerings. The next priority is to evaluate the impact of our sessions and to roll out engagement sessions for all staff to build a healthy culture where compassionate principles are the backdrop for our interactions. We will also explore opportunities as part of our IMTP for 25/26 into bite sized learning.
- 5.5** The Advisory Review on the Trust's Wellbeing provision provided a valuable check point for the further development of our service. The recommendations in the report will shape the 2026-27 actions, in line with the cultural priorities set out in paragraph 2.2.
- 5.6** Staff Networks have matured in the last few months and these groups are on the cusp of taking action to improve working lives for underrepresented groups.
- 5.7** The Staff Engagement framework has been introduced to structure our work across departments in Employee Voice. This will create a joined-up approach where we are purposeful in the messaging we send out and how we create dialogue and engagement. The Speaking Up Safely mechanism will operate well within a climate of trust.
- 5.8** Finally, the key aspect of Culture and Inclusion which knits all other aspects is the work on culture. This has been a focus for the Board during November and December 2025. Building a positive culture, in which employees feel higher degrees of interpersonal trust and engagement are necessary in achieve the high performance that we aspire to.

6 CONCLUSION

- 6.1** Since the last Culture and Inclusion report, significant discussions have taken place on building a positive culture. A Board Development Session in November 2025 shaped a business case for additional capacity and expertise to support staff in living our values and ensuring that moments that matter are handled compassionately and effectively.

This will lead to:

- A Board Development Programme to strengthen leadership by example.
- Work on Governance, Culture, and Leadership to embed these principles across the organisation.

6.2 Roles and Responsibilities

Clarity on roles and responsibilities remains critical to making effective and impactful decisions.

6.3 Measuring Progress

The People and OD indicators within the Performance Management Framework have been refreshed to ensure reliable tracking of progress on culture and inclusion. This work will be iterative and in time, this will be supplemented by a Quality Dashboard incorporating Staff Experience indicators.

6.4 Compassionate Leadership

Compassionate Leadership is embedded in our leadership and management development programmes. The next priority is to evaluate impact and roll out engagement sessions for all staff, creating a culture where compassionate principles underpin every interaction. Opportunities for bite-sized learning will also be explored as part of the IMTP for 2025/26.

6.5 Wellbeing

The Advisory Review of the Trust's Wellbeing provision provided a valuable checkpoint for further development. Recommendations will shape the 2026–27 action plan, aligned with cultural priorities outlined in section 2.2.

6.6 Staff Networks

Staff Networks have matured significantly and are now positioned to take meaningful action to improve working lives for underrepresented groups.

6.7 Staff Engagement

The Staff Engagement Framework has been introduced to create a joined-up approach to Employee Voice, ensuring purposeful messaging and meaningful dialogue. The Speaking Up Safely mechanism will only operate effectively within a climate of trust, which remains a key focus.

6.8 Culture as the Foundation

Culture is the thread that connects all aspects of this work. Building a positive culture—where employees experience trust, feeling safe to speak up, inclusion, and engagement—is essential to achieving the high performance we aspire to. This has been a central focus for the Board moving forward.

7. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)												
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:												
Choose an item												
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐												
RELATED STRATEGIC RISK - BOARD ASSURANCE FRAMEWORK (BAF) <i>For more information: <u>STRATEGIC RISK DESCRIPTIONS</u></i>	Choose an item Risk 06 – Organisational Culture											
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below											
	<table> <tr> <td>Safe</td> <td>☒</td> </tr> <tr> <td>Timely</td> <td>☐</td> </tr> <tr> <td>Effective</td> <td>☒</td> </tr> <tr> <td>Equitable</td> <td>☐</td> </tr> <tr> <td>Efficient</td> <td>☐</td> </tr> <tr> <td>Patient Centred</td> <td>☐</td> </tr> </table>	Safe	☒	Timely	☐	Effective	☒	Equitable	☐	Efficient	☐	Patient Centred
Safe	☒											
Timely	☐											
Effective	☒											
Equitable	☐											
Efficient	☐											
Patient Centred	☐											

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). <i>[Please include narrative to explain the selected domain in no more than 3 succinct points].</i> Click or tap here to enter text
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Health and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.</i>	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: <i>For more information: https://www.gov.wales/socio-economic-duty-overview</i>	Not required Click or tap here to enter text. Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals:	

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.asp <u>x</u>	Not required - please outline why this is not required
	<i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i>
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	<i>[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].</i>

8. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	As described in Board Assurance Framework Risk 06.
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Creating a positive working environment, which is characterised by effective values and behaviours, systems and processes, to enable the Trust to meet or exceed service expectations.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	31.3.27
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Moments that matter

Progressing our Journey to Excellence



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

What have we already done

Reflecting our Board discussions to date

Framework for Our Board Development:

Strategy – defining long term direction and impact

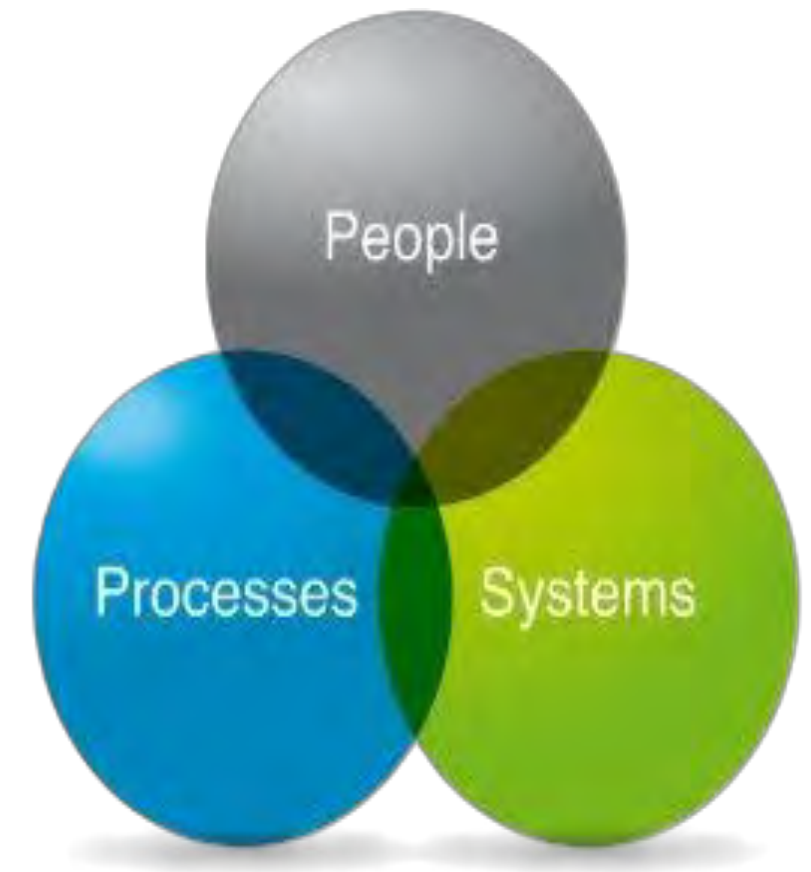
Culture – defining the organisation's working environment

Assurance/Governance – ensuring assurance, transparency and effective decision making



Where are we now?

Do we have a high performing culture



A High Performing Culture is characterised by:

- **A Clear Vision**
- **Shared Goals**
- **Strong Leadership**
- **Continuous Improvement**

Creating an environment where employees are engaged and aligned with organisation values

Our Culture - the “To Be”

Our People Strategy commitment:



Healthy and Engaged People: we want to cultivate a culture of compassion, inclusion and wellbeing.

We focus on the following:
Wellbeing

Supply and Shape

Education and Learning

Leadership and Succession

Digital Ready

Workforce Attraction and Retention

Moments that matter

What is important for our staff?



Achievements to date

What have we done so far?

- Engagement and Re-design of Trust Values
- Sickness Absence Review & Development of a Staff Wellbeing Service
- Implementing Avoidable Employee Harm principles
- Development of Attraction campaigns and branding
- Roll out of NHS Wales Staff Survey and continued above average Trust engagement
- People Development Steering Group - Focus on Shape & Supply of our workforce
- Healthy & Engaged Steering Group work programme – Focus on Culture & Inclusion

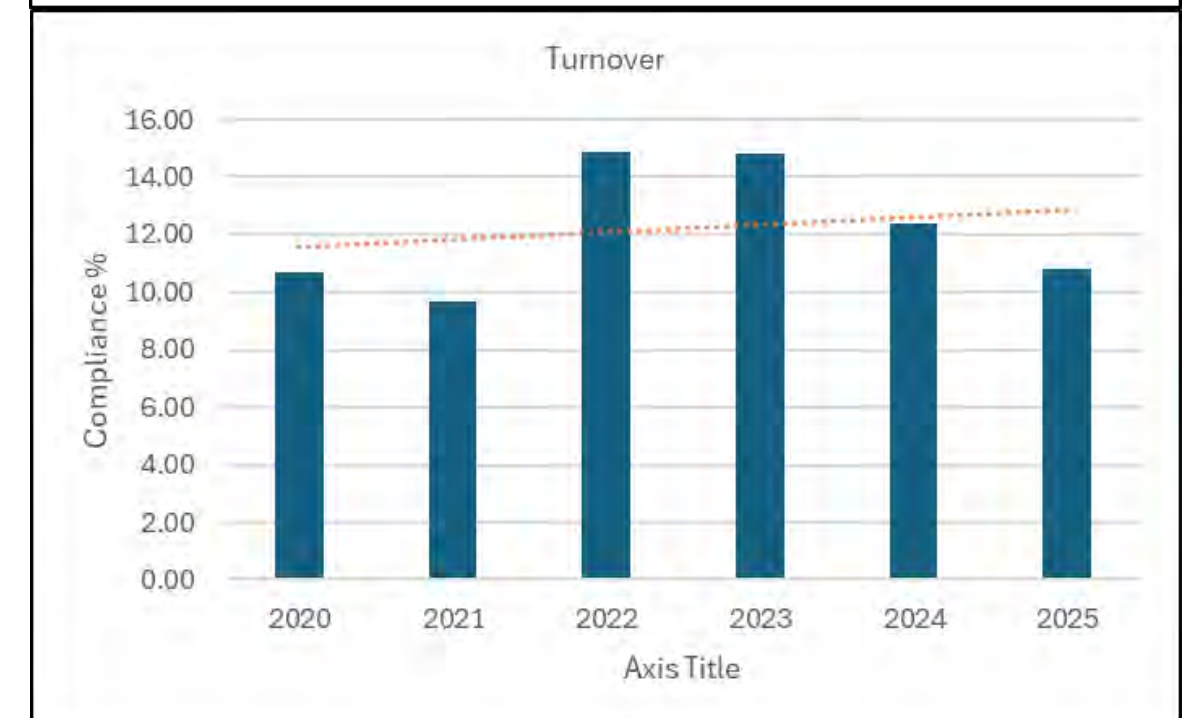
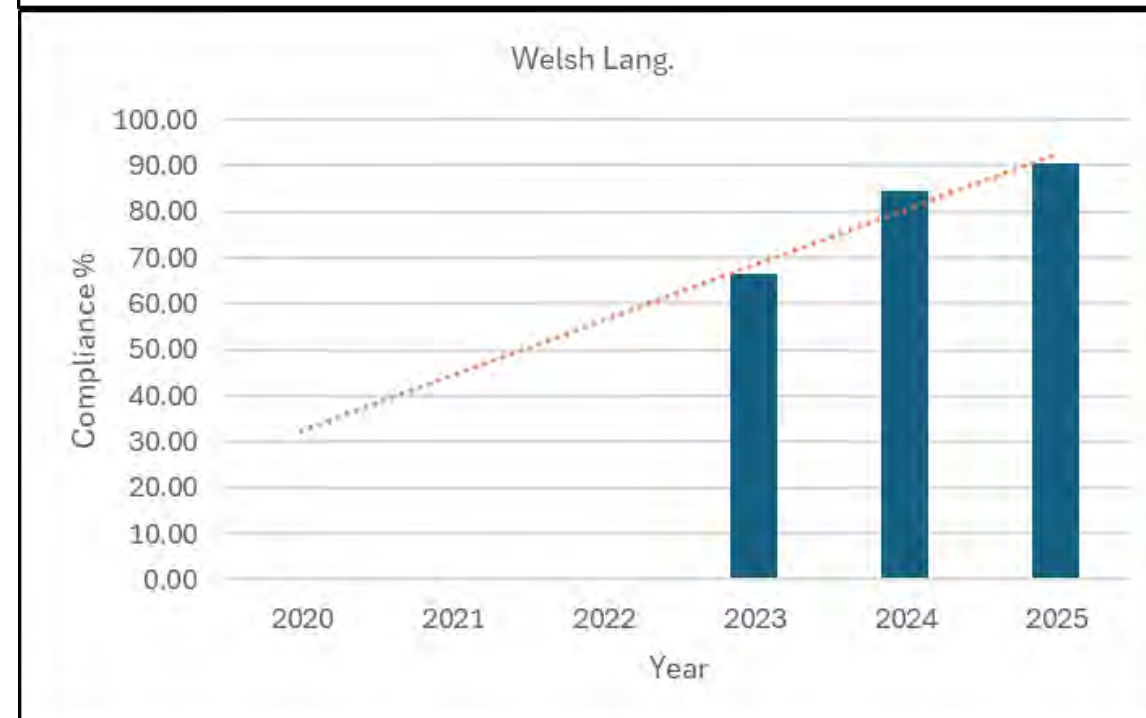
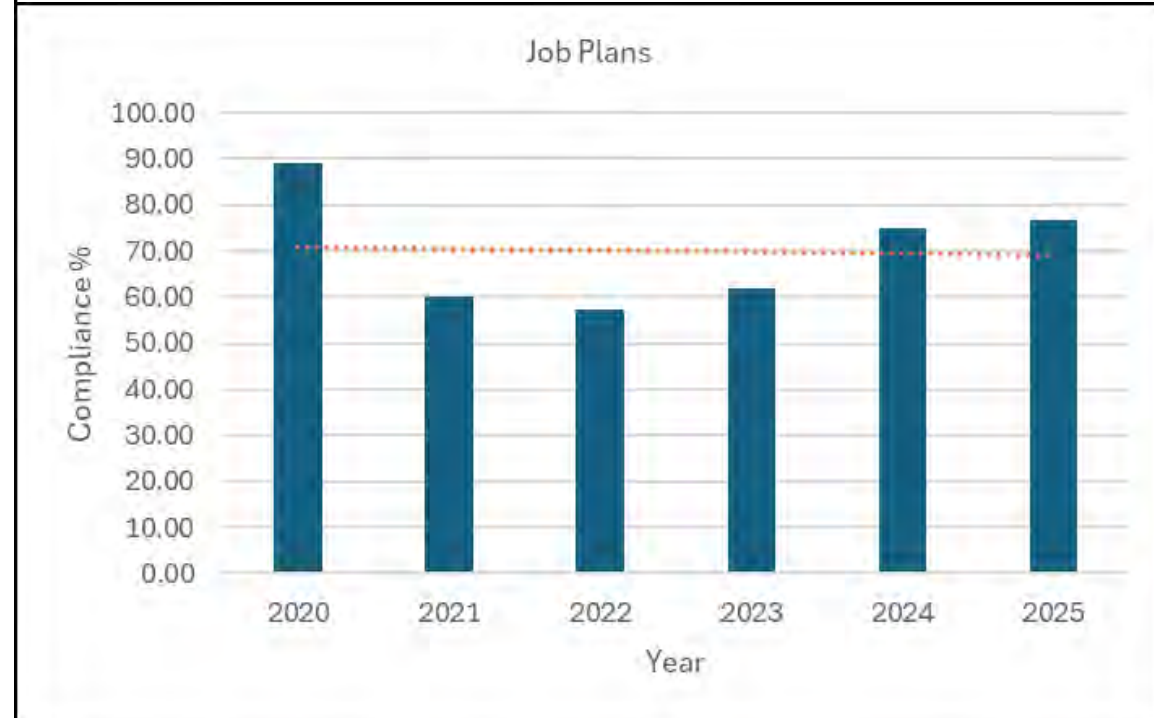
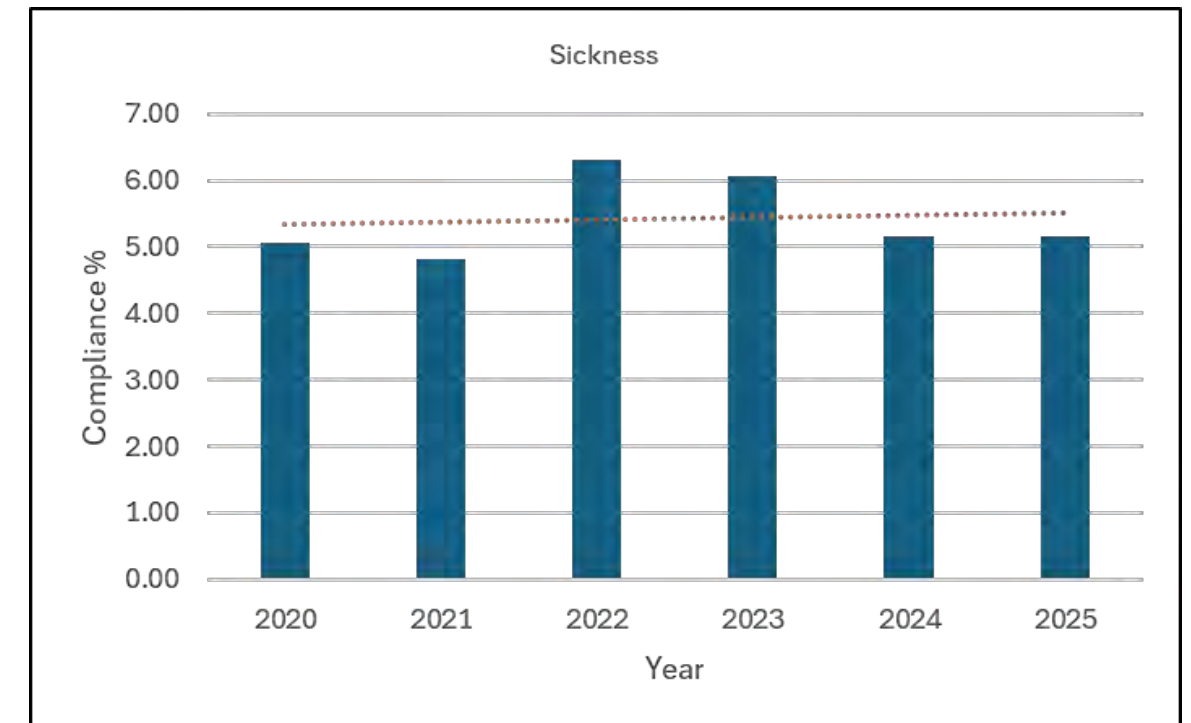
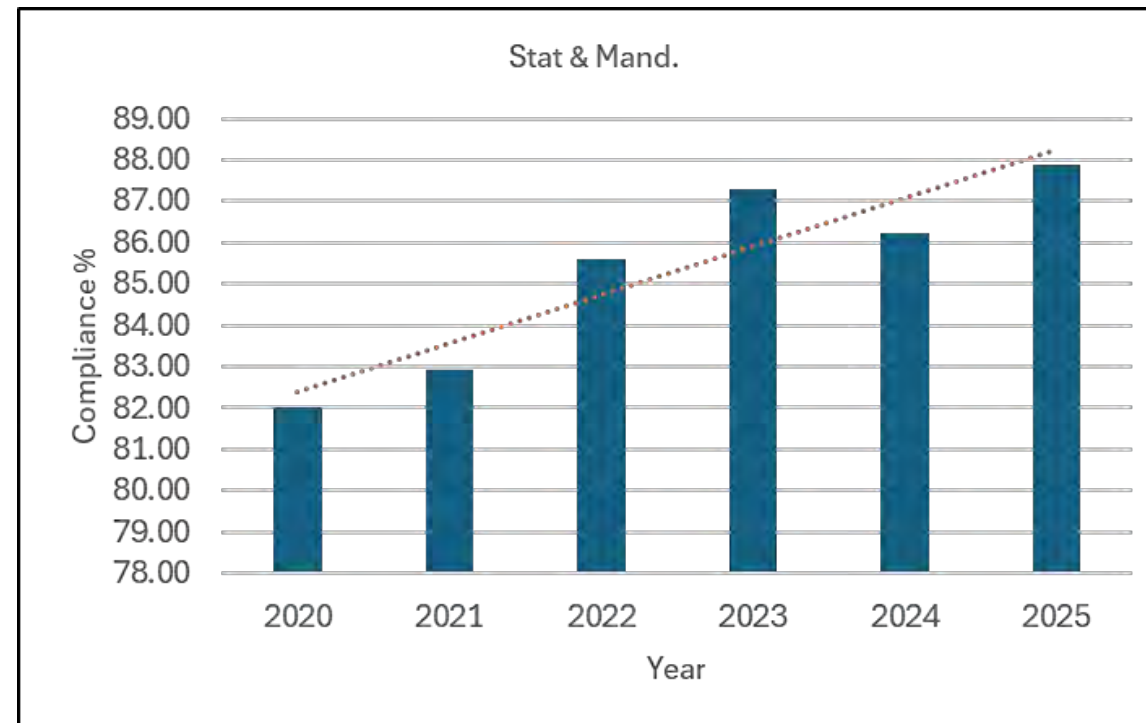
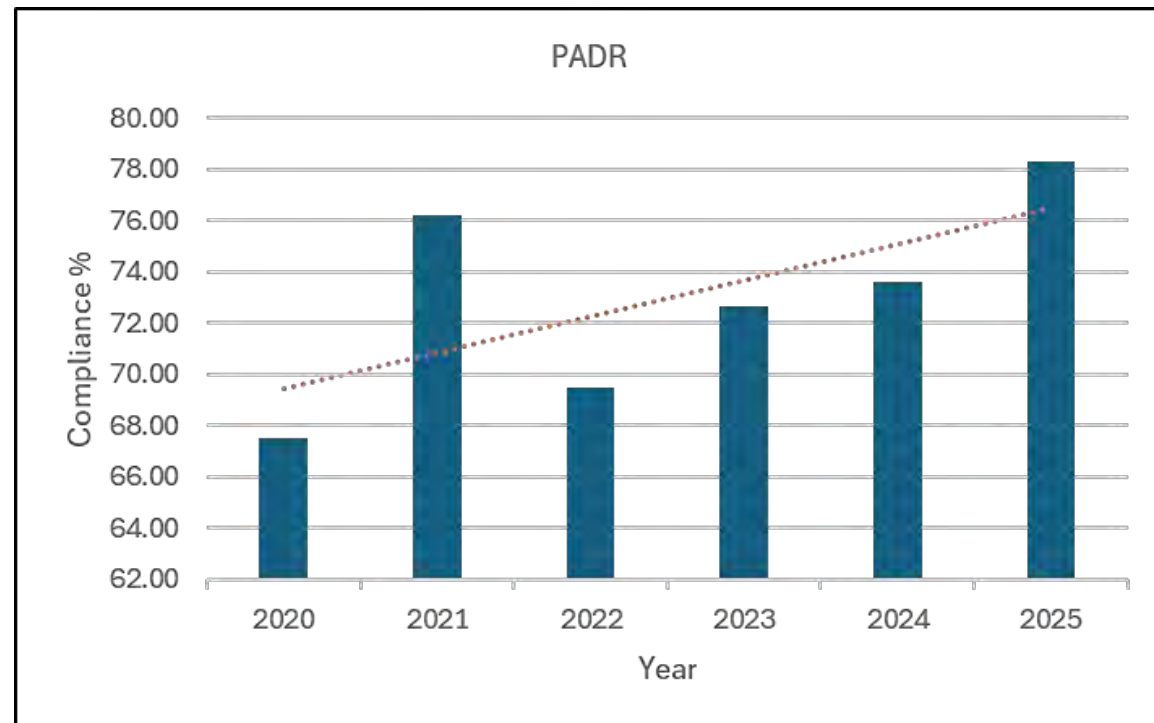
The current position

A workforce metrics heatmap

	PADR	Stat and Mand	Sickness Absence	Job Plans	Welsh Language	Turnover
Velindre University NHS Trust	81.05	87.83	5.14	67.07	91.32	9.82
Corporate Services	73.95	85.66	4.3	NA	93.36	11.68
Research Development and Innovation	66.67	89.29	4.36	NA	95.71	13.64
Transforming Cancer Services	41.67	83.75	2.66	NA	81.25	6.9
Velindre Cancer Service	82.82	85.97	5.14	65.38	88.2	7.94
Welsh Blood Service	86.09	93.25	5.89	100	97.19	12.54

The changing position

A five-year review of workforce metrics



Employer brand

How people see the Trust



What We Do Well

People see us a place to work	Glassdoor score of 4 stars and 75% of people recommending us a place to work, we have comparable scores to companies such as IBM, Admiral and Google.
We fill most roles	The conversation rates for posts advertised in the Trust are 75% compared to a labour market average of just 36%
Our vacancy rates remain low	Comparing our vacancy rates to other NHS organisations in Wales we see the highest rates are 8-11% whereas the Trust is consistently around 4-5%
We have a Social Media presence	Social media plays a crucial role in developing an employer brand today and we have spent time over the last 12 months, building a strong social media recruitment practices.

What We Can Improve

- Help people understand who we are
- Recruitment prioritisation
- Targeted attraction activity

"I didn't know Welsh Blood Service was part of Velindre"

"I have no idea there were so many different types of jobs available"



Feeling motivated in work

How people connect to our purpose



What We Do Well

People are engaged	The Trust's 2024 Staff Survey Engagement Index Score of 76.5% is higher than the NHS Wales average of 72%
People are proud of where they work and the care provided to patients and donors	84.3% of people in the 2024 Staff Survey noted they are proud to tell people where they work. This is almost 10% higher than the NHS Wales average of 74.6% Equally 84.5% of staff noted that if a family member or friend received care from the Trust they would be happy with the standards provided, compared to the NHS Wales average of just 58.1%
People feel trusted to do their job	89% of people in the NHS Wales Staff Survey confirmed they feel trusted to do their job.

What We Can Improve

- Help people understand how they are contributing
- Develop compassionate leaders

“My team doesn’t support patients, we work with blood donors. I’m not sure how we link together as a Trust really.”

I do not feel valued by management, feels like the more you can do the more you get 'used' - they don't listen, rarely communicate and only contact you when there's a problem, with the emphasis on blaming someone else

“I am very proud of the organisation I work for. I love my job”

“We receive very positive feedback from patients and families which makes even difficult days worthwhile”

Being Part of The Team

How people connect with each other

What We Do Well

	"I am very happy to be a member of the team; we have a great team and I always feel valued by my colleagues and manager"
	"I fee; valued as a member of my team. I am fortunate to have managers who listen and a caring team"
We have good team working	75.2% of respondents in the Staff Survey felt there was positive or extremally positive relationships within teams compared to 74.8% in NHS Wales.

What We Can Improve

	"There is never time for reflection, team meetings or team building"
Management connection to staff	"I don't feel valued or empowered to make and be involved in decisions that affect me and my role"
	In all staff survey questions relating to management relationships with staff the Trust scored below the NHS Wales average.
	Managers providing clear feedback scored 68.4% compared to 72.7% in Wales.
	Managers involving staff in decision making scored 63.9% compared to 68.6% in Wales.



Being Part of The Team

How people connect with each other

What We Do Well

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Management connection to staff	In all staff survey questions relating to management relationships with staff the Trust scored below the NHS Wales average. Managers providing clear feedback scored 68.4% compared to 72.7% in Wales. Managers involving staff in decision making scored 63.9% compared to 68.6% in Wales.



Having a chance to grow

How people develop and innovate

What We Do Well

Statutory and Mandatory	Statutory and mandatory training remains above the target and has done so for over 5 years.
Strategic intention	The Trust's People Strategy clearly maps out the intention to have a highly skilled and developed workforce with a comprehensive action plan aligned to the strategy.
Educational opportunities	2% of staff currently engaged in further development and higher educational, aligned with the national labour market averages of 2%.

What We Can Improve

- Continuous learning was ranked one of the lowest scores in our 2024 Staff Survey at 70% compared to NHS Wales at 72%.
- On the face of it we have several excellent metrics related to personal development, but this doesn't correlate with the reality of people's experience.

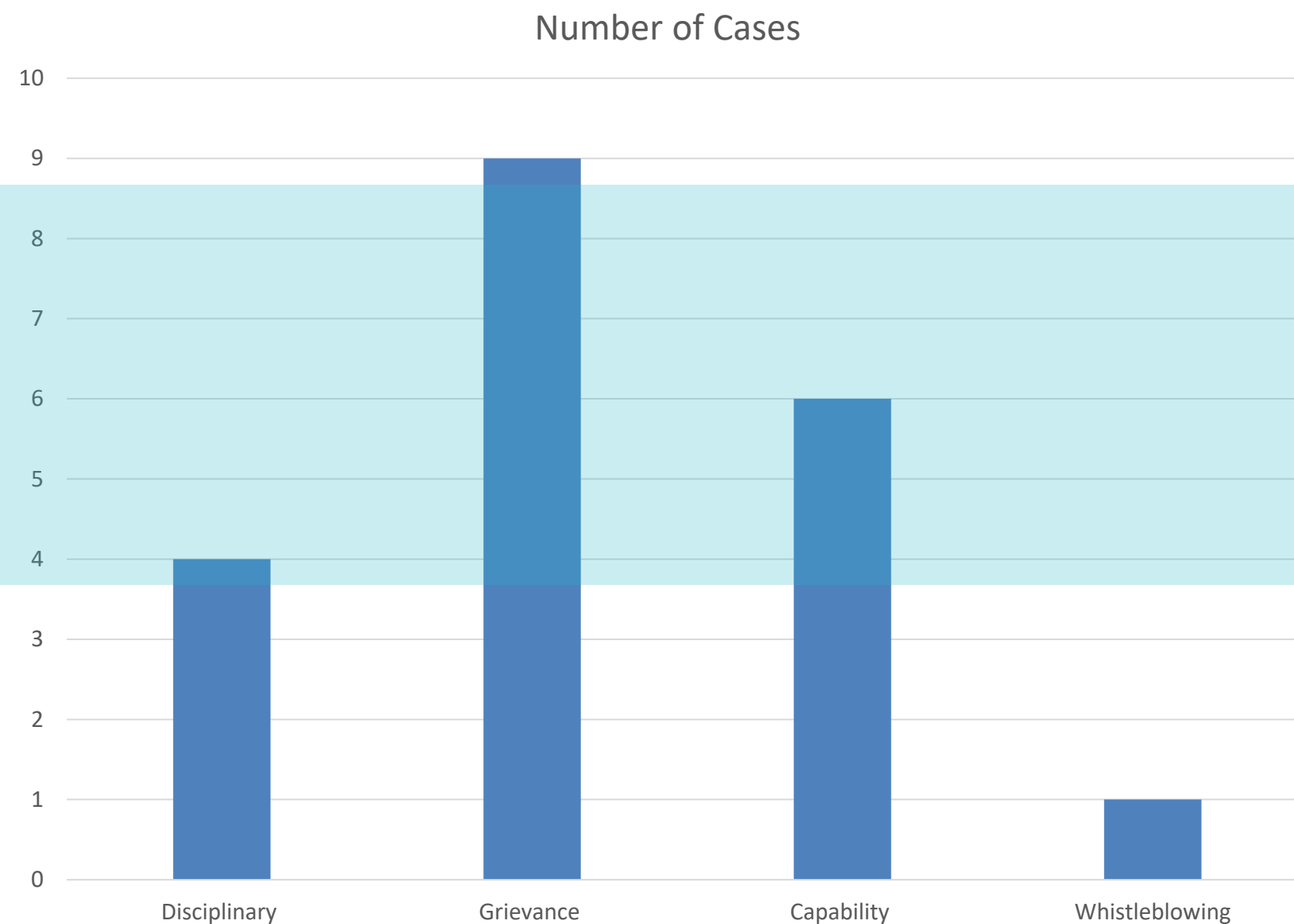
"I have received no formal training for my role, PADR's don't exist and career development is impossible"

"I felt that advancing in my professional development was made extremely difficult in the role I'm leaving"



Employee Relations Landscape

Are we tackling the tough conversations?



When we look at the number of Employee Relations Cases live within the Trust, this is less than 1% of the total employee headcount.

Leadership Matters

How we all take leadership in this space

**Leaders create culture.
Culture drives behaviour.
Behaviour produces results.**

Areas of Opportunity

What is the baseline telling us we need to improve?

- 1. Trust/Speaking up Safely**
- 2. We need to listen to understand and then act**
- 3. Compassionate Leadership**
- 4. Empower our staff to focus on improvement**
- 5. Our assurance needs improving**
- 6. Too many priorities**

Culture & Leadership

What we will do

Commission a Culture & Leadership partner to support us

- To review our discovery baseline and identify if we need to do more
- To help us define what good looks like
- To shape a programme of work to get us there

Set up a *Culture & Leadership Forum*

- To co-create the work with our colleagues across the organisation
- To help us see the big picture and ensure we create the environment under which our people can flourish (taking us from good to great)
- To help us stay on track and oversee the programme of work
- Provide leadership and champion the work to ensure embedding
- To set the tone for our future, this will include colleagues from our future leaders and won't look like our usual Steering Groups
- Include key partners for engagement to help embed



TRUST BOARD	
NHS Staff Survey 2025	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Budgen, Organisational Development Specialist
PRESENTED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
APPROVED BY	Sarah Jenkins, Executive Director of People and Organisational Development (Interim)
EXECUTIVE SUMMARY	The Trust increased its response rate to the 2025 NHS Staff Survey and saw a slight drop in the Employee Engagement Index. Key issues to be addressed are the climate around healthy working environment, flexible working and learning and improving. Response to these findings will be channelled through the Culture and Leadership programme in 2026 which will complement the work of the Trust's Staff Survey group.
RECOMMENDATION / ACTIONS	To note the findings and maintain support for the Culture and Leadership programme.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	13.3.26
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
EMB supported the paper and set out a desire to have one plan, one focus and one team working together to improve staff experience. This would be sited within the culture and leadership programme currently being commissioned. EMB endorsed five topics for focus in 2026: • Team Time • Psychological Safety • Healthy Working Environment • Access to Flexible Working • Options for Learning and Improving. They committed to running an Ask Me Anything open session in April 2026 to share the report with staff. They set a target response rate in 2026 of above 50%.	
7 LEVELS OF ASSURANCE	
Item for Information/Noting and not for Assurance.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance
APPENDICES	
1	Velindre NHS Staff Survey Report 2025
2	Comparison of respondents with workforce profile (contained within this document)

1. SITUATION

- 1.1 The third annual NHS Wales Staff Survey was undertaken in October to November 2025. The Trust's standard report is attached at Appendix 1. Further insights contained in this paper are from the on-line Dashboard which works alongside standard reporting.
- 1.2 In terms of benchmarking, the NHS Staff Survey uses NHS Wales figures for Response Rate and Staff Engagement Index. The remaining data, including themes and individual questions, uses a benchmarking group of Health Board results. This follows a request from the Trust to be moved from the benchmarking group of Trusts/Authorities to the Health Board group as this more closely matches the activities of our staff. For clarity, the VUNHST Staff Survey report does not include results for NHS Wales Shared Services Partnership.

2. RESULTS

- 2.1 The Trust achieved a **response rate** of 41.3%, which is 807 people. This was 188 more people than in 2024 and the rate is higher than the NHS Wales Response Rate of 30%.

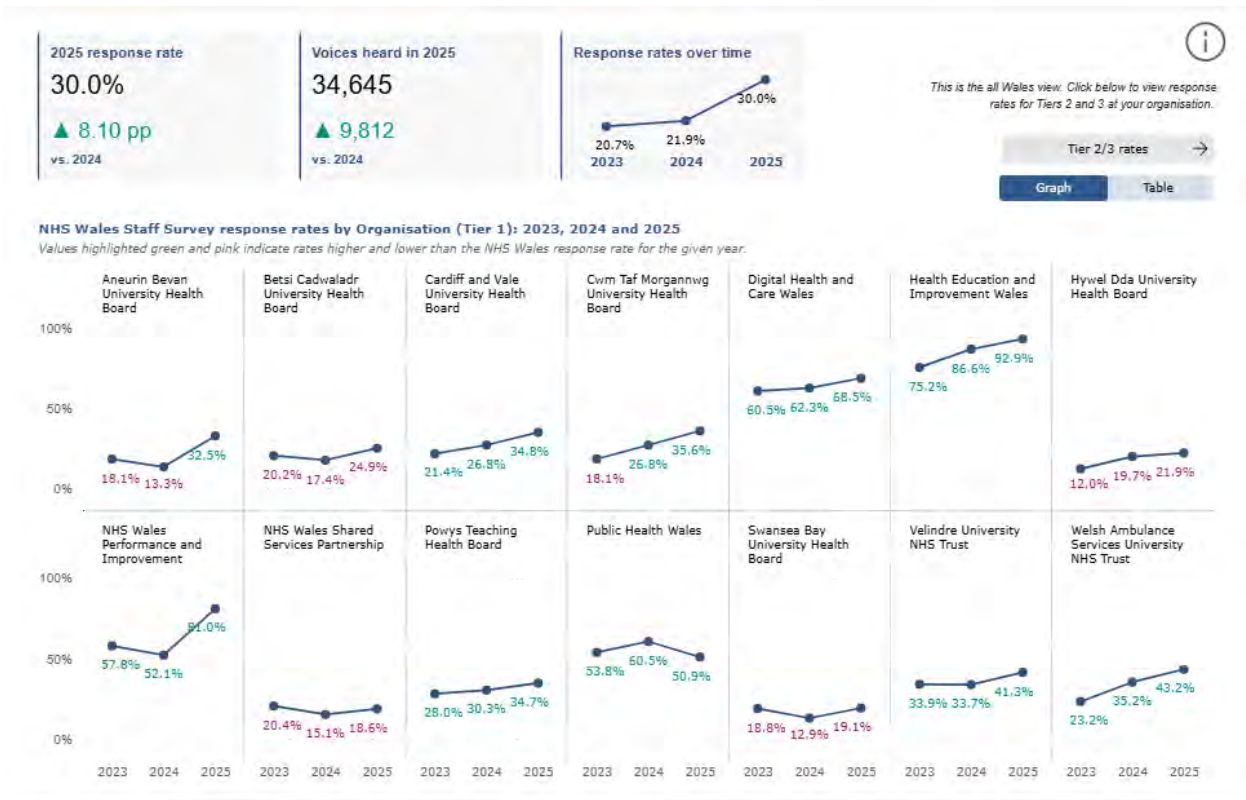


Figure 1 – VUNHST response rate compared with other NHS Wales organisations

2.2 The Trust's **Staff Engagement Index** was 75.7%, which was higher than the NHS Wales average of 70.8%. However, this has declined by 0.8 percentage points since 2024.



Figure 2 – VUNHST Staff Engagement Index compared with other NHS Wales organisations

2.3 All three elements of the Staff Engagement Index, *Contribution, Engagement and Advocacy*, declined marginally in the Trust. The constituent questions showed that staff were more likely to be happy to go the extra mile and to be proud to work for the Trust but less likely to be involved in changes or to look forward to going to work.

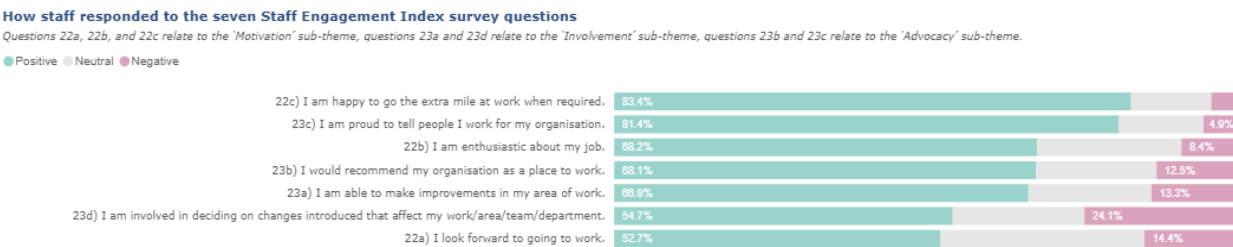


Figure 3 – VUNHST responses to Staff Engagement Index questions

2.4 The Trust scored over the average for all ten themes compared with Health Boards.

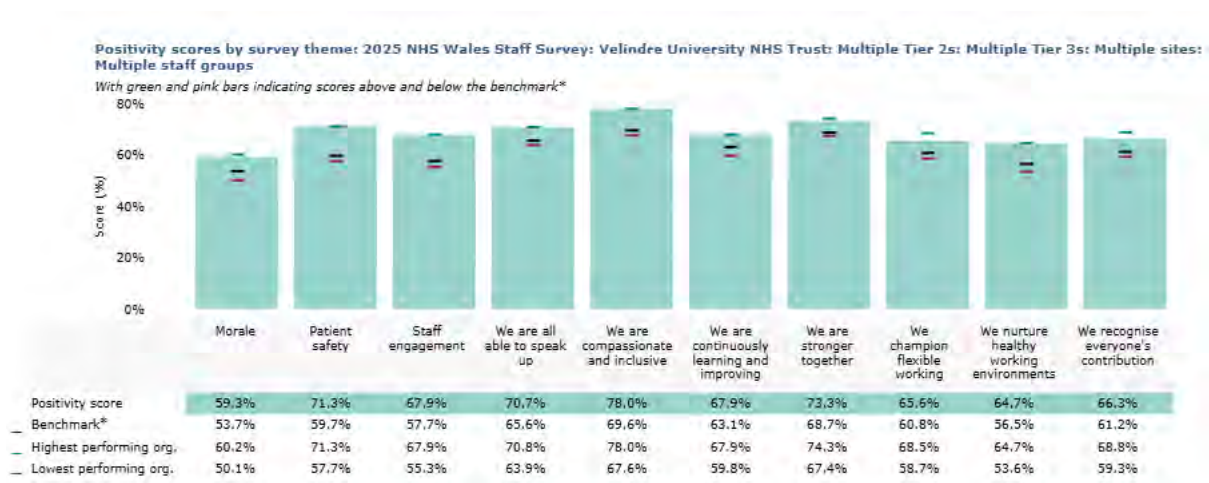


Figure 4 – VUNHST results by theme

2.5 When ranked in order, the strongest theme for VUNHST is Compassionate and Inclusive and the weakest is Morale.

Theme	Positivity score	Benchmark	Variance
We are compassionate and inclusive	78.0%	69.6%	▲ 8.37 pp
We are stronger together	73.3%	68.7%	▲ 4.55 pp
Patient safety	71.3%	59.7%	▲ 11.55 pp
We are all able to speak up	70.7%	65.6%	▲ 5.16 pp
We are continuously learning and improving	67.9%	63.1%	▲ 4.76 pp
Staff engagement	67.9%	57.7%	▲ 10.19 pp
We recognise everyone's contribution	66.3%	61.2%	▲ 5.04 pp
We champion flexible working	65.6%	60.8%	▲ 4.79 pp
We nurture healthy working environments	64.7%	56.5%	▲ 8.14 pp
Morale	59.3%	53.7%	▲ 5.62 pp

Figure 5 – Positivity scores by theme 2025

2.6 The top three Negativity scores, which reflect active dissatisfaction, are *We are continuously learning and improving*, *We champion flexible working* and *Morale*. This highlights Learning and improving as an area for attention, which was not clear when looking at the Positivity scores.

Theme	Negativity score	Benchmark	Variance
We are continuously learning and improving	18.3% 	21.5%	▼ -3.20 pp
We champion flexible working	18.2% 	19.1%	▼ -0.94 pp
Morale	17.8% 	21.5%	▼ -3.71 pp
We nurture healthy working environments	15.9% 	22.6%	▼ -6.78 pp
We recognise everyone's contribution	13.8% 	16.5%	▼ -2.69 pp
We are stronger together	13.1% 	15.4%	▼ -2.30 pp
We are all able to speak up	12.6% 	15.8%	▼ -3.23 pp
Staff engagement	11.6% 	16.2%	▼ -4.62 pp
Patient safety	10.1% 	15.1%	▼ -5.04 pp
We are compassionate and inclusive	8.7% 	12.3%	▼ -3.61 pp

Figure 6 – Negativity scores by theme 2025

2.7 All ten themes reflect a stable picture in the results over the past three years.

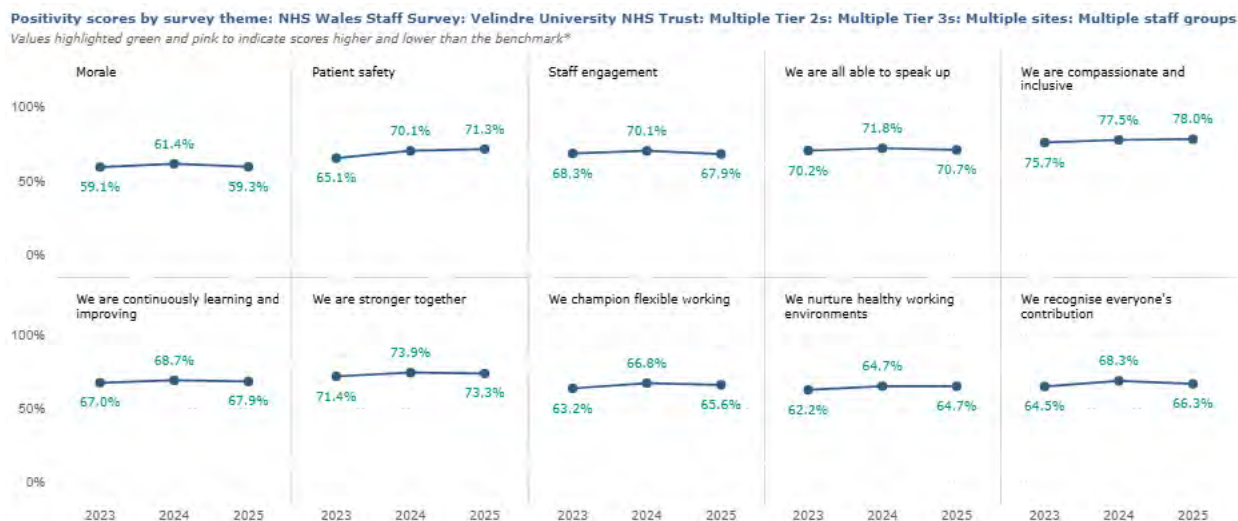


Figure 7 – VUNHST changes in themes over time

3. RESULTS IN CONTEXT OF VUNHST

3.1 To ensure our People and OD metrics show a breadth of data to help us better understand, we have now included some key staff survey results (6 measures) into the Performance Management Framework. The progression in these is shown below. Only two scores are below the average which shows we have relatively strong positivity across all themes in each Division, relative to Health Boards.

	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*

Green is higher than benchmark, pink is lower
Health Board Benchmark shown by *

Figure 8 – Performance Management Framework NHS Staff Survey metrics

- 3.2 Last year, three themes, *PADR*, *Team Time* and *Psychological Safety*, were chosen from the 2024 results to focus efforts at Trust and Divisional levels on common aims. The results specific to these are:

	2024	2025	Commentary
PADR	73.1%	76.9%	Improved by 3.8 percentage points.
We are stronger together	73.9%	73.3%	Declined by 0.6 percentage points.
Psychological safety - We are able to speak up - Compassionate leadership - Negative experiences	71.8% 73.7% 93.1%	70.7% 72.5% 92.2%	The three measures that most closely reflect perceptions of psychological safety all show a decline between 2024 and 2025.

- 3.3 Appendix 2, contained within this document, shows the demographic breakdown of respondents and the workforce. The categories in the Staff Survey are not

identical to those in ESR however some key statistics from this are:

- Gender - 66.3% reported female compared with 74.6% of the workforce. However, just 22.4% reported male, with the 10.6% saying prefer not to say and fewer than 10 people in each category for non-binary or self-describe.
- Sexual orientation – 79.8% heterosexual, 10.8% prefer not to say, 4.3% bisexual, 2.4% gay or lesbian, 1.4% each for asexual and self-describe. This is broadly comparable to the workforce as a whole, where 83.2% record themselves as heterosexual.
- Age - largest group 51-65 at 31.8%. Prefer not to say 11.3%
- Ethnic origin – 80.2% of responses coded to White categories and 10.2% prefer not to say. This compares with 88.13% of the workforce reporting themselves as White.
- Religion – no religion, 33.3% Christian, 16% prefer not to say, 1.6% self-describe and 5 categories of fewer than 10 responses. The workforce profile has different categories and the largest three are Christianity 38.58%, Atheism 26.92% and I do not wish to disclose at 15.21%.
- Disability – 73.7% said no, 11.3% prefer not to say and 14.9% yes. The workforce profile records 83.8% as no, 9.35% as prefer not to say/unspecified/not declared and 6.85% as yes.
- Neurodiversity – 77.6% of respondents recorded no, with 10.6% saying yes and 11.8% prefer not to say. This category is not reported from ESR.

3.4 These figures show the response to the survey was broadly in line with the workforce. The areas that show the greatest difference are:

- Gender – the response rates show that women are underrepresented in the survey although 10.6% of respondents chose Prefer not to say.
- Ethnic origin – it is possible that the ethnic origin of respondents is broader than the composition of the workforce as White is 8 percentage points lower in the survey than in the workforce. However, this may be balanced by the 10.2% who said Prefer not to say.
- Disability – a higher proportion of respondents said they had a disability at 14.9% compared to the ESR figure of 6.85% although there are significant numbers opting for prefer not say/undeclared/unspecified in both the survey and ESR.

4. ASSESSMENT

- 4.1 This report is a snapshot of staff thoughts and feelings about their working lives taken between October and November 2025. The survey is a mirror on the experience of staff and results are a reflection of the context within which people have been working over the period in question. This is a dynamic space where culture change may be supporting progress whilst other issues also arise to impact negatively on staff experience. This is the reason for needing a systemic approach to improving organisational culture rather than a series of disparate projects addressing specific features of a poor culture.
- 4.2 Key messages from this Trust-level report are that the Trust is keeping pace with other NHS organisations in relation to participation in the survey and the Employee Engagement Index. We are above average in all ten themes for our benchmarking group of Health Boards. Allowing us to move to a comparison with other organisations in a clinical setting is important. This is more representative than simply our size. This puts the Trust in a strong position for making further improvements and enabling a positive culture.
- 4.3 There is a high degree of stability in the results over the past three years with no single area showing a dramatic change (despite the change of category of reporting). This is a positive result for demonstrating that things are not declining in the Trust significantly, but also opens the door for making practical changes that have a long-term impact over the next 12 months.
- 4.4 Morale is shown as the area of greatest dissatisfaction. Perceptions of morale are reflections of experience in the other themes and therefore need to be addressed through concrete actions in those other areas. Following on from Morale, the themes which emerge as requiring specific attention are *Nurturing healthy working environments*, *Flexible working* and *Learning and improving*, especially in Velindre Cancer Service.
- 4.5 Progress with the three topics highlighted for attention last year has been partial. *PADR* has seen a definite rise in satisfaction. It is recognised that new launching of the policy and documentation in April 2025 which was supported by a refreshed training module through the Fundamentals of Management programme has had a positive impact. This shows the benefit of having a defined project addressing a larger theme.
- 4.6 Improvements in relation to *Team Time* and *Psychological Safety* have been less obvious. These themes connect more to relationships, with more action taking place at local level, due to the nature of those topics. These should be items for continued focus in 2026-27. Indeed our Cultural Baseline already recognises the importance of this, as well as the feedback from staff around the management of change in VCS to introduce the new leadership structure.

5 SUMMARY OF MATTERS FOR CONSIDERATION

- 5.1 These results align with the report to the Trust Board in November 2025 on the Cultural Baseline. There are six themes from the Cultural Baseline that our staff have identified are important to them:
1. Trust/Speaking up Safely
 2. We need to listen to understand and then act
 3. Compassionate Leadership
 4. Empower our staff to focus on improvement
 5. Reduce our Priorities
 6. Reducing Bullying and Harassment
- 5.2 Connecting our Staff Survey results with these themes is important as a measure to understand the key priorities for our staff right now. This is what we need to focus on as part of our programme of work on Culture & Leadership and should be part of a framework for action in 2026-27. *Trust/Psychological Safety* remains something we need to improve upon. This work will build on the topics of *Team Time and Psychological Safety* which were chosen for focus in 2025-26.
- 5.3 In addition, directly from the results of the 2025 survey we need to consider actions to ***improve the healthy working environment, widening access to flexible working and developing options for learning and improving***, as our lowest results (recognising they all remain above benchmark).
- 5.4 The Velindre NHS Staff Survey group worked effectively in stimulating action planning in different areas of the Trust. From April 2026, the membership will be updated to reflect new organisational structures and will be an effective forum for disseminating results and engaging staff in creating improvements. Alongside this, the Culture and Leadership programme will be commissioned to give a Trust-wide approach to the five themes as noted in 5.1.

6 IMPACT ASSESSMENT

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

A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) For more information: STRATEGIC RISK DESCRIPTIONS	06 -Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☐
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: For more information: https://www.gov.wales/socio-economic-duty-overview	Not required
	Click or tap here to enter text. Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals:	

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required - please outline why this is not required
	This report is for information.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[

7 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Choose an item
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

Comparison of NHS Staff Survey Respondents Oct/Nov 2025 with Workforce Profile of 31 March 2025

Number and % of responses to the survey question: What best describes your gender?						
2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups						
	Number of responses*	% of responses		Gender	Headcount	%
Female	530	66.3%		Female	1,427	74.59
Male	179	22.4%		Male	486	25.41
Non-binary	<10			Grand Total	1,913	100.00
Prefer not to say	85	10.6%				
Prefer to self-describe (please specify)	<10					
Total	799	100.0%				
Number and % of responses to the survey question: Which of the following terms best describes your sexual orientation?						
2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups						
	Number of responses*	% of responses		Sexuality	Headcount	%
Asexual	11	1.4%		Bisexual	44	2.30
Bisexual	34	4.3%		Gay or Lesbian	53	2.77
Gay or lesbian	19	2.4%		Heterosexual or Straight	1,591	83.17
Heterosexual or Straight	637	79.8%		Not stated (person)	93	4.86
Prefer not to say	86	10.8%		Other sexual orier	4	0.21
Prefer to self-describe (please specify)	11	1.4%		Undecided	3	0.00
Total	798	100.0%		Unspecified	125	6.53
				Grand Total	1,913	100.00
Number and % of responses to the survey question: Age						
2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups						
	Number of responses*	% of responses		Age Band	Headcount	%
16 - 20	<10			<=20 Years	12	0.63
21 - 30	117	14.6%		21-25	129	6.74
31 - 40	159	19.8%		26-30	226	11.81
41 - 50	176	21.9%		31-35	225	11.76
51 - 65	256	31.8%		36-40	231	12.08
66+	<10			41-45	241	12.60
Prefer not to say	91	11.3%		46-50	200	10.45
Total	804	100.0%		51-55	245	12.81
				56-60	230	12.02
				61-65	142	7.42
				66-70	21	1.10
				>=71 Years	11	0.58
				Grand Total	1,913	100.00
Number and % of responses to the survey question: Which race or ethnicity best describes you?						
2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups						
	Number of responses*	% of responses		Ethnic Origin	Headcount	%
Another race or ethnicity - please identify	10	1.2%		Asian	65	3.40
Arabic	<10			Black	31	1.62
Asian / British Asian: Chinese	<10			Chinese	13	0.68
Asian / British Asian: Indian	10	1.2%		Mixed	20	1.05
Asian / British Asian: Other	<10			Not Stated	35	1.83
Asian / British Asian: Pakistani	<10			Other	16	0.84
Black / British Black: African	<10			Unspecified	47	2.46
Black / British Black: Caribbean	<10			White	1,686	88.13
Mixed Race: Asian & White	<10			Grand Total	1,913	100.00
Mixed Race: Black & White	<10					
Mixed Race: Other	25	3.1%				
Prefer not to say	82	10.2%				
White: British (British / English / Northern Irish / Scottish / Welsh)	611	76.1%				
White: European	33	4.1%				
Total	803	100.0%				

Number and % of responses to the survey question: What do you consider your religion to be?										Religious Belief	Headcount	%																																				
2025 NHS Wales Staff Survey: Velindre University NHS Trust: Multiple Tier 2s: Multiple Tier 3s: Multiple sites: Multiple staff groups										Atheism	515	26.92																																				
<table><tr><th></th><th>Number of responses*</th><th>% of responses</th></tr><tr><td>▲</td><td></td><td></td></tr><tr><td>Buddhist</td><td><10</td><td></td></tr><tr><td>Christian</td><td>267</td><td>33.3%</td></tr><tr><td>Hindu</td><td><10</td><td></td></tr><tr><td>Jewish</td><td><10</td><td></td></tr><tr><td>Muslim</td><td><10</td><td></td></tr><tr><td>No religion</td><td>384</td><td>47.9%</td></tr><tr><td>Prefer not to say</td><td>128</td><td>16.0%</td></tr><tr><td>Prefer to self-describe (please specify)</td><td>13</td><td>1.6%</td></tr><tr><td>Sikh</td><td><10</td><td></td></tr><tr><td>Total</td><td>801</td><td>100.0%</td></tr></table>											Number of responses*	% of responses	▲			Buddhist	<10		Christian	267	33.3%	Hindu	<10		Jewish	<10		Muslim	<10		No religion	384	47.9%	Prefer not to say	128	16.0%	Prefer to self-describe (please specify)	13	1.6%	Sikh	<10		Total	801	100.0%	Buddhism	4	0.21
	Number of responses*	% of responses																																														
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Sikh	<10																																															
Total	801	100.0%																																														
										Christianity	738	38.58																																				
										Hinduism	11	0.58																																				
										I do not wish to di	291	15.21																																				
										Islam	34	1.78																																				
										Jainism	-	0.00																																				
										Judaism	2	0.10																																				
										Other	190	9.93																																				
										Sikhism	-	0.00																																				
										Unspecified	128	6.69																																				
										Grand Total	1,913	100.00																																				

Contents of report

This report contains information on the results of the **2025 NHS Wales Staff Survey** for **Velindre University NHS Trust**, including:

1. Survey response rate
2. Staff Engagement Index score
3. Summary of results by theme and sub-theme
4. Question-level results
5. Information on respondents

For information

The 2025 NHS Wales Staff survey was open to all employees in NHS Wales for the 2 month period of 6th October to 1st December 2025. The survey is organised by 10 themes and 20 sub-themes.

Data source

The data presented in this report has been provided by IQVIA Inc., the organisation responsible for delivering the 2025, 2024 and 2023 NHS Wales Staff Surveys. The data is stored, and has been collected from, the Health Education and Improvement Wales (HEIW) data warehouse.

Methodology

To preserve the anonymity of survey respondents, the data in section 5 of this report has been suppressed for instances of less than 10 responses. For example, where less than 10 people with a particular characteristic completed a survey, the number and % of people completing a survey with this particular characteristic is not shown. Any blank responses to questions have also been excluded from the analysis.

Positivity and negativity scores have been calculated for each theme and sub-theme, and are based on the percentage of people that responded positively or negatively to each question included in each theme and sub-theme. To calculate the Staff Engagement Index score, responses to the 7 relevant questions were weighted based on their scale position from 1 to 5 (on a scale of strongly disagree to strongly agree, or Never to Always). The index score was then calculated as the average of: the weighted percentage scores for (i) questions 22a, 22b, and 22c, (ii) questions 23a and 23d, and (iii) questions 23b and 23c. The higher the staff engagement index score, the higher the proportion of people that responded positively to the questions. The Staff Engagement Index score therefore increases as the proportion of people responding positively to these seven questions increases.

For the purpose of benchmarking, organisations have been grouped and a separate NHS Wales organisational average has been calculated for 'Health Board' organisations and 'Trust/Authority' organisations. The NHS Wales organisational average reported in this document therefore relates to Health Board organisations. The organisations included in this benchmark group are: Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cardiff and Vale UHB, Cwm Taf Morgannwg UHB, Hywel Dda UHB, Powys Teaching HB, Swansea Bay UHB, and Velindre University NHS Trust.

Contact details: This report has been developed by the Data and Analytics Team at Health Education and Improvement Wales (HEIW). Please contact HEIW.ATeam@wales.nhs.uk with any queries or feedback.

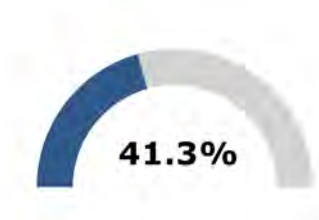


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Addysg a Gwellu Iechyd
Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

1. Survey response rate

807 staff employed at **Velindre University NHS Trust** completed the survey in 2025 (out of an eligible **1,955**). This equates to a response rate of **41.3%**. This is compared with the 30.0% overall NHS Wales response rate for 2025.



2. Staff Engagement Index score

Velindre University NHS Trust achieved a **Staff Engagement Index score of 75.7%** in 2025. This is compared with the 70.8% NHS Wales Staff Engagement Index score for 2025.



Table 1: Responses to Staff Engagement Index questions from the 2025 survey, where respondents were asked to rate their agreement with each statement on a scale from 1 to 5 (ranging from strongly disagree to strongly agree, or from never to always).

Sub-theme and question	Positive responses (%)	Benchmark	Variance	Negative responses (%)	Benchmark
Ability to contribute towards improvement at work (Involvement)					
23a) I am able to make improvements in my area of work.	66.9%	58.2%	▲ 8.63 pp	13.3%	16.9%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	54.7%	44.7%	▲ 9.91 pp	24.1%	29.5%
Intrinsic psychological engagement (Motivation)					
22a) I look forward to going to work.	52.7%	48.5%	▲ 4.20 pp	14.4%	17.4%
22b) I am enthusiastic about my job.	68.2%	64.1%	▲ 4.16 pp	8.4%	10.3%
22c) I am happy to go the extra mile at work when required.	83.4%	77.2%	▲ 6.24 pp	3.6%	5.8%
Staff Advocacy and recommendation (Advocacy)					
23b) I would recommend my organisation as a place to work.	68.1%	53.2%	▲ 14.89 pp	12.5%	19.2%
23c) I am proud to tell people I work for my organisation.	81.4%	58.0%	▲ 23.35 pp	4.9%	14.5%

3. Summary of results by theme and sub-theme

Table 2: Positivity scores by theme in 2025, ordered by positivity score highest to lowest, and compared with the NHS Wales average for Health Board organisations

Theme	Positivity score		Benchmark	Variance
We are compassionate and inclusive	78.0%		69.6%	▲ 8.37 pp
We are stronger together	73.3%		68.7%	▲ 4.55 pp
Patient safety	71.3%		59.7%	▲ 11.55 pp
We are all able to speak up	70.7%		65.6%	▲ 5.16 pp
We are continuously learning and improving	67.9%		63.1%	▲ 4.76 pp
Staff engagement	67.9%		57.7%	▲ 10.19 pp
We recognise everyone's contribution	66.3%		61.2%	▲ 5.04 pp
We champion flexible working	65.6%		60.8%	▲ 4.79 pp
We nurture healthy working environments	64.7%		56.5%	▲ 8.14 pp
Morale	59.3%		53.7%	▲ 5.62 pp

Table 3: Negativity scores by theme in 2025, ordered by negativity score highest to lowest, and compared with the NHS Wales average for Health Board organisations

Theme	Negativity score		Benchmark	Variance
We are continuously learning and improving	18.3%		21.5%	▼ -3.20 pp
We champion flexible working	18.2%		19.1%	▼ -0.94 pp
Morale	17.8%		21.5%	▼ -3.71 pp
We nurture healthy working environments	15.9%		22.6%	▼ -6.78 pp
We recognise everyone's contribution	13.8%		16.5%	▼ -2.69 pp
We are stronger together	13.1%		15.4%	▼ -2.30 pp
We are all able to speak up	12.6%		15.8%	▼ -3.23 pp
Staff engagement	11.6%		16.2%	▼ -4.62 pp
Patient safety	10.1%		15.1%	▼ -5.04 pp
We are compassionate and inclusive	8.7%		12.3%	▼ -3.61 pp

Table 4: Positivity scores by theme in 2025, 2024 and 2023, compared with the NHS Wales average for Health Board organisations

Theme	Year	Positivity score	Annual trend	Benchmark	Variance
Morale	2023	59.1%		54.1%	▲ 5.03 pp
	2024	61.4%	▲ 2.25 pp	54.6%	▲ 6.74 pp
	2025	59.3%	▼ -2.11 pp	53.7%	▲ 5.62 pp
Patient safety	2023	65.1%		53.8%	▲ 11.31 pp
	2024	70.1%	▲ 4.92 pp	58.7%	▲ 11.38 pp
	2025	71.3%	▲ 1.24 pp	59.7%	▲ 11.55 pp
Staff engagement	2023	68.3%		60.3%	▲ 7.98 pp
	2024	70.1%	▲ 1.74 pp	59.6%	▲ 10.49 pp
	2025	67.9%	▼ -2.16 pp	57.7%	▲ 10.19 pp
We are all able to speak up	2023	70.2%		65.8%	▲ 4.42 pp
	2024	71.8%	▲ 1.58 pp	66.2%	▲ 5.61 pp
	2025	70.7%	▼ -1.08 pp	65.6%	▲ 5.16 pp
We are compassionate and inclusive	2023	75.7%		69.6%	▲ 6.09 pp
	2024	77.5%	▲ 1.80 pp	70.0%	▲ 7.53 pp
	2025	78.0%	▲ 0.48 pp	69.6%	▲ 8.37 pp
We are continuously learning and improving	2023	67.0%		64.1%	▲ 2.89 pp
	2024	68.7%	▲ 1.66 pp	64.0%	▲ 4.71 pp
	2025	67.9%	▼ -0.76 pp	63.1%	▲ 4.76 pp
We are stronger together	2023	71.4%		68.5%	▲ 2.92 pp
	2024	73.9%	▲ 2.49 pp	69.2%	▲ 4.71 pp
	2025	73.3%	▼ -0.58 pp	68.7%	▲ 4.55 pp
We champion flexible working	2023	63.2%		58.1%	▲ 5.16 pp
	2024	66.8%	▲ 3.55 pp	61.5%	▲ 5.32 pp
	2025	65.6%	▼ -1.17 pp	60.8%	▲ 4.79 pp
We nurture healthy working environments	2023	62.2%		56.1%	▲ 6.09 pp
	2024	64.7%	▲ 2.55 pp	57.8%	▲ 6.95 pp
	2025	64.7%	▼ -0.10 pp	56.5%	▲ 8.14 pp
We recognise everyone's contribution	2023	64.5%		61.5%	▲ 2.97 pp
	2024	68.3%	▲ 3.83 pp	62.1%	▲ 6.19 pp
	2025	66.3%	▼ -2.04 pp	61.2%	▲ 5.04 pp

Table 5: Positivity scores by theme and sub-theme, compared with the NHS Wales average for Health Board organisations

Theme	Sub-theme	Year	Positivity score	Annual trend	Benchmark	Variance
Morale	Stressors	2023	60.4%		57.6%	▲ 2.81 pp
		2024	63.4%	▲ 3.03 pp	57.8%	▲ 5.66 pp
		2025	60.0%	▼ -3.44 pp	56.6%	▲ 3.41 pp
	Thinking about leaving	2023	58.2%		54.7%	▲ 3.51 pp
		2024	59.6%	▲ 1.43 pp	55.9%	▲ 3.75 pp
		2025	57.8%	▼ -1.81 pp	55.2%	▲ 2.61 pp
	Work pressure	2023	57.9%		46.4%	▲ 11.50 pp
		2024	59.6%	▲ 1.75 pp	46.7%	▲ 12.89 pp
		2025	59.8%	▲ 0.14 pp	45.7%	▲ 14.03 pp
Patient safety	No related sub-theme	2023	65.1%		53.8%	▲ 11.31 pp
		2024	70.1%	▲ 4.92 pp	58.7%	▲ 11.38 pp
		2025	71.3%	▲ 1.24 pp	59.7%	▲ 11.55 pp
Staff engagement	Ability to contribute towards improvement at work (Involvement)	2023	62.6%		56.3%	▲ 6.36 pp
		2024	63.4%	▲ 0.79 pp	53.9%	▲ 9.55 pp
		2025	60.8%	▼ -2.65 pp	51.5%	▲ 9.27 pp
	Intrinsic psychological engagement (Motivation)	2023	68.1%		65.5%	▲ 2.64 pp
		2024	70.1%	▲ 1.96 pp	64.7%	▲ 5.44 pp
		2025	68.1%	▼ -1.99 pp	63.2%	▲ 4.87 pp
	Staff Advocacy and recommendation (Advocacy)	2023	74.3%		56.7%	▲ 17.60 pp
		2024	76.7%	▲ 2.39 pp	57.7%	▲ 19.04 pp
		2025	74.8%	▼ -1.94 pp	55.6%	▲ 19.11 pp
We are all able to speak up	Autonomy and control	2023	74.4%		72.7%	▲ 1.71 pp
		2024	76.7%	▲ 2.29 pp	71.9%	▲ 4.73 pp
		2025	73.8%	▼ -2.90 pp	70.9%	▲ 2.83 pp
	Raising concerns	2023	66.1%		59.0%	▲ 7.13 pp
		2024	66.9%	▲ 0.84 pp	60.5%	▲ 6.48 pp
		2025	67.7%	▲ 0.76 pp	60.2%	▲ 7.48 pp
We are compassionate and inclusive	Compassionate culture	2023	79.3%		70.3%	▲ 8.98 pp
		2024	80.9%	▲ 1.56 pp	70.7%	▲ 10.20 pp
		2025	81.4%	▲ 0.50 pp	70.3%	▲ 11.02 pp
	Compassionate Leadership	2023	68.5%		66.7%	▲ 1.73 pp
		2024	73.7%	▲ 5.18 pp	68.7%	▲ 4.94 pp
		2025	72.5%	▼ -1.16 pp	68.2%	▲ 4.31 pp
	Diversity and Equality	2023	68.2%		62.6%	▲ 5.69 pp
		2024	69.3%	▲ 1.01 pp	64.1%	▲ 5.20 pp
		2025	71.0%	▲ 1.73 pp	63.1%	▲ 7.89 pp
	Inclusion	2023	74.6%		72.7%	▲ 1.90 pp
		2024	74.1%	▼ -0.53 pp	71.1%	▲ 2.94 pp
		2025	75.7%	▲ 1.64 pp	71.0%	▲ 4.72 pp

Theme	Sub-theme	Year	Positivity score	Annual trend	Benchmark	Variance
We are continuously learning and improving	Development	2023	63.4%		60.3%	▲ 3.06 pp
		2024	66.6%	▲ 3.15 pp	60.2%	▲ 6.40 pp
		2025	63.3%	▼ -3.21 pp	58.8%	▲ 4.52 pp
	PDR/Appraisal	2023	74.4%		72.0%	▲ 2.35 pp
		2024	73.1%	▼ -1.26 pp	71.6%	▲ 1.51 pp
		2025	76.9%	▲ 3.84 pp	71.9%	▲ 5.04 pp
We are stronger together	Line management	2023	68.1%		66.1%	▲ 1.97 pp
		2024	73.2%	▲ 5.14 pp	68.3%	▲ 4.92 pp
		2025	71.2%	▼ -1.96 pp	67.6%	▲ 3.67 pp
	Team working	2023	74.1%		70.4%	▲ 3.70 pp
		2024	74.4%	▲ 0.32 pp	69.9%	▲ 4.55 pp
		2025	75.0%	▲ 0.55 pp	69.7%	▲ 5.27 pp
We champion flexible working	Support for work-life balance	2023	63.2%		58.1%	▲ 5.16 pp
		2024	66.8%	▲ 3.55 pp	61.5%	▲ 5.32 pp
		2025	65.6%	▼ -1.17 pp	60.8%	▲ 4.79 pp
We nurture healthy working environments	Burnout	2023	32.1%		26.4%	▲ 5.68 pp
		2024	36.1%	▲ 4.02 pp	30.7%	▲ 5.44 pp
		2025	36.3%	▲ 0.24 pp	29.2%	▲ 7.18 pp
	Health and safety climate	2023	51.5%		42.3%	▲ 9.19 pp
		2024	53.7%	▲ 2.21 pp	43.3%	▲ 10.38 pp
		2025	54.6%	▲ 0.85 pp	42.0%	▲ 12.52 pp
	Negative experiences	2023	91.6%		86.9%	▲ 4.68 pp
		2024	93.1%	▲ 1.55 pp	87.0%	▲ 6.12 pp
		2025	92.2%	▼ -0.90 pp	85.9%	▲ 6.34 pp
We recognise everyone's contribution	No related sub-theme	2023	64.5%		61.5%	▲ 2.97 pp
		2024	68.3%	▲ 3.83 pp	62.1%	▲ 6.19 pp
		2025	66.3%	▼ -2.04 pp	61.2%	▲ 5.04 pp

4. Question-level results

Table 6: Percentage of respondents who answered positively and negatively to the core questions included in the 2025 survey, grouped by theme

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
Morale							
02a) I have unrealistic time pressures.	2023	32.5%		27.2%	▲ 5.27 pp	27.5%	33.1%
	2024	33.7%	▲ 1.26 pp	28.7%	▲ 5.04 pp	25.4%	30.1%
	2025	32.3%	▼ -1.37 pp	28.0%	▲ 4.32 pp	26.7%	32.0%
02b) I am able to meet all the conflicting demands on my time at work.	2023	54.7%		50.6%	▲ 4.16 pp	14.6%	15.8%
	2024	58.8%	▲ 4.07 pp	51.1%	▲ 7.73 pp	14.1%	15.4%
	2025	57.8%	▼ -1.04 pp	50.0%	▲ 7.76 pp	13.0%	15.8%
02c) I have adequate supplies, materials and equipment to do my work.	2023	78.1%		57.7%	▲ 20.40 pp	7.0%	15.2%
	2024	76.8%	▼ -1.27 pp	55.9%	▲ 20.92 pp	6.7%	17.5%
	2025	77.5%	▲ 0.66 pp	54.7%	▲ 22.79 pp	5.9%	17.6%
02d) There are enough staff at this organisation for me to do my job properly.	2023	40.8%		30.9%	▲ 9.91 pp	25.0%	37.0%
	2024	43.5%	▲ 2.68 pp	33.3%	▲ 10.19 pp	25.8%	34.8%
	2025	44.1%	▲ 0.64 pp	32.5%	▲ 11.55 pp	22.7%	35.7%
04a) My immediate manager (line manager) encourages me at work.	2023	71.2%		69.0%	▲ 2.25 pp	11.6%	13.6%
	2024	76.8%	▲ 5.60 pp	71.0%	▲ 5.85 pp	10.4%	12.9%
	2025	73.1%	▼ -3.76 pp	70.7%	▲ 2.34 pp	11.8%	12.8%
14a) I always know what my work responsibilities are.	2023	84.4%		81.6%	▲ 2.76 pp	7.9%	9.1%
	2024	83.4%	▼ -1.03 pp	81.6%	▲ 1.73 pp	8.6%	9.1%
	2025	82.2%	▼ -1.12 pp	82.4%	▼ -0.18 pp	9.4%	8.6%
14d) I have a choice in deciding how to do my work.	2023	64.6%		66.9%	▼ -2.31 pp	14.4%	14.2%
	2024	74.8%	▲ 10.20 pp	71.1%	▲ 3.62 pp	9.4%	12.9%
	2025	68.4%	▼ -6.31 pp	68.6%	▼ -0.18 pp	14.2%	13.7%
15f) Relationships at work are strained.	2023	48.9%		46.6%	▲ 2.32 pp	25.1%	27.1%
	2024	52.9%	▲ 3.98 pp	46.5%	▲ 6.40 pp	24.3%	28.1%
	2025	49.3%	▼ -3.68 pp	45.0%	▲ 4.26 pp	27.2%	29.5%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%		54.3%	▲ 6.58 pp	20.5%	24.6%
	2024	58.9%	▼ -1.95 pp	47.7%	▲ 11.25 pp	21.3%	28.0%
	2025	54.7%	▼ -4.27 pp	44.7%	▲ 9.91 pp	24.1%	29.5%
24a) I am satisfied in my current role and intend to remain in it for the foreseeable future.	2023	58.1%		56.6%	▲ 1.47 pp	18.2%	19.0%
	2024	57.0%	▼ -1.09 pp	56.5%	▲ 0.48 pp	19.8%	19.8%
	2025	56.9%	▼ -0.12 pp	56.8%	▲ 0.07 pp	18.7%	19.5%
24b) I often think about leaving this organisation.	2023	52.8%		47.0%	▲ 5.77 pp	26.3%	29.4%
	2024	52.8%	▲ 0.04 pp	47.7%	▲ 5.14 pp	25.9%	28.9%
	2025	50.7%	▼ -2.16 pp	46.8%	▲ 3.89 pp	26.0%	29.5%
24c) I will probably look for a job at a new organisation in the next 12 months.	2023	57.5%		53.7%	▲ 3.85 pp	20.9%	20.8%
	2024	59.0%	▲ 1.41 pp	55.7%	▲ 3.27 pp	20.4%	20.3%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
24c) I will probably look for a job at a new organisation in the next 12 months.	2025	57.7%	▼ -1.30 pp	55.3%	▲ 2.31 pp	17.9%	20.2%
24d) As soon as I can find another job, I will leave this organisation.	2023	64.4%		61.4%	▲ 2.95 pp	12.8%	14.7%
	2024	69.8%	▲ 5.37 pp	63.6%	▲ 6.11 pp	13.7%	14.4%
	2025	66.2%	▼ -3.59 pp	62.0%	▲ 4.16 pp	13.5%	15.0%
Patient safety							
13b) My organisation treats staff who are involved in an error, near miss or incident, fairly.	2023	54.4%		44.2%	▲ 10.15 pp	8.2%	11.4%
	2024	66.9%	▲ 12.48 pp	52.0%	▲ 14.85 pp	9.1%	14.1%
	2025	64.5%	▼ -2.35 pp	52.3%	▲ 12.18 pp	10.1%	14.4%
13c) My organisation encourages us to report errors, near misses or incidents.	2023	84.2%		74.0%	▲ 10.17 pp	3.9%	7.7%
	2024	86.0%	▲ 1.77 pp	75.9%	▲ 10.04 pp	5.5%	9.6%
	2025	87.8%	▲ 1.78 pp	76.5%	▲ 11.28 pp	3.6%	9.3%
13d) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	2023	68.2%		53.4%	▲ 14.86 pp	6.5%	12.0%
	2024	71.7%	▲ 3.43 pp	57.6%	▲ 14.10 pp	8.2%	14.9%
	2025	75.1%	▲ 3.47 pp	58.8%	▲ 16.32 pp	8.2%	14.6%
13e) We are given feedback about changes made in response to reported errors, near misses and incidents.	2023	53.7%		43.6%	▲ 10.08 pp	13.9%	20.1%
	2024	55.0%	▲ 1.30 pp	48.5%	▲ 6.49 pp	17.2%	23.2%
	2025	57.1%	▲ 2.12 pp	50.8%	▲ 6.34 pp	18.5%	22.2%
Staff engagement							
22a) I look forward to going to work.	2023	52.8%		49.7%	▲ 3.10 pp	11.8%	15.1%
	2024	56.2%	▲ 3.43 pp	50.4%	▲ 5.86 pp	13.5%	15.7%
	2025	52.7%	▼ -3.57 pp	48.5%	▲ 4.20 pp	14.4%	17.4%
22b) I am enthusiastic about my job.	2023	69.5%		66.7%	▲ 2.73 pp	6.0%	8.4%
	2024	69.8%	▲ 0.33 pp	65.3%	▲ 4.55 pp	8.1%	9.4%
	2025	68.2%	▼ -1.57 pp	64.1%	▲ 4.16 pp	8.4%	10.3%
22c) I am happy to go the extra mile at work when required.	2023	82.1%		80.0%	▲ 2.10 pp	2.8%	4.4%
	2024	84.3%	▲ 2.15 pp	78.4%	▲ 5.85 pp	2.3%	5.0%
	2025	83.4%	▼ -0.82 pp	77.2%	▲ 6.24 pp	3.6%	5.8%
23a) I am able to make improvements in my area of work.	2023	64.4%		58.3%	▲ 6.13 pp	13.5%	15.3%
	2024	67.9%	▲ 3.52 pp	60.1%	▲ 7.86 pp	11.3%	16.4%
	2025	66.9%	▼ -1.04 pp	58.2%	▲ 8.63 pp	13.3%	16.9%
23b) I would recommend my organisation as a place to work.	2023	65.4%		54.7%	▲ 10.76 pp	13.3%	17.7%
	2024	69.1%	▲ 3.67 pp	55.5%	▲ 13.57 pp	10.7%	17.8%
	2025	68.1%	▼ -0.99 pp	53.2%	▲ 14.89 pp	12.5%	19.2%
23c) I am proud to tell people I work for my organisation.	2023	83.2%		58.7%	▲ 24.44 pp	3.0%	12.9%
	2024	84.3%	▲ 1.16 pp	59.8%	▲ 24.53 pp	4.6%	13.7%
	2025	81.4%	▼ -2.92 pp	58.0%	▲ 23.35 pp	4.9%	14.5%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%		54.3%	▲ 6.58 pp	20.5%	24.6%
	2024	58.9%	▼ -1.95 pp	47.7%	▲ 11.25 pp	21.3%	28.0%
	2025	54.7%	▼ -4.27 pp	44.7%	▲ 9.91 pp	24.1%	29.5%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
We are all able to speak up							
14a) I always know what my work responsibilities are.	2023	84.4%		81.6%	▲ 2.76 pp	7.9%	9.1%
	2024	83.4%	▼ -1.03 pp	81.6%	▲ 1.73 pp	8.6%	9.1%
	2025	82.2%	▼ -1.12 pp	82.4%	▼ -0.18 pp	9.4%	8.6%
14b) I am trusted to do my job.	2023	86.1%		87.6%	▼ -1.50 pp	6.0%	5.1%
	2024	89.0%	▲ 2.87 pp	87.0%	▲ 1.99 pp	4.0%	5.7%
	2025	87.6%	▼ -1.45 pp	87.4%	▲ 0.21 pp	5.7%	5.5%
14c) There are frequent opportunities for me to show initiative in my role.	2023	76.0%		73.0%	▲ 3.01 pp	9.6%	11.3%
	2024	77.2%	▲ 1.26 pp	72.2%	▲ 5.02 pp	9.5%	12.3%
	2025	76.0%	▼ -1.26 pp	71.5%	▲ 4.49 pp	10.1%	12.2%
14d) I have a choice in deciding how to do my work.	2023	64.6%		66.9%	▼ -2.31 pp	14.4%	14.2%
	2024	74.8%	▲ 10.20 pp	71.1%	▲ 3.62 pp	9.4%	12.9%
	2025	68.4%	▼ -6.31 pp	68.6%	▼ -0.18 pp	14.2%	13.7%
14i) I would feel secure raising concerns about unsafe clinical practice.	2023	76.3%		73.6%	▲ 2.70 pp	6.3%	9.3%
	2024	77.0%	▲ 0.68 pp	74.2%	▲ 2.80 pp	6.2%	10.5%
	2025	77.5%	▲ 0.47 pp	74.8%	▲ 2.68 pp	6.0%	10.4%
14j) I would feel secure raising concerns about unethical behaviour.	2023	78.4%		76.4%	▲ 2.00 pp	9.8%	10.5%
	2024	78.5%	▲ 0.05 pp	74.9%	▲ 3.53 pp	9.5%	12.2%
	2025	77.4%	▼ -1.08 pp	75.0%	▲ 2.39 pp	8.9%	11.9%
14k) I am confident my organisation would address my concern.	2023	58.9%		50.6%	▲ 8.36 pp	16.3%	19.1%
	2024	58.0%	▼ -0.90 pp	52.5%	▲ 5.50 pp	16.1%	21.2%
	2025	58.2%	▲ 0.18 pp	52.2%	▲ 6.06 pp	15.2%	21.0%
17d) I feel safe to speak up about anything that concerns me in this organisation.	2023	64.2%		55.2%	▲ 9.05 pp	15.1%	19.7%
	2024	67.7%	▲ 3.48 pp	57.8%	▲ 9.87 pp	14.1%	19.5%
	2025	69.1%	▲ 1.39 pp	56.7%	▲ 12.34 pp	14.5%	19.7%
17e) If I spoke up about something that concerned me, I am confident my organisation would address my concern.	2023	52.6%		39.1%	▲ 13.54 pp	17.0%	24.8%
	2024	53.6%	▲ 1.02 pp	42.8%	▲ 10.80 pp	18.3%	25.5%
	2025	56.4%	▲ 2.71 pp	42.4%	▲ 13.99 pp	17.8%	26.1%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%		54.3%	▲ 6.58 pp	20.5%	24.6%
	2024	58.9%	▼ -1.95 pp	47.7%	▲ 11.25 pp	21.3%	28.0%
	2025	54.7%	▼ -4.27 pp	44.7%	▲ 9.91 pp	24.1%	29.5%
We are compassionate and inclusive							
01h) I feel valued by my team.	2023	69.6%		67.3%	▲ 2.35 pp	12.8%	16.3%
	2024	73.1%	▲ 3.49 pp	66.7%	▲ 6.47 pp	13.4%	17.8%
	2025	71.5%	▼ -1.68 pp	66.7%	▲ 4.80 pp	14.5%	17.2%
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.	2023	74.7%		74.7%	▼ -0.01 pp	11.1%	12.4%
	2024	78.1%	▲ 3.40 pp	72.6%	▲ 5.49 pp	10.6%	15.1%
	2025	76.8%	▼ -1.37 pp	72.1%	▲ 4.72 pp	12.2%	14.8%
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.	2023	68.2%		66.2%	▲ 2.04 pp	14.4%	15.2%
	2024	73.9%	▲ 5.62 pp	68.3%	▲ 5.54 pp	11.4%	14.7%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.	2025	71.8%	▼ -2.06 pp	67.9%	▲ 3.92 pp	14.8%	14.8%
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.	2023	70.2%		69.1%	▲ 1.05 pp	14.2%	14.4%
	2024	76.1%	▲ 5.96 pp	70.7%	▲ 5.39 pp	9.6%	14.7%
	2025	74.3%	▼ -1.89 pp	69.9%	▲ 4.36 pp	14.0%	14.5%
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.	2023	67.0%		64.9%	▲ 2.12 pp	14.6%	14.8%
	2024	71.0%	▲ 3.97 pp	67.1%	▲ 3.90 pp	12.3%	15.1%
	2025	71.4%	▲ 0.46 pp	66.8%	▲ 4.64 pp	12.8%	14.8%
14l) I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)	2023	68.2%		62.6%	▲ 5.69 pp	7.9%	10.9%
	2024	69.3%	▲ 1.01 pp	64.1%	▲ 5.20 pp	8.4%	11.6%
	2025	71.0%	▲ 1.73 pp	63.1%	▲ 7.89 pp	9.3%	11.8%
15c) The people I work with are understanding and kind to one another.	2023	76.1%		75.1%	▲ 1.07 pp	9.1%	9.2%
	2024	74.8%	▼ -1.34 pp	73.3%	▲ 1.46 pp	10.3%	10.3%
	2025	77.4%	▲ 2.62 pp	73.2%	▲ 4.20 pp	9.1%	10.2%
15d) The people I work with are polite and treat each other with respect.	2023	78.0%		75.8%	▲ 2.28 pp	8.1%	8.5%
	2024	74.3%	▼ -3.76 pp	73.4%	▲ 0.89 pp	10.4%	9.8%
	2025	78.3%	▲ 3.99 pp	73.1%	▲ 5.17 pp	9.3%	10.1%
16a) People here are compassionate towards colleagues when they face problems.	2023	79.5%		75.9%	▲ 3.59 pp	4.9%	7.8%
	2024	78.3%	▼ -1.13 pp	75.1%	▲ 3.26 pp	6.8%	8.8%
	2025	77.8%	▼ -0.53 pp	74.7%	▲ 3.15 pp	7.5%	9.2%
16b) People here give good support to colleagues who are distressed.	2023	79.8%		77.0%	▲ 2.80 pp	6.1%	7.8%
	2024	79.0%	▼ -0.87 pp	76.8%	▲ 2.17 pp	7.7%	8.6%
	2025	80.5%	▲ 1.52 pp	76.3%	▲ 4.13 pp	6.8%	8.7%
16c) People here are compassionate in the way they behave towards patients/ service users.	2023	86.1%		83.3%	▲ 2.81 pp	1.6%	2.8%
	2024	88.2%	▲ 2.02 pp	83.3%	▲ 4.88 pp	2.0%	4.0%
	2025	89.1%	▲ 0.90 pp	83.3%	▲ 5.74 pp	1.6%	4.0%
16d) People here take effective action to help patients/service users in distress.	2023	86.1%		82.9%	▲ 3.22 pp	1.1%	2.5%
	2024	87.4%	▲ 1.28 pp	83.0%	▲ 4.43 pp	1.0%	3.5%
	2025	88.1%	▲ 0.67 pp	83.3%	▲ 4.79 pp	1.1%	3.5%
17a) Care of patients / service users is my organisation's top priority.	2023	82.4%		67.1%	▲ 15.30 pp	3.5%	12.8%
	2024	86.1%	▲ 3.66 pp	67.8%	▲ 18.25 pp	3.4%	12.7%
	2025	86.7%	▲ 0.62 pp	66.7%	▲ 19.96 pp	4.9%	14.6%
17b) My organisation acts on concerns raised by patients / service users.	2023	78.1%		63.1%	▲ 14.96 pp	3.3%	8.7%
	2024	78.5%	▲ 0.47 pp	64.4%	▲ 14.12 pp	3.3%	9.5%
	2025	80.7%	▲ 2.19 pp	64.7%	▲ 15.99 pp	2.8%	9.7%
17c) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	2023	82.6%		53.5%	▲ 29.14 pp	4.0%	19.3%
	2024	84.5%	▲ 1.90 pp	55.2%	▲ 29.36 pp	3.6%	19.0%
	2025	83.7%	▼ -0.86 pp	55.3%	▲ 28.41 pp	3.5%	19.1%
17d) I feel safe to speak up about anything that concerns me in this organisation.	2023	64.2%		55.2%	▲ 9.05 pp	15.1%	19.7%
	2024	67.7%	▲ 3.48 pp	57.8%	▲ 9.87 pp	14.1%	19.5%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
17d) I feel safe to speak up about anything that concerns me in this organisation.	2025	69.1%	▲ 1.39 pp	56.7%	▲ 12.34 pp	14.5%	19.7%
We are continuously learning and improving							
18a) This organisation offers me challenging work.	2023	71.9%		71.9%	▲ 0.05 pp	8.1%	7.4%
	2024	75.3%	▲ 3.35 pp	71.1%	▲ 4.20 pp	7.2%	8.0%
	2025	71.6%	▼ -3.64 pp	69.9%	▲ 1.73 pp	8.6%	8.5%
18b) There are opportunities for me to develop my career in this organisation.	2023	52.8%		52.2%	▲ 0.59 pp	22.8%	23.0%
	2024	56.9%	▲ 4.10 pp	51.5%	▲ 5.39 pp	17.7%	24.2%
	2025	54.2%	▼ -2.68 pp	49.6%	▲ 4.65 pp	21.8%	25.3%
18c) I have opportunities to improve my knowledge and skills.	2023	70.7%		67.4%	▲ 3.31 pp	14.0%	14.3%
	2024	75.4%	▲ 4.71 pp	67.7%	▲ 7.71 pp	8.6%	15.1%
	2025	70.2%	▼ -5.24 pp	66.3%	▲ 3.90 pp	13.2%	15.6%
18d) I feel supported to develop my potential.	2023	59.1%		55.1%	▲ 4.03 pp	19.8%	20.2%
	2024	64.4%	▲ 5.27 pp	55.2%	▲ 9.21 pp	16.4%	21.5%
	2025	59.8%	▼ -4.61 pp	53.7%	▲ 6.07 pp	19.7%	21.7%
18e) I am able to access the right learning and development opportunities when I need to.	2023	62.5%		55.1%	▲ 7.32 pp	15.4%	19.2%
	2024	60.8%	▼ -1.64 pp	55.3%	▲ 5.49 pp	15.8%	19.7%
	2025	60.9%	▲ 0.13 pp	54.7%	▲ 6.28 pp	16.2%	20.0%
19b) If yes, to what extent do you agree with the following statements? It helped me to improve how I do my job.	2023	66.0%		64.6%	▲ 1.42 pp	34.0%	35.4%
	2024	63.2%	▼ -2.78 pp	64.5%	▼ -1.23 pp	36.8%	35.5%
	2025	69.6%	▲ 6.39 pp	65.3%	▲ 4.31 pp	30.4%	34.7%
19c) It helped me agree clear objectives for my work.	2023	82.2%		78.8%	▲ 3.42 pp	17.8%	21.2%
	2024	81.7%	▼ -0.50 pp	77.8%	▲ 3.88 pp	18.3%	22.2%
	2025	82.7%	▲ 1.01 pp	77.8%	▲ 4.85 pp	17.3%	22.2%
19d) It left me feeling that my work is valued by my organisation.	2023	74.9%		72.7%	▲ 2.20 pp	25.1%	27.3%
	2024	74.4%	▼ -0.46 pp	72.6%	▲ 1.87 pp	25.6%	27.4%
	2025	78.5%	▲ 4.09 pp	72.6%	▲ 5.93 pp	21.5%	27.4%
We are stronger together							
01a) The team I work in has a set of shared objectives.	2023	80.5%		74.8%	▲ 5.71 pp	8.4%	10.9%
	2024	81.8%	▲ 1.32 pp	75.4%	▲ 6.46 pp	8.3%	12.0%
	2025	84.0%	▲ 2.11 pp	76.2%	▲ 7.77 pp	8.3%	11.5%
01b) The team I work in often meets to discuss the team's effectiveness.	2023	68.4%		62.1%	▲ 6.36 pp	18.4%	24.0%
	2024	67.8%	▼ -0.62 pp	62.6%	▲ 5.21 pp	18.6%	24.1%
	2025	69.5%	▲ 1.69 pp	61.9%	▲ 7.59 pp	17.8%	23.8%
01c) Team members trust each other.	2023	71.9%		66.8%	▲ 5.08 pp	13.3%	15.9%
	2024	73.7%	▲ 1.77 pp	66.2%	▲ 7.46 pp	11.5%	17.2%
	2025	72.7%	▼ -0.97 pp	65.6%	▲ 7.09 pp	13.1%	17.1%
01d) Team members understand each other's roles.	2023	76.8%		71.0%	▲ 5.84 pp	13.0%	15.5%
	2024	71.4%	▼ -5.44 pp	70.3%	▲ 1.06 pp	13.9%	16.1%
	2025	73.7%	▲ 2.26 pp	70.7%	▲ 2.93 pp	14.4%	15.9%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
01e) Team members take time out to reflect and learn.	2023	51.8%		51.8%	▼ -0.06 pp	24.2%	24.2%
	2024	52.5%	▲ 0.76 pp	53.4%	▼ -0.90 pp	22.9%	23.7%
	2025	53.7%	▲ 1.23 pp	53.7%	▲ 0.01 pp	21.8%	23.6%
01f) Team members are able to communicate closely with each other to achieve the team's objectives.	2023	74.7%		69.6%	▲ 5.15 pp	10.5%	14.1%
	2024	75.7%	▲ 0.96 pp	69.1%	▲ 6.60 pp	11.1%	15.7%
	2025	74.8%	▼ -0.94 pp	68.7%	▲ 6.04 pp	11.5%	15.5%
01g) I enjoy working with the colleagues in my team.	2023	83.9%		81.3%	▲ 2.61 pp	5.1%	5.8%
	2024	83.5%	▼ -0.39 pp	79.4%	▲ 4.04 pp	5.0%	8.2%
	2025	83.9%	▲ 0.45 pp	79.6%	▲ 4.36 pp	4.9%	8.1%
01h) I feel valued by my team.	2023	69.6%		67.3%	▲ 2.35 pp	12.8%	16.3%
	2024	73.1%	▲ 3.49 pp	66.7%	▲ 6.47 pp	13.4%	17.8%
	2025	71.5%	▼ -1.68 pp	66.7%	▲ 4.80 pp	14.5%	17.2%
01i) I feel able to ask other members of this team for help when I need it.	2023	87.9%		83.9%	▲ 3.97 pp	4.7%	6.6%
	2024	85.8%	▼ -2.11 pp	81.4%	▲ 4.34 pp	6.1%	9.0%
	2025	86.4%	▲ 0.66 pp	81.1%	▲ 5.37 pp	6.5%	8.9%
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.	2023	74.7%		74.7%	▼ -0.01 pp	11.1%	12.4%
	2024	78.1%	▲ 3.40 pp	72.6%	▲ 5.49 pp	10.6%	15.1%
	2025	76.8%	▼ -1.37 pp	72.1%	▲ 4.72 pp	12.2%	14.8%
01k) Team members work well with other teams.	2023	74.7%		71.1%	▲ 3.64 pp	8.8%	10.4%
	2024	75.1%	▲ 0.34 pp	71.2%	▲ 3.83 pp	8.1%	11.5%
	2025	77.6%	▲ 2.56 pp	70.4%	▲ 7.25 pp	8.0%	11.7%
04a) My immediate manager (line manager) encourages me at work.	2023	71.2%		69.0%	▲ 2.25 pp	11.6%	13.6%
	2024	76.8%	▲ 5.60 pp	71.0%	▲ 5.85 pp	10.4%	12.9%
	2025	73.1%	▼ -3.76 pp	70.7%	▲ 2.34 pp	11.8%	12.8%
04b) My immediate manager (line manager) gives me clear feedback on my work.	2023	64.6%		61.7%	▲ 2.83 pp	16.5%	18.1%
	2024	68.4%	▲ 3.83 pp	64.3%	▲ 4.09 pp	14.9%	17.2%
	2025	66.1%	▼ -2.27 pp	63.9%	▲ 2.26 pp	16.5%	17.4%
04c) My immediate manager (line manager) asks for my opinion before making decisions that affect my work.	2023	58.9%		56.3%	▲ 2.69 pp	21.8%	24.4%
	2024	63.9%	▲ 4.91 pp	59.2%	▲ 4.66 pp	19.6%	22.8%
	2025	62.3%	▼ -1.51 pp	58.0%	▲ 4.39 pp	21.3%	23.2%
04d) My immediate manager (line manager) takes a positive interest in my health and well-being.	2023	71.1%		67.7%	▲ 3.35 pp	12.6%	15.6%
	2024	75.0%	▲ 3.99 pp	70.5%	▲ 4.49 pp	10.0%	14.6%
	2025	72.7%	▼ -2.38 pp	69.6%	▲ 3.10 pp	13.1%	14.9%
04e) My immediate manager (line manager) values my work.	2023	72.1%		70.6%	▲ 1.54 pp	11.8%	12.1%
	2024	78.4%	▲ 6.30 pp	72.4%	▲ 6.05 pp	9.4%	12.5%
	2025	74.9%	▼ -3.47 pp	71.5%	▲ 3.48 pp	10.7%	12.1%
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.	2023	68.2%		66.2%	▲ 2.04 pp	14.4%	15.2%
	2024	73.9%	▲ 5.62 pp	68.3%	▲ 5.54 pp	11.4%	14.7%
	2025	71.8%	▼ -2.06 pp	67.9%	▲ 3.92 pp	14.8%	14.8%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.	2023	70.2%		69.1%	▲ 1.05 pp	14.2%	14.4%
	2024	76.1%	▲ 5.96 pp	70.7%	▲ 5.39 pp	9.6%	14.7%
	2025	74.3%	▼ -1.89 pp	69.9%	▲ 4.36 pp	14.0%	14.5%
04h) My immediate manager (line manager) recognises the importance of staff emotional wellbeing.	2023	69.1%		69.2%	▼ -0.13 pp	13.7%	14.3%
	2024	75.2%	▲ 6.12 pp	70.9%	▲ 4.31 pp	10.6%	14.4%
	2025	74.4%	▼ -0.81 pp	69.9%	▲ 4.50 pp	13.2%	14.6%
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.	2023	67.0%		64.9%	▲ 2.12 pp	14.6%	14.8%
	2024	71.0%	▲ 3.97 pp	67.1%	▲ 3.90 pp	12.3%	15.1%
	2025	71.4%	▲ 0.46 pp	66.8%	▲ 4.64 pp	12.8%	14.8%
We champion flexible working							
14e) I am satisfied with the opportunity for flexible working patterns.	2023	65.4%		58.2%	▲ 7.17 pp	20.9%	21.4%
	2024	68.3%	▲ 2.97 pp	62.5%	▲ 5.81 pp	14.6%	19.3%
	2025	67.0%	▼ -1.39 pp	60.8%	▲ 6.15 pp	18.4%	19.8%
14f) My organisation is committed to helping me balance my work and home life.	2023	58.9%		50.5%	▲ 8.47 pp	22.6%	23.3%
	2024	59.4%	▲ 0.44 pp	54.8%	▲ 4.63 pp	16.7%	21.1%
	2025	58.6%	▼ -0.75 pp	53.9%	▲ 4.71 pp	21.0%	21.9%
14g) I achieve a good balance between my work life and my home life.	2023	57.9%		56.5%	▲ 1.44 pp	24.6%	23.0%
	2024	62.9%	▲ 5.05 pp	58.6%	▲ 4.39 pp	17.0%	21.5%
	2025	63.0%	▲ 0.10 pp	58.8%	▲ 4.26 pp	20.0%	20.8%
14h) I can approach my immediate manager (line manager) to talk openly about flexible working.	2023	70.7%		67.1%	▲ 3.57 pp	15.1%	14.7%
	2024	76.4%	▲ 5.71 pp	70.0%	▲ 6.45 pp	10.7%	14.1%
	2025	73.8%	▼ -2.60 pp	69.8%	▲ 4.05 pp	13.5%	14.1%
We nurture healthy working environments							
02a) I have unrealistic time pressures.	2023	32.5%		27.2%	▲ 5.27 pp	27.5%	33.1%
	2024	33.7%	▲ 1.26 pp	28.7%	▲ 5.04 pp	25.4%	30.1%
	2025	32.3%	▼ -1.37 pp	28.0%	▲ 4.32 pp	26.7%	32.0%
02b) I am able to meet all the conflicting demands on my time at work.	2023	54.7%		50.6%	▲ 4.16 pp	14.6%	15.8%
	2024	58.8%	▲ 4.07 pp	51.1%	▲ 7.73 pp	14.1%	15.4%
	2025	57.8%	▼ -1.04 pp	50.0%	▲ 7.76 pp	13.0%	15.8%
02c) I have adequate supplies, materials and equipment to do my work.	2023	78.1%		57.7%	▲ 20.40 pp	7.0%	15.2%
	2024	76.8%	▼ -1.27 pp	55.9%	▲ 20.92 pp	6.7%	17.5%
	2025	77.5%	▲ 0.66 pp	54.7%	▲ 22.79 pp	5.9%	17.6%
02d) There are enough staff at this organisation for me to do my job properly.	2023	40.8%		30.9%	▲ 9.91 pp	25.0%	37.0%
	2024	43.5%	▲ 2.68 pp	33.3%	▲ 10.19 pp	25.8%	34.8%
	2025	44.1%	▲ 0.64 pp	32.5%	▲ 11.55 pp	22.7%	35.7%
09a) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Patients / service users, their relatives, or other members of the public	2023	86.0%		72.1%	▲ 13.85 pp	12.8%	26.2%
	2024	89.8%	▲ 3.87 pp	75.3%	▲ 14.54 pp	9.3%	23.4%
	2025	86.9%	▼ -2.91 pp	72.6%	▲ 14.32 pp	12.0%	25.9%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
09b) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Managers / Team leaders	2023	81.7%		79.2%	▲ 2.54 pp	15.1%	17.1%
	2024	87.8%	▲ 6.06 pp	81.6%	▲ 6.16 pp	9.3%	15.4%
	2025	84.9%	▼ -2.85 pp	82.1%	▲ 2.87 pp	12.6%	14.9%
09c) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Other colleagues	2023	79.3%		75.8%	▲ 3.42 pp	17.6%	20.7%
	2024	81.0%	▲ 1.69 pp	77.5%	▲ 3.41 pp	16.1%	19.6%
	2025	82.9%	▲ 1.94 pp	77.9%	▲ 4.98 pp	15.0%	19.1%
10a) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From patients / service users	2023	94.4%		89.7%	▲ 4.73 pp	5.3%	9.5%
	2024	94.8%	▲ 0.41 pp	90.2%	▲ 4.64 pp	5.2%	9.3%
	2025	95.4%	▲ 0.59 pp	88.5%	▲ 6.93 pp	3.9%	10.9%
10b) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From staff / colleagues	2023	92.8%		94.3%	▼ -1.53 pp	6.7%	4.7%
	2024	96.1%	▲ 3.32 pp	95.2%	▲ 0.88 pp	3.9%	4.1%
	2025	96.1%	▲ 0.03 pp	95.0%	▲ 1.15 pp	3.1%	4.1%
11a) In the last 12 months how many times have you personally experienced abuse at work from patients / service users, their relatives, or other members of the public?	2023	93.0%		82.0%	▲ 11.00 pp	6.7%	16.9%
	2024	89.9%	▼ -3.06 pp	72.6%	▲ 17.28 pp	9.8%	26.3%
	2025	86.9%	▼ -3.01 pp	69.4%	▲ 17.51 pp	12.2%	29.1%
12a) In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives, or other members of the public	2023	98.6%		91.0%	▲ 7.62 pp	1.1%	8.5%
	2024	99.0%	▲ 0.43 pp	92.3%	▲ 6.72 pp	1.0%	7.3%
	2025	98.9%	▼ -0.15 pp	89.4%	▲ 9.52 pp	0.2%	10.2%
12b) In the last 12 months how many times have you personally experienced physical violence at work from...? Managers / Team leaders	2023	99.1%		99.3%	▼ -0.15 pp	0.5%	0.3%
	2024	100.0%	▲ 0.88 pp	99.2%	▲ 0.80 pp	0.0%	0.5%
	2025	99.0%	▼ -1.00 pp	99.2%	▼ -0.24 pp	0.2%	0.3%
12c) In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues	2023	99.5%		98.8%	▲ 0.65 pp	0.2%	0.7%
	2024	99.7%	▲ 0.20 pp	99.0%	▲ 0.72 pp	0.3%	0.7%
	2025	99.1%	▼ -0.55 pp	99.0%	▲ 0.11 pp	0.0%	0.6%
20a) How often, if at all, do you find your work emotionally exhausting?	2023	28.4%		18.3%	▲ 10.12 pp	34.0%	43.1%
	2024	30.6%	▲ 2.20 pp	20.8%	▲ 9.82 pp	27.2%	36.3%
	2025	29.7%	▼ -0.94 pp	19.8%	▲ 9.89 pp	29.6%	38.9%
20b) How often, if at all, do you feel burnt out because of your work?	2023	32.3%		25.3%	▲ 6.96 pp	33.0%	37.9%
	2024	34.3%	▲ 2.03 pp	29.9%	▲ 4.38 pp	24.2%	31.5%
	2025	35.9%	▲ 1.60 pp	28.0%	▲ 7.92 pp	25.3%	34.5%
20c) How often, if at all, does your work frustrate you?	2023	18.4%		15.3%	▲ 3.15 pp	39.1%	45.9%
	2024	23.7%	▲ 5.32 pp	20.5%	▲ 3.23 pp	31.7%	37.6%
	2025	24.4%	▲ 0.64 pp	20.9%	▲ 3.47 pp	30.0%	38.5%
20d) How often, if at all, are you exhausted at the thought of another day/shift at work?	2023	37.2%		30.7%	▲ 6.47 pp	29.3%	34.8%
	2024	46.2%	▲ 8.99 pp	38.6%	▲ 7.56 pp	22.8%	27.1%
	2025	46.4%	▲ 0.21 pp	36.2%	▲ 10.18 pp	23.3%	30.0%
20e) How often, if at all, do you feel worn out at the end of your working day/shift?	2023	21.1%		16.9%	▲ 4.12 pp	43.3%	46.9%

Question	Year	Positive responses (%)	Annual trend	Benchmark	Variance	Negative responses (%)	Benchmark
20e) How often, if at all, do you feel worn out at the end of your working day/shift?	2024	24.0%	▲ 2.93 pp	21.2%	▲ 2.81 pp	31.5%	38.7%
	2025	26.2%	▲ 2.21 pp	19.9%	▲ 6.28 pp	34.5%	41.5%
20f) How often, if at all, do you feel that every working hour is tiring for you?	2023	50.9%		47.2%	▲ 3.66 pp	18.6%	21.8%
	2024	59.8%	▲ 8.96 pp	53.7%	▲ 6.12 pp	13.3%	18.0%
	2025	57.9%	▼ -1.90 pp	50.2%	▲ 7.71 pp	14.4%	20.5%
20g) How often, if at all, do you not have enough energy for family and friends during leisure time?	2023	36.3%		31.0%	▲ 5.31 pp	26.3%	31.8%
	2024	34.2%	▼ -2.11 pp	30.0%	▲ 4.21 pp	31.3%	33.9%
	2025	34.1%	▼ -0.12 pp	29.3%	▲ 4.83 pp	33.2%	34.5%
21a) My organisation takes positive action on health and wellbeing.	2023	51.4%		45.2%	▲ 6.19 pp	16.3%	18.5%
	2024	56.0%	▲ 4.57 pp	47.8%	▲ 8.19 pp	16.7%	18.9%
	2025	61.2%	▲ 5.20 pp	45.0%	▲ 16.13 pp	15.6%	20.8%
We recognise everyone's contribution							
04e) My immediate manager (line manager) values my work.	2023	72.1%		70.6%	▲ 1.54 pp	11.8%	12.1%
	2024	78.4%	▲ 6.30 pp	72.4%	▲ 6.05 pp	9.4%	12.5%
	2025	74.9%	▼ -3.47 pp	71.5%	▲ 3.48 pp	10.7%	12.1%
15a) I get recognition for good work.	2023	58.4%		56.7%	▲ 1.71 pp	16.5%	20.1%
	2024	64.8%	▲ 6.36 pp	57.5%	▲ 7.29 pp	15.8%	20.3%
	2025	60.7%	▼ -4.09 pp	56.2%	▲ 4.54 pp	17.5%	20.8%
15b) The organisation values my work.	2023	53.2%		47.2%	▲ 5.93 pp	18.1%	21.6%
	2024	59.1%	▲ 5.90 pp	48.8%	▲ 10.29 pp	14.6%	21.3%
	2025	56.1%	▼ -2.91 pp	47.6%	▲ 8.51 pp	17.3%	22.1%
15e) The people I work with show appreciation to one another.	2023	74.2%		71.5%	▲ 2.71 pp	8.9%	9.7%
	2024	71.0%	▼ -3.20 pp	69.9%	▲ 1.11 pp	10.3%	11.1%
	2025	73.3%	▲ 2.33 pp	69.7%	▲ 3.66 pp	9.8%	11.1%

Table 7: Number and percentage of responses to each question in the 2025 survey. %s are rounded so may not add up to 100%.

Question and response	Total responses	%	
01a) The team I work in has a set of shared objectives.			
Strongly agree	265	33.0%	
Agree	410	51.0%	
Neither agree nor disagree	62	7.7%	
Disagree	48	6.0%	
Strongly disagree	19	2.4%	
	804		
01b) The team I work in often meets to discuss the team's effectiveness.			
Strongly agree	236	29.4%	
Agree	322	40.1%	
Neither agree nor disagree	102	12.7%	
Disagree	100	12.5%	
Strongly disagree	43	5.4%	
	803		
01c) Team members trust each other.			
Strongly agree	257	32.0%	
Agree	327	40.7%	
Neither agree nor disagree	114	14.2%	
Disagree	71	8.8%	
Strongly disagree	34	4.2%	
	803		
01d) Team members understand each other's roles.			
Strongly agree	241	29.9%	
Agree	352	43.7%	
Neither agree nor disagree	96	11.9%	
Disagree	90	11.2%	
Strongly disagree	26	3.2%	
	805		
01e) Team members take time out to reflect and learn.			
Strongly agree	139	17.3%	
Agree	292	36.4%	
Neither agree nor disagree	196	24.4%	
Disagree	132	16.5%	
Strongly disagree	43	5.4%	
	802		
01f) Team members are able to communicate closely with each other to achieve the team's objectives.			
Strongly agree	232	29.0%	
Agree	366	45.8%	
Neither agree nor disagree	110	13.8%	
Disagree	62	7.8%	
Strongly disagree	30	3.8%	
	800		

Question and response	Total responses	%	
01g) I enjoy working with the colleagues in my team.			
Strongly agree	377	47.0%	
Agree	296	36.9%	
Neither agree nor disagree	90	11.2%	
Disagree	22	2.7%	
Strongly disagree	17	2.1%	
	802		
01h) I feel valued by my team.			
Strongly agree	288	35.7%	
Agree	288	35.7%	
Neither agree nor disagree	113	14.0%	
Disagree	72	8.9%	
Strongly disagree	45	5.6%	
	806		
01i) I feel able to ask other members of this team for help when I need it.			
Strongly agree	372	46.3%	
Agree	323	40.2%	
Neither agree nor disagree	57	7.1%	
Disagree	37	4.6%	
Strongly disagree	15	1.9%	
	804		
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.			
Strongly agree	270	33.5%	
Agree	348	43.2%	
Neither agree nor disagree	89	11.1%	
Disagree	58	7.2%	
Strongly disagree	40	5.0%	
	805		
01k) Team members work well with other teams.			
Strongly agree	242	30.1%	
Agree	383	47.6%	
Neither agree nor disagree	116	14.4%	
Disagree	42	5.2%	
Strongly disagree	22	2.7%	
	805		
02a) I have unrealistic time pressures.			
Always	52	6.5%	
Often	163	20.3%	
Sometimes	329	40.9%	
Rarely	198	24.6%	
Never	62	7.7%	
	804		
02b) I am able to meet all the conflicting demands on my time at work.			
Always	106	13.2%	
Often	359	44.6%	
Sometimes	235	29.2%	

Question and response	Total responses	%	
Rarely	87	10.8%	
Never	18	2.2%	
	805		
02c) I have adequate supplies, materials and equipment to do my work.			
Always	285	35.5%	
Often	337	42.0%	
Sometimes	134	16.7%	
Rarely	41	5.1%	
Never	06	0.7%	
	803		
02d) There are enough staff at this organisation for me to do my job properly.			
Always	102	12.7%	
Often	253	31.4%	
Sometimes	267	33.2%	
Rarely	134	16.6%	
Never	49	6.1%	
	805		
03a) How many hours a week are you contracted to work?			
Up to 29 hours	115	14.4%	
30 or more hours	677	84.5%	
I am a bank worker	09	1.1%	
	801		
03b) On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours? Please include paid overtime, bank shifts, and additional paid hours on-call.			
6 - 10 hours	32	4.0%	
0 Hours	611	76.3%	
Up to 5 hours	135	16.9%	
11 or more hours	23	2.9%	
	801		
03c) On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? Please include unpaid overtime and additional unpaid hours on-call.			
6 - 10 hours	64	8.0%	
0 Hours	426	53.0%	
Up to 5 hours	290	36.1%	
11 or more hours	24	3.0%	
	804		
04a) My immediate manager (line manager) encourages me at work.			
Strongly agree	303	37.8%	
Agree	283	35.3%	
Neither agree nor disagree	121	15.1%	
Disagree	59	7.4%	
Strongly disagree	36	4.5%	
	802		
04b) My immediate manager (line manager) gives me clear feedback on my work.			
Strongly agree	253	31.6%	
Agree	276	34.5%	
Neither agree nor disagree	139	17.4%	

Question and response	Total responses	%	
Disagree	77	9.6%	
Strongly disagree	55	6.9%	
800			
04c) My immediate manager (line manager) asks for my opinion before making decisions that affect my work.			
Strongly agree	260	32.4%	
Agree	240	29.9%	
Neither agree nor disagree	131	16.3%	
Disagree	101	12.6%	
Strongly disagree	70	8.7%	
802			
04d) My immediate manager (line manager) takes a positive interest in my health and well-being.			
Strongly agree	331	41.3%	
Agree	251	31.3%	
Neither agree nor disagree	114	14.2%	
Disagree	59	7.4%	
Strongly disagree	46	5.7%	
801			
04e) My immediate manager (line manager) values my work.			
Strongly agree	318	39.7%	
Agree	283	35.3%	
Neither agree nor disagree	115	14.3%	
Disagree	47	5.9%	
Strongly disagree	39	4.9%	
802			
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.			
Strongly agree	294	36.8%	
Agree	279	35.0%	
Neither agree nor disagree	107	13.4%	
Disagree	74	9.3%	
Strongly disagree	44	5.5%	
798			
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.			
Strongly agree	309	38.6%	
Agree	285	35.6%	
Neither agree nor disagree	94	11.8%	
Disagree	71	8.9%	
Strongly disagree	41	5.1%	
800			
04h) My immediate manager (line manager) recognises the importance of staff emotional wellbeing.			
Strongly agree	322	40.4%	
Agree	272	34.1%	
Neither agree nor disagree	99	12.4%	
Disagree	52	6.5%	
Strongly disagree	53	6.6%	
798			
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.			
Strongly agree	307	38.3%	

Question and response	Total responses	%	
Agree	266	33.2%	
Neither agree nor disagree	126	15.7%	
Disagree	60	7.5%	
Strongly disagree	43	5.4%	
802			
05a) Does your organisation act fairly with regard to career progression/promotion, regardless of age, disability, ethnic background, gender, gender identity, religion or sexual orientation?			
Yes	488	60.8%	
Don't know	216	26.9%	
No	73	9.1%	
Prefer not to say	26	3.2%	
803			
05b) In the last 12 months have you sought a progression opportunity in your workplace?			
No	501	62.2%	
Yes	251	31.2%	
Prefer not to say	28	3.5%	
Don't know	25	3.1%	
805			
05c) If no, please tick the reasons for this.			
You enjoy the team you work with now	220	44.0%	
Other (please specify)	206	41.2%	
You haven't received encouragement or mentorship	36	7.2%	
You don't feel like you fit in the organisation	20	4.0%	
Personal experience of discrimination	07	1.4%	
Previous unfair unsuccessful attempts	06	1.2%	
Witnessed discrimination of other staff	03	0.6%	
Your line manager says you are not ready	02	0.4%	
500			
05d) In the coming 12 months would you consider applying for a progression opportunity in your workplace?			
Yes	313	38.9%	
No	295	36.6%	
Don't know	167	20.7%	
Prefer not to say	30	3.7%	
805			
05e) If no, please tick the reasons for this.			
You enjoy the team you work with now	146	49.0%	
Other (please specify)	107	35.9%	
You don't feel like you fit in the organisation	16	5.4%	
You haven't received encouragement or mentorship	14	4.7%	
Personal experience of discrimination	07	2.3%	
Previous unfair unsuccessful attempts	06	2.0%	
Witnessed discrimination of other staff	02	0.7%	
298			
06a) In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives, or other members of the public?			
No	742	92.4%	
Prefer not to say	37	4.6%	

Question and response	Total responses	%	
Yes	24	3.0%	
	803		
06b) If yes, on what grounds have you experienced discrimination?			
	801	96.3%	
Ethnic background	07	0.8%	
Gender	06	0.7%	
Other (please specify)	06	0.7%	
Disability	03	0.4%	
Sexual orientation	02	0.2%	
Sex	02	0.2%	
Religion	02	0.2%	
Age	02	0.2%	
Pregnancy / maternity	01	0.1%	
	832		
07a) In the last 12 months have you personally experienced discrimination at work from a manager/ team leader?			
No	702	88.9%	
Yes	45	5.7%	
Prefer not to say	43	5.4%	
	790		
07b) If yes, on what grounds have you experienced discrimination?			
Other (please specify)	19	28.8%	
Age	13	19.7%	
Disability	11	16.7%	
Gender	08	12.1%	
Ethnic background	07	10.6%	
Sex	05	7.6%	
Religion	02	3.0%	
Pregnancy / maternity	01	1.5%	
	66		
08a) In the last 12 months have you personally experienced discrimination at work from other colleagues?			
No	714	90.7%	
Yes	41	5.2%	
Prefer not to say	32	4.1%	
	787		
08b) If yes, on what grounds have you experienced discrimination?			
	795	93.2%	
Other (please specify)	14	1.6%	
Age	12	1.4%	
Gender	12	1.4%	
Ethnic background	05	0.6%	
Sex	05	0.6%	
Disability	05	0.6%	
Sexual orientation	02	0.2%	
Religion	02	0.2%	

Question and response	Total responses	%
Pregnancy / maternity	01	0.1%
	853	
09a) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Patients / service users, their relatives, or other members of the public		
1-2	74	9.2%
3-5	15	1.9%
Prefer not to say	09	1.1%
6-10	06	0.7%
More than 10	01	0.1%
Never	698	86.9%
	803	
09b) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Managers / Team leaders		
1-2	57	7.1%
3-5	23	2.9%
Prefer not to say	20	2.5%
More than 10	14	1.7%
6-10	07	0.9%
Never	682	84.9%
	803	
09c) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Other colleagues		
1-2	76	9.6%
3-5	21	2.6%
Prefer not to say	17	2.1%
6-10	13	1.6%
More than 10	09	1.1%
Never	659	82.9%
	795	
09d) The last time you experienced harassment or bullying at work, did you or a colleague report it?		
Not applicable	515	64.4%
No	142	17.8%
Yes, I reported it	104	13.0%
Don't know	23	2.9%
Yes, a colleague reported it	16	2.0%
	800	
10a) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From patients / service users		
1-2	23	2.9%
3-5	07	0.9%
Prefer not to say	06	0.7%
6-10	01	0.1%
Never	765	95.4%
	802	
10b) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From staff / colleagues		
1-2	18	2.2%

Question and response	Total responses	%	
Prefer not to say	06	0.7%	
3-5	05	0.6%	
More than 10	02	0.2%	
Never	772	96.1%	
803			
11a) In the last 12 months how many times have you personally experienced abuse at work from patients / service users, their relatives, or other members of the public?			
1-2	71	8.9%	
3-5	21	2.6%	
Prefer not to say	07	0.9%	
6-10	04	0.5%	
More than 10	02	0.2%	
Never	697	86.9%	
802			
11b) The last time you experienced abuse at work (work from patients / service users, their relatives, or other members of the public) did you or a colleague report it?			
Yes, I reported it	49	46.2%	
No	35	33.0%	
Yes, a colleague reported it	12	11.3%	
Not applicable	07	6.6%	
Don't know	03	2.8%	
106			
12a) In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives, or other members of the public			
Prefer not to say	07	0.9%	
1-2	02	0.2%	
Never	792	98.9%	
801			
12b) In the last 12 months how many times have you personally experienced physical violence at work from...? Managers / Team leaders			
Prefer not to say	06	0.7%	
1-2	01	0.1%	
More than 10	01	0.1%	
Never	795	99.0%	
803			
12c) In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues			
Prefer not to say	07	0.9%	
Never	793	99.1%	
800			
12d) The last time you experienced physical violence at work, did you or a colleague report it?			
Not applicable	07	63.6%	
Yes, I reported it	02	18.2%	
No	01	9.1%	
Don't know	01	9.1%	
11			
13a) In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?			
No	470	58.8%	
Yes	241	30.2%	

Question and response	Total responses	%	
Not applicable	57	7.1%	
Prefer not to say	30	3.8%	
5	01	0.1%	
	799		
13b) My organisation treats staff who are involved in an error, near miss or incident, fairly.			
Not applicable	67	8.9%	
Strongly agree	152	20.3%	
Agree	288	38.5%	
Neither agree nor disagree	173	23.1%	
Disagree	46	6.1%	
Strongly disagree	23	3.1%	
	749		
13c) My organisation encourages us to report errors, near misses or incidents.			
Not applicable	28	3.7%	
Strongly agree	312	41.8%	
Agree	319	42.7%	
Neither agree nor disagree	62	8.3%	
Disagree	16	2.1%	
Strongly disagree	10	1.3%	
	747		
13d) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.			
Not applicable	47	6.3%	
Strongly agree	203	27.3%	
Agree	320	43.1%	
Neither agree nor disagree	116	15.6%	
Disagree	38	5.1%	
Strongly disagree	19	2.6%	
	743		
13e) We are given feedback about changes made in response to reported errors, near misses and incidents.			
Not applicable	51	6.8%	
Strongly agree	143	19.1%	
Agree	255	34.1%	
Neither agree nor disagree	170	22.7%	
Disagree	93	12.4%	
Strongly disagree	36	4.8%	
	748		
14a) I always know what my work responsibilities are.			
Strongly agree	266	33.0%	
Agree	396	49.2%	
Neither agree nor disagree	67	8.3%	
Disagree	64	8.0%	
Strongly disagree	12	1.5%	
	805		
14b) I am trusted to do my job.			
Strongly agree	344	42.8%	
Agree	360	44.8%	

Question and response	Total responses	%	
Neither agree nor disagree	54	6.7%	
Disagree	29	3.6%	
Strongly disagree	17	2.1%	
	804		
14c) There are frequent opportunities for me to show initiative in my role.			
Strongly agree	264	32.9%	
Agree	346	43.1%	
Neither agree nor disagree	112	13.9%	
Disagree	57	7.1%	
Strongly disagree	24	3.0%	
	803		
14d) I have a choice in deciding how to do my work.			
Strongly agree	228	28.3%	
Agree	323	40.1%	
Neither agree nor disagree	140	17.4%	
Disagree	80	9.9%	
Strongly disagree	34	4.2%	
	805		
14e) I am satisfied with the opportunity for flexible working patterns.			
Strongly agree	270	33.5%	
Agree	269	33.4%	
Neither agree nor disagree	118	14.7%	
Disagree	90	11.2%	
Strongly disagree	58	7.2%	
	805		
14f) My organisation is committed to helping me balance my work and home life.			
Strongly agree	208	25.8%	
Agree	264	32.8%	
Neither agree nor disagree	164	20.4%	
Disagree	105	13.0%	
Strongly disagree	64	8.0%	
	805		
14g) I achieve a good balance between my work life and my home life.			
Strongly agree	192	24.0%	
Agree	313	39.1%	
Neither agree nor disagree	136	17.0%	
Disagree	106	13.2%	
Strongly disagree	54	6.7%	
	801		
14h) I can approach my immediate manager (line manager) to talk openly about flexible working.			
Strongly agree	299	37.3%	
Agree	293	36.5%	
Neither agree nor disagree	102	12.7%	
Disagree	64	8.0%	
Strongly disagree	44	5.5%	
	802		

Question and response	Total responses	%	
14i) I would feel secure raising concerns about unsafe clinical practice.			
Strongly agree	270	33.8%	
Agree	349	43.7%	
Neither agree nor disagree	132	16.5%	
Disagree	27	3.4%	
Strongly disagree	21	2.6%	
	799		
14j) I would feel secure raising concerns about unethical behaviour.			
Strongly agree	270	33.5%	
Agree	353	43.9%	
Neither agree nor disagree	110	13.7%	
Disagree	45	5.6%	
Strongly disagree	27	3.4%	
	805		
14k) I am confident my organisation would address my concern.			
Strongly agree	183	22.8%	
Agree	284	35.4%	
Neither agree nor disagree	213	26.6%	
Disagree	82	10.2%	
Strongly disagree	40	5.0%	
	802		
14l) I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)			
Strongly agree	179	22.3%	
Agree	391	48.7%	
Neither agree nor disagree	158	19.7%	
Disagree	41	5.1%	
Strongly disagree	34	4.2%	
	803		
15a) I get recognition for good work.			
Strongly agree	164	20.4%	
Agree	324	40.3%	
Neither agree nor disagree	175	21.8%	
Disagree	99	12.3%	
Strongly disagree	42	5.2%	
	804		
15b) The organisation values my work.			
Strongly agree	134	16.6%	
Agree	318	39.5%	
Neither agree nor disagree	214	26.6%	
Disagree	86	10.7%	
Strongly disagree	53	6.6%	
	805		
15c) The people I work with are understanding and kind to one another.			
Strongly agree	249	30.9%	
Agree	375	46.5%	
Neither agree nor disagree	109	13.5%	

Question and response	Total responses	%	
Disagree	52	6.5%	
Strongly disagree	21	2.6%	
	806		
15d) The people I work with are polite and treat each other with respect.			
Strongly agree	246	30.6%	
Agree	384	47.7%	
Neither agree nor disagree	100	12.4%	
Disagree	55	6.8%	
Strongly disagree	20	2.5%	
	805		
15e) The people I work with show appreciation to one another.			
Strongly agree	225	28.2%	
Agree	361	45.2%	
Neither agree nor disagree	135	16.9%	
Disagree	53	6.6%	
Strongly disagree	25	3.1%	
	799		
15f) Relationships at work are strained.			
Strongly agree	75	9.4%	
Agree	143	17.8%	
Neither agree nor disagree	189	23.6%	
Disagree	274	34.2%	
Strongly disagree	121	15.1%	
	802		
16a) People here are compassionate towards colleagues when they face problems.			
Strongly agree	218	27.2%	
Agree	406	50.6%	
Neither agree nor disagree	118	14.7%	
Disagree	43	5.4%	
Strongly disagree	17	2.1%	
	802		
16b) People here give good support to colleagues who are distressed.			
Strongly agree	229	28.7%	
Agree	414	51.8%	
Neither agree nor disagree	102	12.8%	
Disagree	34	4.3%	
Strongly disagree	20	2.5%	
	799		
16c) People here are compassionate in the way they behave towards patients/ service users.			
Strongly agree	334	42.0%	
Agree	374	47.0%	
Neither agree nor disagree	74	9.3%	
Disagree	06	0.8%	
Strongly disagree	07	0.9%	
	795		
16d) People here take effective action to help patients/service users in distress.			
Strongly agree	340	43.1%	

Question and response	Total responses	%	
Agree	355	45.0%	
Neither agree nor disagree	85	10.8%	
Disagree	03	0.4%	
Strongly disagree	06	0.8%	
	789		
17a) Care of patients / service users is my organisation's top priority.			
Strongly agree	347	43.5%	
Agree	344	43.2%	
Neither agree nor disagree	67	8.4%	
Disagree	30	3.8%	
Strongly disagree	09	1.1%	
	797		
17b) My organisation acts on concerns raised by patients / service users.			
Strongly agree	268	33.8%	
Agree	373	47.0%	
Neither agree nor disagree	131	16.5%	
Disagree	15	1.9%	
Strongly disagree	07	0.9%	
	794		
17c) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.			
Strongly agree	301	37.8%	
Agree	365	45.9%	
Neither agree nor disagree	102	12.8%	
Disagree	15	1.9%	
Strongly disagree	13	1.6%	
	796		
17d) I feel safe to speak up about anything that concerns me in this organisation.			
Strongly agree	209	26.2%	
Agree	343	42.9%	
Neither agree nor disagree	131	16.4%	
Disagree	76	9.5%	
Strongly disagree	40	5.0%	
	799		
17e) If I spoke up about something that concerned me, I am confident my organisation would address my concern.			
Strongly agree	164	20.4%	
Agree	288	35.9%	
Neither agree nor disagree	207	25.8%	
Disagree	96	12.0%	
Strongly disagree	47	5.9%	
	802		
18a) This organisation offers me challenging work.			
Strongly agree	196	24.4%	
Agree	380	47.3%	
Neither agree nor disagree	159	19.8%	
Disagree	51	6.3%	

Question and response	Total responses	%	
Strongly disagree	18	2.2%	
	804		
18b) There are opportunities for me to develop my career in this organisation.			
Strongly agree	144	17.9%	
Agree	292	36.3%	
Neither agree nor disagree	193	24.0%	
Disagree	114	14.2%	
Strongly disagree	61	7.6%	
	804		
18c) I have opportunities to improve my knowledge and skills.			
Strongly agree	193	24.1%	
Agree	369	46.1%	
Neither agree nor disagree	133	16.6%	
Disagree	77	9.6%	
Strongly disagree	29	3.6%	
	801		
18d) I feel supported to develop my potential.			
Strongly agree	161	20.0%	
Agree	319	39.7%	
Neither agree nor disagree	165	20.5%	
Disagree	108	13.4%	
Strongly disagree	50	6.2%	
	803		
18e) I am able to access the right learning and development opportunities when I need to.			
Strongly agree	152	18.9%	
Agree	338	42.0%	
Neither agree nor disagree	184	22.9%	
Disagree	95	11.8%	
Strongly disagree	35	4.4%	
	804		
19a) In the last 12 months, have you had an appraisal, PADR, annual review or development review?			
Yes	676	83.9%	
No	116	14.4%	
Can't Remember	14	1.7%	
	806		
19b) If yes, to what extent do you agree with the following statements? It helped me to improve how I do my job.			
Yes, to some extent	336	49.8%	
No	205	30.4%	
Yes, definitely	134	19.9%	
	675		
19c) It helped me agree clear objectives for my work.			
Yes, to some extent	321	47.5%	
Yes, definitely	238	35.2%	
No	117	17.3%	
	676		

Question and response	Total responses	%	
19d) It left me feeling that my work is valued by my organisation.			
Yes, to some extent	291	43.1%	
Yes, definitely	239	35.4%	
No	145	21.5%	
	675		
20a) How often, if at all, do you find your work emotionally exhausting?			
Always	41	5.1%	
Often	196	24.4%	
Sometimes	327	40.8%	
Rarely	181	22.6%	
Never	57	7.1%	
	802		
20b) How often, if at all, do you feel burnt out because of your work?			
Always	56	7.0%	
Often	147	18.3%	
Sometimes	311	38.8%	
Rarely	205	25.6%	
Never	83	10.3%	
	802		
20c) How often, if at all, does your work frustrate you?			
Always	55	6.9%	
Often	185	23.1%	
Sometimes	365	45.6%	
Rarely	154	19.3%	
Never	41	5.1%	
	800		
20d) How often, if at all, are you exhausted at the thought of another day/shift at work?			
Always	55	6.9%	
Often	132	16.5%	
Sometimes	243	30.3%	
Rarely	243	30.3%	
Never	129	16.1%	
	802		
20e) How often, if at all, do you feel worn out at the end of your working day/shift?			
Always	83	10.4%	
Often	192	24.1%	
Sometimes	314	39.3%	
Rarely	173	21.7%	
Never	36	4.5%	
	798		
20f) How often, if at all, do you feel that every working hour is tiring for you?			
Always	34	4.3%	
Often	80	10.1%	
Sometimes	220	27.7%	
Rarely	280	35.3%	
Never	180	22.7%	
	794		

Question and response	Total responses	%	
20g) How often, if at all, do you not have enough energy for family and friends during leisure time?			
Always	67	8.4%	
Often	199	24.8%	
Sometimes	262	32.7%	
Rarely	203	25.3%	
Never	70	8.7%	
	801		
21a) My organisation takes positive action on health and wellbeing.			
Strongly agree	125	15.6%	
Agree	365	45.6%	
Neither agree nor disagree	186	23.2%	
Disagree	82	10.2%	
Strongly disagree	43	5.4%	
	801		
21b) In the last 12 months, have you experienced musculoskeletal problems (MSK) as a result of work activities?			
No	642	80.0%	
Yes	161	20.0%	
	803		
21c) During the last 12 months have you felt unwell as a result of work-related stress?			
No	530	66.3%	
Yes	270	33.8%	
	800		
21d) In the last three months have you ever come to work despite not feeling well enough to perform your duties?			
Yes	407	50.6%	
No	397	49.4%	
	804		
21e) Have you felt pressure from your manager to come to work?			
No	332	80.4%	
Yes	81	19.6%	
	413		
22a) I look forward to going to work.			
Always	107	13.3%	
Often	317	39.4%	
Sometimes	265	32.9%	
Rarely	87	10.8%	
Never	29	3.6%	
	805		
22b) I am enthusiastic about my job.			
Always	219	27.2%	
Often	331	41.1%	
Sometimes	188	23.3%	
Rarely	52	6.5%	
Never	16	2.0%	
	806		
22c) I am happy to go the extra mile at work when required.			
Always	383	47.7%	
Often	287	35.7%	

Question and response	Total responses	%	
Sometimes	104	13.0%	
Rarely	16	2.0%	
Never	13	1.6%	
	803		
23a) I am able to make improvements in my area of work.			
Strongly agree	155	19.2%	
Agree	384	47.6%	
Neither agree nor disagree	160	19.9%	
Disagree	75	9.3%	
Strongly disagree	32	4.0%	
	806		
23b) I would recommend my organisation as a place to work.			
Strongly agree	186	23.2%	
Agree	361	45.0%	
Neither agree nor disagree	156	19.4%	
Disagree	57	7.1%	
Strongly disagree	43	5.4%	
	803		
23c) I am proud to tell people I work for my organisation.			
Strongly agree	325	40.6%	
Agree	327	40.8%	
Neither agree nor disagree	110	13.7%	
Disagree	27	3.4%	
Strongly disagree	12	1.5%	
	801		
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.			
Strongly agree	160	19.9%	
Agree	280	34.8%	
Neither agree nor disagree	171	21.2%	
Disagree	118	14.7%	
Strongly disagree	76	9.4%	
	805		
24a) I am satisfied in my current role and intend to remain in it for the foreseeable future.			
Strongly agree	174	21.7%	
Agree	282	35.2%	
Neither agree nor disagree	196	24.4%	
Disagree	92	11.5%	
Strongly disagree	58	7.2%	
	802		
24b) I often think about leaving this organisation.			
Strongly agree	52	6.5%	
Agree	157	19.6%	
Neither agree nor disagree	187	23.3%	
Disagree	222	27.6%	
Strongly disagree	185	23.0%	
	803		

Question and response	Total responses	%
24c) I will probably look for a job at a new organisation in the next 12 months.		
Strongly agree	57	7.1%
Agree	87	10.8%
Neither agree nor disagree	196	24.4%
Disagree	235	29.3%
Strongly disagree	228	28.4%
	803	
24d) As soon as I can find another job, I will leave this organisation.		
Strongly agree	49	6.1%
Agree	59	7.4%
Neither agree nor disagree	162	20.3%
Disagree	241	30.2%
Strongly disagree	287	36.0%
	798	

5. Information on respondents

This section of the report provides background information on the **807 staff at Velindre University NHS Trust** that completed a survey in 2025. This includes a breakdown of the number and percentage of survey respondents by the following characteristics:

- Age
- Sex
- Gender reassignment
- Sexual orientation
- Race
- Religion or belief
- Disability

To preserve the anonymity of survey respondents, data in Table 8 has been suppressed where fewer than 10 respondents provided the same response to a question. In such cases, the number and percentage of staff selecting that response are not shown. Blank responses have been excluded from the analysis.

Table 8: Background information on respondents to the 2025 survey

Question and response	Total responses	%	
25) What best describes your gender?			
Female	530	66.3%	
Male	179	22.4%	
Non-binary	<10	<10	
Prefer not to say	85	10.6%	
Prefer to self describe (please specify)	<10	<10	
	799		
26) Is this the same as the sex you were assigned at birth?			
No	<10	<10	
Prefer not to say	64	8.1%	
Yes	724	91.6%	
	790		
26a) Sex assigned at birth			
Female	530	66.3%	
Male	179	22.4%	
Non-binary	<10	<10	
Prefer not to say	85	10.6%	
Prefer to self describe (please specify)	<10	<10	
	799		
27) Which of the following terms best describes your sexual orientation?			
Asexual	11	1.4%	
Bisexual	34	4.3%	
Gay or lesbian	19	2.4%	
Heterosexual or Straight	637	79.8%	
Prefer not to say	86	10.8%	
Prefer to self-describe (please specify)	11	1.4%	
	798		

Question and response	Total responses	%
28) Age		
16 - 20	<10	<10
21 - 30	117	14.6%
31 - 40	159	19.8%
41 - 50	176	21.9%
51 - 65	256	31.8%
66+	<10	<10
Prefer not to say	91	11.3%
	804	
29) Which race or ethnicity best describes you?		
Another race or ethnicity – please identify	10	1.2%
Arabic	<10	<10
Asian / British Asian: Chinese	<10	<10
Asian / British Asian: Indian	10	1.2%
Asian / British Asian: Other	<10	<10
Asian / British Asian: Pakistani	<10	<10
Black / British Black: African	<10	<10
Black / British Black: Caribbean	<10	<10
Mixed Race: Asian & White	<10	<10
Mixed Race: Black & White	<10	<10
Mixed Race: Other	25	3.1%
Prefer not to say	82	10.2%
White: British (British / English / Northern Irish / Scottish / Welsh)	611	76.1%
White: European	33	4.1%
White: Irish	11	1.4%
	803	
30) What do you consider your religion to be?		
Buddhist	<10	<10
Christian	267	33.3%
Hindu	<10	<10
Jewish	<10	<10
Muslim	<10	<10
No religion	384	47.9%
Prefer not to say	128	16.0%
Prefer to self-describe (please specify)	13	1.6%
Sikh	<10	<10
	801	
31) Do you have an impairment that can affect day-to-day activities, this can be either a physical or hidden disability?		
No	587	73.7%
Prefer not to say	90	11.3%
Yes	119	14.9%
	796	
33) Do you consider yourself Neurodiverse or Neurodivergent? (E.g., Autism, ADHD, Dyslexia)		
No	600	77.6%
Prefer not to say	91	11.8%

Question and response	Total responses	%	
Yes	82	10.6%	
773			
34) Do you provide unpaid care by looking after someone (a family member, friend or neighbour) who is older, disabled or seriously ill?			
No	607	76.6%	
Prefer not to say	63	8.0%	
Yes	122	15.4%	
792			

TRUST BOARD	
Reviewing the Board Committee Structure	
DATE OF MEETING	26 March 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Non Gwilym, Interim Director of Corporate Governance
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Carl James, Interim CEO
EXECUTIVE SUMMARY	This paper sets out the case for changing the Velindre University NHS Trust's Board Committee structure. It summarises the strategic drivers for change and highlights where the current arrangements can be strengthened to provide clearer assurance, more effective oversight and increased strategic capacity for the Trust in its next phase.
RECOMMENDATION / ACTIONS	The Trust Board is asked to NOTE the proposal and AGREE the proposed principles, proposed structure and timetable for implementation.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
n/a	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Board has considered the key principles outlined in this paper at various forums including the January Private Board meeting and the February Board Development meeting in February 2026. The output of those discussions has informed the development of this paper.	
7 LEVELS OF ASSURANCE	
n/a	
APPENDICES	
n/a	

1. Background and Context

The Trust is reviewing its governance and Board Committee arrangements as part of its wider Board development programme. A key consideration of this work is the need to ensure that governance structures remain fit for purpose, proportionate, and aligned with the Trust's strategic ambitions, risk profile, and operational complexity. To date, the review has been informed by:

- The Board's experience of operating the current committee framework;
- Emerging strategic challenges and opportunities, including major capital development, service transformation, and innovation; and
- The need to strengthen assurance, clarify accountabilities, and reduce duplication across governance forums in line with Welsh Government standards and public expectations.

2. Key themes Identified by the Board

The Board has identified a number of issues impacting the current Board Committee model. These include:

- The need to strengthen committee oversight in key areas such as quality and experience, finance and portfolio oversight, workforce, culture and engagement oversight.
- Responding to the Welsh Government's new approach to accountability.
- Strengthening the efficiency and effectiveness of assurances.
- Improving report quality.
- Strengthening the visibility of patient and donor voices.
- Creating capacity for forward-looking and futures discussions.
- Strengthening the governance arrangements of hosted services.

- Refreshing the approach to managing risk domains, assurance routes and committee purpose

3. Strategic Drivers for Change

The coming years present a significant opportunity for the Trust to strengthen and expand its national and international system leadership across the blood and cancer landscape, as reflected in discussions at the Trust's Public Accountability Meeting with the Welsh Government in January 2026. By building on its expertise, partnerships and ambition, the Trust is well placed to support and shape service transformation, advance research and innovation, and drive meaningful collaboration, delivering tangible benefits for patients, donors and the wider population.

More specifically:

- **Strategic Infrastructure Investment: Supporting Effective System Leadership**

The development of the new Velindre Cancer Centre represents a transformational opportunity for the cancer service and Trust. Effective governance arrangements are required to manage transition, readiness, risk, and benefits realisation. Similarly, investment in Welsh Blood Service digital systems, infrastructure and the Trust's response to the Infected Blood Inquiry presents a significant opportunity to position the service at the heart of blood and transplantation health across Wales.

- **Advancing Research and Innovation Leadership Across the Blood and Cancer Systems**

The Trust's role in research and innovation continues to grow in scale and complexity and the Board requires clear, structured assurance that the Trust's activities are not only strategically aligned, but also well-governed and delivering intended outcomes.

- **External Accountability and Assurance**

As the May 2026 Senedd election approaches, the Trust, like all NHS Wales organisations, will likely be subject to heightened external scrutiny and expectation.

- **Increased digital interdependencies and the impact of AI and new technologies**

The Trust's services are increasingly reliant on digital infrastructure and data flows that extend beyond organisational boundaries, creating both opportunities and new categories of risk. Strengthening governance in this area will enable the Trust to harness new technologies to improve quality, productivity and the experience of patients, donors and staff.

- **Good governance at the heart of organisational culture: embedding Strong Governance from Board to Front Line**

Restructuring the Board's Committees represents one element of the work required to strengthen organisational governance. In parallel, there is a need to continue to support colleagues across divisions and corporate services, and position governance as a key enabler to their success given the role it plays in creating the conditions that help people do the right work, in the right way with the right support – consistently and safely.

A new structure for Board Committees

4.1 Key changes – proposed principles

The Trust Board is asked to agree the following principles:

- Stand down the Strategic Development Committee.
- Re-scope the Quality, Safety and Performance Committee to encompass Quality, Safety and Experience.
- Establish a new People, Culture and Engagement Committee.
- Establish a new Finance, Performance, Planning and Portfolio Committee.
- Reform the governance of the Trust's charity to clearly distinguish between meetings of the Corporate Trustee focused on strategic matters, and a dedicated committee responsible for the allocation of charitable funds.
- Reconstitute the Audit Committee as the Audit, Risk and Assurance Committee.
- Give further consideration to the most appropriate placement of Digital within the revised committee structure (currently proposed within the Quality, Safety and Experience Committee).
- Review oversight arrangements and scope for each committee.

The proposed new structure is as follows:

	Trust Board
1	Quality, Safety and Experience (6 meetings per annum)
2	Finance, Performance, Planning and Portfolio (6 meetings per annum)
3	People, Culture and Engagement (6 meetings per annum)
4	Audit, Risk and Assurance (quarterly)
5	i. Charity Corporate Trustee meeting ii. Charitable Funds Investment Sub-Committee iii. Charitable Funds Bids Sub-Committee <i>*meeting frequency to be confirmed</i>
6	Research, Development and Innovation Sub-Committee (quarterly)
7	Remuneration Committee (as required)
8	nVCC (monthly)

Arrangements for the NWSSP Audit Committee will be reviewed as part of the work of the NWSSP Governance Review Implementation Group.

5. Timescales and next steps

The proposed timetable sets out a phased and controlled approach to reviewing, agreeing and implementing the new Board Committee structure.

Early activity focuses on establishing programme oversight and completing baseline mapping of current committee arrangements. Detailed work will be undertaken in April to draft revised Terms of Reference and Cycles of Business. In May, the transition plan will be considered by Board Committees, supported by completion of Quality Impact Assessment, with Trust Board approval sought during the May cycle. The new committee structure will go live from June 2026, with final amendments to Standing Orders approved in July. The timetable also includes a six-month initial review and a full post-implementation effectiveness review at twelve months to ensure the arrangements remain effective and proportionate. The work will be supported by Line of Sight, our partner in supporting good governance and board effectiveness.

Week	Milestone	By when?
1	Baseline committee mapping completed	End of February
3	Review Terms of Reference (ToR) and assurance flows completed - 121 Committee Chairs - Draft new ToR	By the end of April (prior to Board Development)
5	- Board Development : Consideration of draft ToR and transition plan	30 April
5	- Transition plan presented to Committees (completed QIA/EQIA) Board Committees consideration - Board Approval Sought	May cycle
6	New committee structure Go-Live adopting ToR and Cycles of Business	From June 2026
7	Approval of final Committee ToR for Standing Orders	July 2026
8	6 months initial review	6 months
9	Full post-implementation effectiveness review	12 months

7. Recommendation

The Trust Board is asked to **NOTE** the proposal and **AGREE** the proposed principles, proposed structure and timetable for implementation.

1. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (BAF)	08 – Organisational and Clinical Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A Quality Impact Assessment is in development and will be presented to the Trust Board in May.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not yet completed (Include further detail below why)
	An assessment against the socio-economic duty will be completed as the work progresses.
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:	

If yes, select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☒ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	A review of the team structure to support the proposed structure is underway and will be presented to the Board in May 2026.
EQUALITY IMPACT ASSESSMENT	An Equality Impact Assessment is in development.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) The new structure will be developed in alignment with the scope of the Trust's statutory duties as outlined in the Model Standing Orders.

2. RISKS

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



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Trust Board

IMTP 2026-27 – 2028-29: FOR APPROVAL

Date of meeting	26/03/2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
Prepared by	Kathy Ikin, Deputy Director of Transformation, Planning and Performance
PRESENTED BY	Kathy Ikin, Deputy Director of Transformation, Planning and Performance
APPROVED BY	Carl James, Chief Executive Officer (interim)
EXECUTIVE SUMMARY	The paper provides: 1. the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) 2026 - 2029 for approval 2. the next steps and key timelines for IMTP completion to enable submission by 31st March 2026.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • Approve the final IMTP 2026-2029 (attached)

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:

Executive Management Board	25/08/2025, 27/10/2025, 12/01/2026, 23/02/26 & 9/03/26 noted



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Strategic Development Committee:	09/09/2025, 27/10/25, 13/01/26, 17/03/26 Endorsed for approval
Trust Board Development session	16/12/25: noted

7 LEVELS OF ASSURANCE

**ASSURANCE RATING ASSESSED
BY BOARD DIRECTOR/SPONSOR**

N/A

APPENDICES

1	Velindre University NHS Trust IMTP 2026 -2029

ACRONYMS and INITIALISM

IMTP	Integrated Medium-Term Plan
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. SITUATION AND BACKGROUND

1.1 IMTP 2026-2029: National Planning Guidance issued

1.1 The Welsh Government issued the national planning guidance '*Transforming Services to Deliver Better Health and Care - NHS Wales Planning Framework 2026-2029*' to support the Trusts development of the IMTP 2026 – 2029 on 19th December 2025. The national guidance is consistent with that issued in 2025-2026 and consistent with the Trust internal planning guidance issued in October 2025 e.g. the planning/financial planning assumptions.

1.3 The Trust has prepared the IMTP 2026 -2029 in accordance with the national planning guidance for submission by 31st March 2026.

2. ASSESSMENT AND MATTERS FOR CONSIDERATION

The Final IMTP Plan

- 2.1 The Trust has worked to develop the IMTP over the last 8 months. The Final IMTP 2026-29 is attached at Annex 1.

Key areas to note in the final plan

- 2.2 The IMTP is compliant with the planning framework, and the Trust is submitting a financially balanced plan.
- 2.3 The key financial risk that remains is full delivery of the cost improvement plans. The mitigation in place to reduce this risk, will be through close monitoring of plans to ensure these plans are realised.
- 2.4 Trust officers are confident that these risks are manageable and that the Welsh Government requirements can be achieved by 31st March 2026.

Key timescales

- 2.5 The key timelines are set out below: -
- Trust Board 26th March 2026: approval
 - Welsh Government submission 31st March 2026

3. IMPACT ASSESSMENT

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



RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) <i>For more information: STRATEGIC RISK DESCRIPTIONS</i>	08 - Financial Sustainability and Long Term Value												
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below												
	<table border="0"> <tr><td>Safe</td><td>☒</td></tr> <tr><td>Timely</td><td>☒</td></tr> <tr><td>Effective</td><td>☒</td></tr> <tr><td>Equitable</td><td>☒</td></tr> <tr><td>Efficient</td><td>☒</td></tr> <tr><td>Patient Centred</td><td>☒</td></tr> </table>	Safe	☒	Timely	☒	Effective	☒	Equitable	☒	Efficient	☒	Patient Centred	☒
	Safe	☒											
Timely	☒												
Effective	☒												
Equitable	☒												
Efficient	☒												
Patient Centred	☒												
Quality and Safety considerations form the central driver of the Trust IMTP													
QUALITY IMPACT ASSESSMENT <i>The duty of quality requires quality-driven decision-making for all strategic decisions.</i>	Yes - Fully completed and signed QIA Enclosed												
	The QIA tool will be completed to support any IMTP service developments												
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required												
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT													
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: NO													
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.												
EQUALITY IMPACT ASSESSMENT <i>For more information:</i> https://nhs.wales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Completed – no negative impact.												
	<i>[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].</i>												
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.												
	Click or tap here to enter text												



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4. RISKS

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



Velindre University NHS Trust

Integrated Medium Term Plan

2026-2029



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Mae'r ddogfen hon hefyd ar gael yn Gymraeg // This document is also available in Welsh.



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FOREWORD FROM OUR CHAIR AND INTERIM CHIEF EXECUTIVE OFFICER

(DRAFT)

We are proud to present the Velindre University NHS Trust Integrated Medium Term Plan for 2026-27 to 2028-29. Our Plan details the excellent work undertaken by our teams from across the Trust and our continued engagement with our many stakeholders.

We have set ourselves a set of ambitious priorities, all centred in improving the outcomes for our patients, donors and communities. In publishing this plan, and in addition to our priorities and ambitions within this plan, we would like to make three further specific commitments to you:

- We will continue to deliver and further develop this Plan in a way that listens to our patients, donors, communities and wider stakeholders.
- We will tirelessly focus on achieving the impact and outcomes set out in this Plan and will regularly report on our progress to achieving them.
- This Plan can only be delivered in collaboration and working together across all our partnerships. We hope you enjoy reviewing our Plan and we, and our teams, look forward to discussing it with you at our various engagement opportunities over the course of the year.

Thank you.

Sara Moseley
Chair

Carl James
Interim Chief Executive Officer

SECTION ONE: CONTEXT

WHO WE ARE

The Trust was established in 1994 and is one of twelve statutory NHS organisations in Wales. We provide a range of specialist services at the national and regional level. The Trust has two main clinical divisions - Velindre Cancer Service and Welsh Blood Service in addition to our corporate functions. Velindre is also responsible for hosting two further All Wales Services on behalf of Welsh Government and NHS Wales, namely NHS Wales Shared Services Partnership and Health Technology Wales.

Velindre Cancer Service



We are a treatment, teaching, research and development centre for oncology services to patients from across South-East Wales and wider, serving a population of 1.7 million. We work closely with local partners in ensuring that our services are offered at appropriate locations, in line with best practice standards. An increasing number of services are also delivered on an outreach basis, bringing care and treatment for our patients closer to their homes

Blood and Transplant Services



We are a national service covering the 3.1 million population of Wales, delivering a safe, sustainable and high quality supply of blood, blood components, stem cells, organs, medicines and diagnostic services for patients across the country. Our remit extends beyond collection and production to include a comprehensive diagnostic offer supporting transfusion, transplantation and immunogenetics, as well as the wholesaling of blood derived medicines to ensure NHS Wales has timely access to the specialist products it needs. Together, these integrated services enable us to support patient care across Wales, contribute

to global stem cell provision, and maintain the resilience and safety of the national blood and transplant system.

Corporate Services



The Trust's core cancer and blood service delivery is supported by a number of Trust-wide corporate services, including Workforce and Organisational Development, Digital Services, Planning and Performance Management, Information and Corporate Governance, Value Based Healthcare, Corporate Medical Services and Quality and Safety, Estates and Sustainability and Finance.

Velindre Charity

The Trust Charity is active in fundraising and holding events, which in 2024-2025 raised £2.8m including grants and donations, and £0.6m from legacies. This funding supports vital research, staff development and important services to enrich the lives and experience of our patients.

Hosted Services

The Trust is responsible for hosting the following organisations on behalf of the Welsh Government and NHS Wales:

- **NHS Wales Shared Services Partnership (NWSSP):** who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services.
- **Health Technology Wales (HTW):** a national body working to improve the quality of care in Wales. It collaborates with partners across health, and the technology sectors to identify, appraise and advise on the adoption of technology or models of care to ensure an all-Wales approach.

SECTION TWO: OUR LONG-TERM STRATEGY

Our purpose

In 2023 we set out our organisational purpose ‘To Improve Lives’. This short statement seeks to describe why the organisation exists with everything we do uniting around this intention. It also sets out that we will improve the lives of the people we serve through treatment and care and by supporting Wales to become healthier to reduce illness.

Our Values

Caring:	We are always kind, supportive, approachable and show compassion to all.
Respectful:	We seek to understand other people’s perspectives. We are always open and transparent.
Accountable	We always take personal responsibility for what we do and how we do it.

Our Strategy: Destination 2033

Our long-term strategy, ‘Destination 2033’ sets out our future vision for the organisation. The strategy is based around the transformation of our clinical services to ensure we provide treatment and care which is as good as the best elsewhere within the United Kingdom and Europe.

Destination 2033 is an organisational strategy which is not only focused on clinical services but also how our support functions will support the provision of world class care and support to our patients, donors and partners.

This Integrated Medium Term Plan (IMTP) sits within the context and framing of our longer-term strategy, setting out what action will be taken over the coming three years to contribute to the realisation of our strategic goals and objectives.

Our Strategic Goals

1. Outstanding for quality, safety and experience
2. An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations
3. A beacon for research, development and innovation in our stated areas of priority

4. An established University Trust which provides highly valued knowledge and training for all
5. A sustainable organisation that plays its part in creating a better future for people across the globe

Delivering our Strategic Objectives for 2026-27 to 2028-29

The Trust's Integrated Medium-Term Plan (IMTP) 2026-27 to 2028-29 is our vehicle for delivering our strategic objectives and is the output of the excellent work undertaken by teams from across the Trust and strong engagement with our many stakeholders.

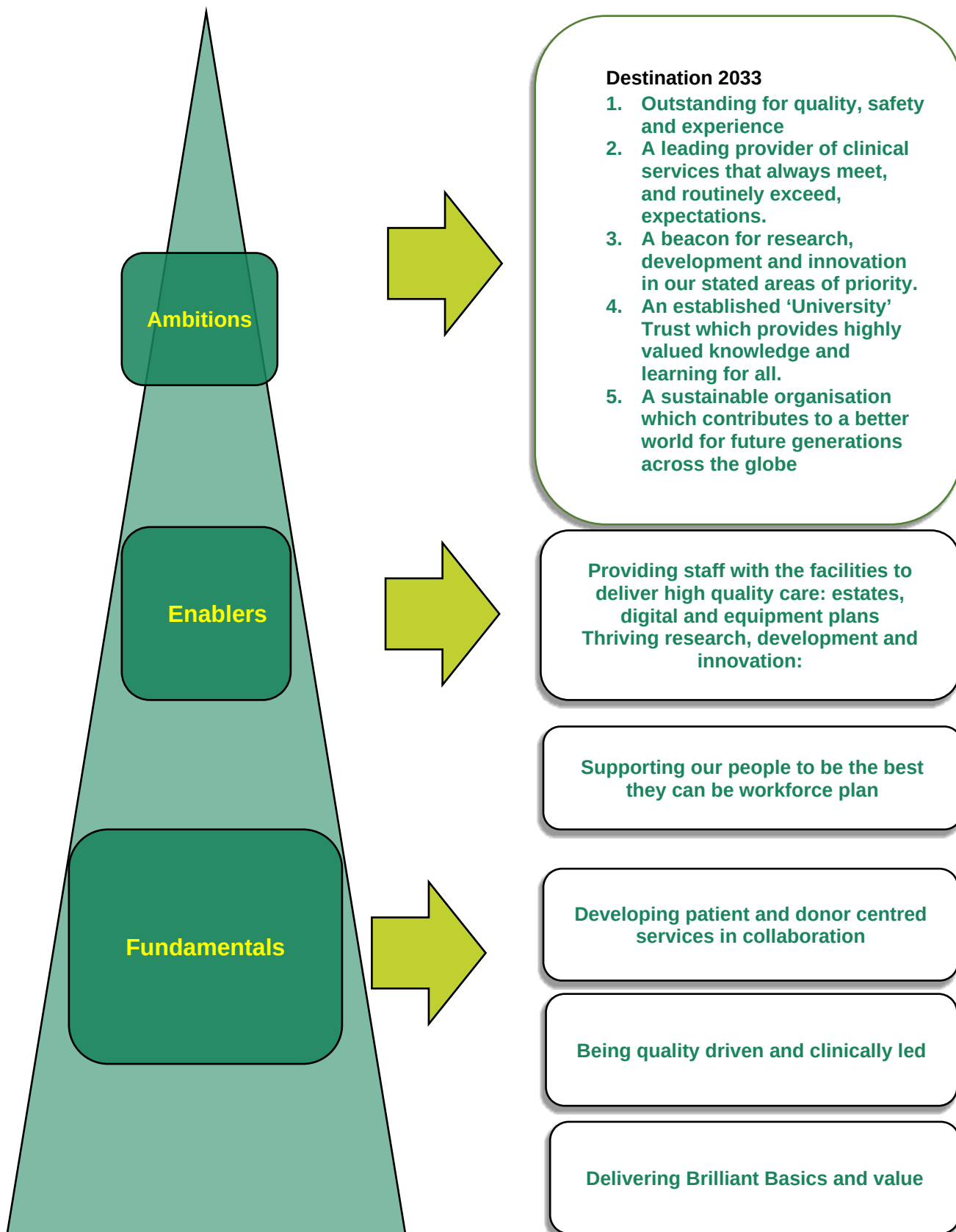
We set ourselves ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care.

Our Strategic Goals and objectives in more detail

Our strategy sets out 5 strategic goals together with the objectives we have set out to support the achievement of our goals.

Destination 2033: Our strategic goals and objectives





Our Well-Being Objectives

The Trust is one of the statutory bodies required to operate within the Well-being of Future Generations Act (WBFGA). Our IMTP demonstrates action to make meaningful progress towards our existing objectives which are set out below:

Objective 1:	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.
Objective 2:	Improve the health and well-being of our staff and people across Wales, by striving to care for the needs of the whole person.
Objective 3:	Create new highly skilled jobs in Wales and attract investment by increasing our focus on research, innovation and new models of delivery.
Objective 4:	Deliver bold solutions to the environment challenges posed by our activities.
Objective 5:	Demonstrate respect for the diverse cultural heritage of modern Wales.
Objective 6:	Bring communities and generations, together through involvement in the planning and delivery of our services.
Objective 7:	Strengthen the international reputation of the Trust as a centre of excellence, teaching research and technical innovation and making a lasting contribution to global well-being.

Our Well-being objectives are intended to support us in delivering the changes required to ensure a healthier, more vibrant, resilient and successful Wales.

The Well-Being Objectives guide our strategy and plans, ensuring sustained focus on the priorities that make the greatest impact; and that we can effectively track progress.

Ensuring Clinical and Scientific Strategy and Quality Standards are designed into everything we do

Our Clinical and Scientific Strategy provides a clear direction for all our services over the next five years. The strategy was written by, and for, our clinical and scientific workforce. We adopted a multi-faceted approach to engage with our clinical and scientific communities, partners, and stakeholders, calling on their wealth of knowledge, expertise, and forward-thinking ideas to inform our shared vision, ambitious strategic aims, and objectives.

Our vision is to “be at the forefront of clinical science delivering excellent, high-quality, person-centred care.” Our strategic aims and objectives are set out below and frame our service development and transformation agenda.

1. Leadership Collaboration	&	Strategic aim: Strengthen clinical and scientific leadership and collaboration to drive the clinical and scientific agenda.
2. Quality		Strategic Aim: Deliver high quality evidence-based, person-centred care to improve experience & outcomes.
3. Research, Development and Innovation		Strategic Aim: Drive clinical & scientific advancements through innovation, research, & development, ensuring preparedness for new developments.
4. Workforce		Strategic Aim: Adapt, develop, and empower a sustainable, diverse, multi-professional clinical and scientific workforce.

The Quality Standards Underpin our Planning

The Duty of Quality and Care Quality Standards are the foundation for the Trust's planning of services and related strategic decision-making. The Duty aims to:

- Improve the quality of health services
- Help people in Wales have more years in good health
- Listen more to people and patients and act on what is shared

Duty of Quality

The Trust's Quality & Safety framework aims to provide assurance to both the Board and our population by embedding ownership and accountability for Quality, safety and experience from frontline services through to Board level. This approach aims to ensure that the care and service we provide is high quality, safe, consistently person focused and aligned with the needs of the population we serve. Considerable quality and safety developments have been made over recent years; however, we recognise that there is further work to do to further strengthen our quality and safety infrastructure. Our approach is underpinned by a supportive, learning-focused, and non-punitive culture aimed at creating psychologically safe environments. In 2024, the Trust updated its Quality & Safety Framework to reflect new legislative duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and it has developed an implementation plan for the revised 2025 Putting Things Right: Listening to People regulations. The Trust undertook self-assessment against the new People's Experience Framework in April 2025 and developed an improvement plan that is being driven forward by the People's Experience Task & Finish Groups. This is aligned with our Quality & Safety Priorities, as reflected in the Quality Priorities Delivery Plan Appendix 2e.



Digital systems—namely Datix, AMaT and QPulse—form the backbone of the Trust's quality and safety infrastructure. These tools support effective monitoring, reporting and triangulation of data, enabling the identification of themes, trends and learning to drive continuous improvement. The Trust is further strengthening this digital capability through a new Quality & Safety Dashboard, adopting learning from Betsi Cadwalader UHB's quality dashboard and balanced scorecard. A pilot to apply Artificial Intelligence across current systems is also underway to enhance efficiency and improve analysis of incidents and concerns. Together, these developments will significantly strengthen the Trust's Quality Management System.

Quality Impact Assessment (QIA) process is the mechanism by which the Trust ensures that quality is being considered in strategic decisions at all levels. Over the past year the QIA process has been strengthened: QIA training and support have been provided, a central repository created, and an audit mechanism introduced.

Quality Statement for Cancer

The Trust is committed to delivery of the Quality Statements as set out by the Cabinet Secretary. High priority actions for the Trust relate specifically to the Quality Statement for Cancer, and Palliative and End of Life Care. The Trust provides leadership and expertise to Health Boards and other partners, in the delivery and improvement of Cancer Services.

This includes:

- our role in the Regional Acute Oncology Service, supporting the management and avoidance of toxicity, - (Equitable)
- our active research trials portfolio in our collaboration as Cardiff Health Partners, - (Effective)
- leadership and delivery of the first definitive treatment within 62 days of the point of suspicion of Cancer, (for those patients referred to us on or before day 38 - (Timely)
- the Clinical Oncology Subcommittee, and SACT metrics, - (Timely)
- our Regional South East Wales Radiology planning programme to support improvement in prompt and timely cancer diagnosis, - (Effective)
- and delivery of the National Optimal Pathways.- (Timely)

We also continue to work with Health Board Partners in the wider delivery of The Quality Statement for Circulatory Disease and Diabetes, for which our focus activities relate to optimising patient pathways, and patient information sharing and access through our Outpatient Transformation work, management of Hospital Initiated Referrals, and Patient Tracking Lists.

There is greater detail on these actions in the Velindre Cancer Service delivery plan.

Our plans for improving clinical services

Destination 2033 sets out our vision for the organisation over the long term at a high level. In support of this we have strategic plans in place for our two front-line clinical services.

Velindre Cancer Service: Shaping Our Future Together



Priority 1: Equitable and consistent care, no matter where; meeting increasing demand

Priority 2: Access to state-of-the-art, world-class, evidence-based treatments

Priority 3: Improving care and support for patients to live well through and beyond cancer

Priority 4: To be an international leader in research, development, innovation and education

Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer.

Welsh Blood Service: Blood and Transplant Services for the Future



- Priority 1:** Build a sustainable donor base that meets clinical need and represents the diverse communities we serve.
- Priority 2:** To provide a world class donor experience.
- Priority 3:** Drive the prudent use of blood across Wales.
- Priority 4:** Quality, safety and value: doing it right, first time.
- Priority 5:** Achieving excellence in research, development and innovation to improve outcomes for our donors and patients.
- Priority 6:** Sustainable services that deliver the greatest value to our communities.
- Priority 7:** Develop great people and a great place to work.

These two plans set out the key strategic objectives for each of our clinical services together with the key actions we will take to achieve them.

Support functions: aligning our support services to deliver our ambitions

We have a range of plans for all of our support functions which are aligned to the achievement of the Trusts ambitions, Destination 2033. Velindre Cancer Services: Shaping Our Future Together and Welsh Blood Service - Blood and Transplant Service: Services for the Future.

These include:

- [Clinical and Scientific Strategy](#)
- [Workforce and People Strategy](#)
- [Digital and Data Strategy](#)
- [Estates Strategy](#)
- [Sustainability Strategy](#)
- Finance Plan

How our strategies and plans fit together



What risks are we managing

The organisation is managing a wide range of risks at a strategic and operational level.

Strategic Risks

In reviewing the Trust's strategic risks against the delivery of our strategic objectives for the year ahead, amendments have been made to ensure the risk statements more clearly reflect the key threats to delivery of the Board's strategic objectives. This has included consideration of both internal risks (for example, organisational capacity, capability and governance arrangements) and external risks (including system-wide pressures and dependencies), to provide a clearer line of sight between what the Board is seeking to achieve and what could prevent delivery.

As part of this review, the Board also committed to redesigning the Board Assurance Framework (BAF) with the aim of strengthening alignment between the Trust's strategic objectives, the principal risks to their delivery, and the assurances in place, so that the BAF provides a coherent and meaningful basis for Board oversight and decision-making.

Ref	Title
1	An increasing demand for services exceeds the Trust's capacity and capability to deliver safe, high-quality care. 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.
2	The scale of complex change being delivered by the Trust exceeds its capacity and capability and results a reduction in service quality. There is a strategic risk that the quality of patient/donor/population outcomes and/or experience across the services managed by the Trust may be adversely impacted if the Trust cannot deliver its ambitious change programmes.
3	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.
4	Failure to open the new Velindre Cancer Centre as planned leads to a delay of the expected benefits for patients and increased costs. There is a strategic risk that the transition to the nVCC from VCC and other dual running arrangements and the changes required to the clinical model are not planned and executed well, leading to the potential of sub optimal or delayed service go live, the impact on the quality of clinical services delivered, the realisation

	of political risk / adverse publicity, commercial obligations not met by the Trust, and increased costs.
5	A lack of delivery against the Trust's sustainability goals will impact negatively on current and future service provision. 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.
6	An inability to develop a great culture and place to work reduces the Trust's ability to attract and retain the most talented workforce and reduces the quality of care for patients and donors. 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.
7	An inability to implement digital systems and technology as a result of insufficient capacity/capability increases the risk of a cyber incident, reduces the quality of care for patients and donors. 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.
8	An inability to implement and maintain effective corporate and clinical governance arrangements will reduce the effectiveness of the Trust. There is a strategic risk that the Trust's corporate and clinical governance arrangements are not sufficiently robust to ensure compliance with statutory duties and responsibilities and to support out people effectively, which may compromise and impact the delivery of our strategic objectives.
9	The Trust becomes financially unsustainable and cannot provide safe and high-quality care. 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.

Operational Risks

The Trust has a robust risk management framework which supports it to manage a wide range of operational risks associated with service delivery. These are aligned with the strategic risks set out in Board Assurance Framework and reported to the

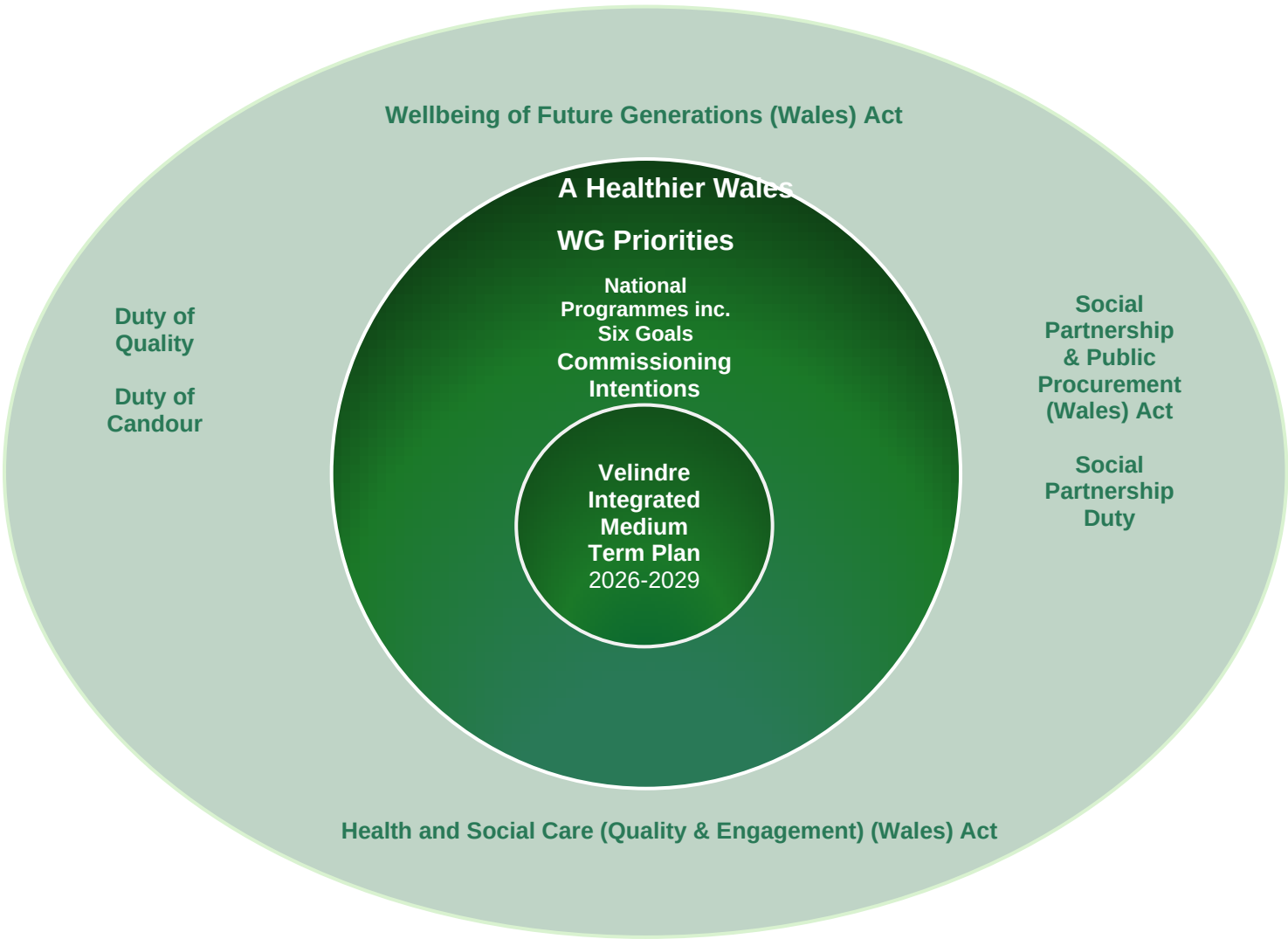
Executive Management Board; the Committees of the Trust Board (Quality, Safety and Performance Committee; the Strategic Development Committee; Audit Committee) and the Trust Board.

All Trust risks are actively managed utilising the National Datix Risk Management system. During the period of this plan, the Trust will be managing procurement and implementation of a new digital risk system (prior to November 2027).

THE CONTEXT AND SHAPING OUR PLAN FOR 2026 -2029

The Well-Being of Future Generations Act (2015)

The Well-being of Future Generations (Wales) Act 2015 (WBFGA) places a statutory duty on named public bodies, including the Trust, to set and publish Wellbeing Objectives that demonstrate how we maximise our contribution to the seven national well-being goals. These objectives must be embedded across all areas of organisational planning and delivery, ensuring that long-term sustainability, prevention, integration, collaboration, and involvement inform how we make decisions and how we use our resources.



In June 2025, Welsh Government announced its ambition for Wales to become the world's first "*Marmot Nation*", adopting Sir Michael Marmot's eight principles to eliminate unfair and avoidable differences in health. These principles highlight how environmental conditions, fair work, community infrastructure and social treatment directly shape health outcomes—and emphasise that protecting the environment is inseparable from promoting health equity.

This ambition aligns closely with Trust's approach to sustainable healthcare. Through the development of the new Velindre Cancer Centre, for example, the organisation is creating a low-carbon, nature-rich environment that supports patient wellbeing while helping reduce the environmental burdens that disproportionately affect disadvantaged communities. Biodiversity improvements, active travel routes and access to green space directly reinforce Marmot's focus on healthy, sustainable places.

Similarly, the Trust's commitment to social value—using procurement to support local employment, apprenticeships and fair work—helps address the wider determinants of health linked to economic inequality. The organisation's efforts to reduce travel demands through virtual clinics, care closer to home and remote monitoring also help ensure that people from rural or deprived areas can more easily access care.

By combining decarbonisation initiatives, fair work practices and equitable models of care, the Trust is already contributing to the foundations of a Marmot-aligned health system, one that improves outcomes not only through treatment, but through the creation of healthier, fairer and more sustainable conditions for the communities it serves.

The Welsh Blood Service plays a critical role in this ambition by reducing inequalities in both access to care and participation in donation. Through targeted engagement with Black, Asian, Mixed and minority ethnic communities; new key performance indicators (KPIs) that track and improve donor diversity; widening access for disabled and Welsh-speaking donors; and implementing national patient blood management pathways that reduce unwarranted clinical variation, WBS helps ensure that lifesaving blood and transplant services are equitable and reflective of the communities we serve.

Our Well-Being Objectives

In 2023, the Trust undertook a comprehensive refresh of its Wellbeing Objectives to ensure continued alignment with the needs and expectations of our staff, patients, partners, and communities. This process involved targeted engagement with colleagues across all services, structured workshops with clinical and corporate teams, and open engagement with the public and key stakeholders. The refreshed objectives therefore reflect both current organisational priorities and the lived experiences of those who depend on our services, while also ensuring the Trust maintains a strong focus on long-term value and improved outcomes for future generations.

Each section of the IMTP demonstrates how planned activities, workforce developments, digital transformation service redesign, financial planning, and capital and estates proposals directly contribute to the delivery of one or more of the Trust's Wellbeing Objectives. Throughout the document, individual chapters are clearly labelled with the specific objective(s) they support, providing transparency on how our priorities align with the Act and evidencing the golden thread that runs from national well-being goals to Trust-wide objectives, to operational and strategic plans.

This approach strengthens the Trust's commitment to sustainable development, ensures that our decision-making is purposefully aligned to long-term health and well-being outcomes, and provides assurance to Welsh Government and stakeholders that the IMTP is not only deliverable but also fully compliant with the statutory expectations of the Well-being of Future Generations Act and reinforces our commitment to the Marmot principles. (The Trust Well-Being Objectives are referenced throughout this plan with the relevant objective number from the below table.)

Trust Well-being Objectives



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 in Wales 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



Demonstrate respect for the diverse cultural heritage of modern Wales



Bring communities and generations together through involvement in the planning and delivery of our services



Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well-being



NB: The Trust Well Being Objective Symbols (1-7) are reflected throughout our plan and indicate how our objectives are integrated into our ways of working.

Five Ways of Working	How this plan addresses the ways of working
 Long Term	• Our IMTP is based on a long-term strategy 'Destination 2033' which is our long-term strategy
 Prevention	• This IMTP has a focus on the Trust's role in population health and health inequalities; together with our Value Based Healthcare programme which is driving high quality care
 Integration	• The plan is an integrated, and financially balanced plan which triangulates activity, workforce and finance, alongside key considerations for our estate and fleet. • The plan aligns and integrates services and service structures which benefit patients, our people and the wider system, aligned to our commissioners' and the minister's priorities for NHS Wales.
 Collaboration	• Collaboration first' will be a concept developed through the lifespan of this IMTP. • We have undertaken reputation audits to determine how we are viewed as a collaborative partner in NHS Wales, and we know we have more to do with our partners in Wales, UK and across the World.
 Involvement	• We will listen to and learn from our patients and donors' experiences and work with them and the wider public to support a user led approach to the design and delivery of our services. We will use our established patient, donor and public engagement arrangements to support this and our ambitions to be an anchor organisation in our communities. • We are committed to the Social Partnership Duty and will involve our Trade Union partners and other staff members in the decisions we make, including them early in the process of strategic transformation and change.

The National Context

Long-term system development: Welsh Government vision for 2035 and wider policy requirements

In 2025-2026 the Cabinet Secretary for Health and Social Care announced a set of a set of refreshed actions to support the delivery of **A Healthier Wales**, in ***Improving Performance Together: Priority Delivery Actions for Better Health and Care 2025-2026***, which set out:

1. Delivery of the key Welsh government priorities for the NHS
 - a. Reducing waiting times (including ambulance patient handover)
 - b. Reducing Pathways of Care delays
 - c. Improving women's health services
2. Strengthening how we run the NHS
 - a. Modernising leadership and culture
 - b. Getting better at regional working
 - c. Improving openness, accountability and collaboration
3. Getting services ready for the future
 - a. More effective prevention of ill health
 - b. Putting more services into the community
 - c. Realising the potential of digital and innovation

Whilst many of the detailed enabling actions are not directly applicable to the Trust or the services we provide you will see throughout our plans, how we will drive support to the NHS Wales Priorities and continue to work collaboratively with the Strategic Programmes for Primary, Planned and Emergency Care, and Mental Health.

The Trust has a direct role in delivery of several recommendations of the Ministerial Advisory Group aimed at improving the performance & productivity of the NHS in Wales. These are summarised earlier in relation to the Quality Statement for Cancer and Palliative and End of Life Care for Velindre Cancer Service.

The Welsh Blood Service will contribute directly to the delivery of the Ministerial Advisory Group recommendations by strengthening the safety, efficiency and productivity of the blood supply chain. Our work will focus on reducing pathway delays through reliable, timely provision of blood and specialist laboratory services, improving preoperative optimisation through enhanced anaemia management, and supporting national and international benchmarking and productivity improvements across transfusion practice.

The Welsh Blood Service has a system leadership role and collaborates closely with the Blood Health National Oversight Group (BHNOG), health boards and Welsh Government to implement evidence based changes, particularly those relating to patient blood management, digital traceability, standardisation of transfusion practice, and reducing unwarranted variation. Through this plan, WBS will play a key role in supporting NHS Wales to deliver the Ministerial Advisory Group's expectations for improved performance, responsiveness and system efficiency.

Wider policy requirements for healthcare organisations

There is a range of legislation which also drives the planning and delivery of services in the Trust and has featured in the development of the IMTP. This includes but is not limited to:

- The Duty of Candour
- The Socio-Economic Duty
- Equality legislation and the Strategic Equality Plan
- Anti-racist Wales Action Plan: 2024 Update
- More than Just Words Action Plan
- Social Partnership and Public Procurement (Wales) Act 2023
- Worker Protection (Amendment of Equality Act 2010) Act 2023

Cabinet Secretary's Priorities

Through this Integrated Medium-Term Plan, we will deliver on many of these objectives of these wider policy requirements directly; set out our ambitions in the role we can play as specialist providers of the Welsh Blood Service and Velindre Cancer Service, how we engage with our partners, whilst contributing to service changes and improvements as an integral part of the wider healthcare system.

The Cabinet Secretary for Health and Social Care's priorities were set out in the 2026-2029 Planning Framework.



Timely Access to Care: the requirement to improve access to care in several key service areas. These include improving ambulance handover times; reducing patient waiting times to access emergency departments; reducing patients waiting for referral to treatment and diagnostics; implementation of the nationally agreed pathways and improving the number of cancer patients commencing their first definitive treatment within 62 days from the point of suspected cancer.

Population Health and Prevention: to support the development of a healthy Welsh population as set out in a Healthier Wales. These include a focus on increasing the number of patients accessing diabetes prevention and care, and vaccination and screening services, alongside a reduction in childhood obesity, improving diabetes care and frailty care.

Community by Design is to support the delivery of integrated services in the community, moving from a hospital by default approach to one of community by design, in particular supporting people with long-term conditions or frailty remain well and receive care in their communities. A reduction of the number of patients delayed in hospital will be delivered through an increase in weekend nursing capacity for community and specialist palliative care nursing.

Women's Health: The Woman's' Health Plan for Wales was launched in December 2024, setting out a 10-year vision and path to improve healthcare services and outcomes for women. In 2025 the priority was the establishment of Women's Health Hubs in each Local Health Board and Trust in Wales. The development of these services will be supported by the Community by Design Programme, which will further build on the integrated services approach.

Access to Mental Health Services: improving the mental health and well-being of the Welsh population through the delivery of timely mental health assessments and targeting the development of sustainable services supported in the Community by Design Programme.

Quality and Safety: the focus is to address harm, waste and unwarranted variation in clinical services to be at the forefront of organisational planning and operational delivery. The Duty of Quality and the Health and Care Standards to shape the decision making, and development of plans to work towards the Quality Statements, including those for cancer, circulatory diseases, diabetes, and Palliative and End of Life Care.

There is a requirement to develop plans to address clinical services that meet the principles for fragility described in the National Clinical Framework. The variation reported in Quality and Outcomes Framework, and National Clinical Audit and Outcome Review Programme have been adopted as an integral part of the Trust quality assurance and governance arrangements.

The table below sets out a summary of the Trust actions to achieve the Cabinet Secretary's Delivery Expectations and Enabling actions, including progress for those brought forward to 2026-2027 with the existing definitions. There are more detailed assessments and commitments within the Ministerial Templates and service delivery plans in the Annexes to this plan.

Cancer Policy

The Welsh Government published the Cancer Improvement Plan for NHS Wales (2023–2026) in 2023 which sets out nine thematic areas for action. These include prevention and public health; early diagnosis and screening; timely access to treatment; effective treatments, improvements in patient experience and in end of life and palliative care. These are underpinned by the key requirements which will support delivery of high-quality cancer services including workforce development, the use of digital technology research and innovation and capital infrastructure.

In support of this, a National Cancer Recovery Programme (2024–2027) was established with a focus on the implementation of resilient service models at a local and regional level; increasing access to diagnostics; and the implementation of the National Optimal Pathways.

Our 2025-2026 set out our Cancer Service Provision and actions to support the provision from Women's Health, these include support for the management and information related to the effects of cancer treatments on, contraception and fertility, Menopause, pelvic health and incontinence, and inclusion in the development of an NHS sexual safety process for women experiencing, violence, domestic abuse and sexual violence. These services are embedded and integrated into our day to day services.

Cancer Genomics and Advanced Therapies and Medicinal Products (AMTPs)

A significant and exciting area of policy development which is being actively integrated into cancer services across Wales is genomics and ATMPs. The key policies are:

- **The Genomics Delivery Plan for Wales (2022–2025):** this builds on the 2017 Genomics for Precision Medicine Strategy, aiming to embed next-generation sequencing (NGS) into routine clinical care. It supports early diagnosis, personalised treatment, and prevention.
- **Advanced Therapies Statement of Intent:** this sets the strategic direction for ATMPs in Wales, aiming to provide equitable access to emerging therapies; and foster collaboration between NHS Wales, academia, and industry.
- **Delivery Plan for Advanced Therapies in Wales (2025–2029):** the delivery plans set out a vision for integrating Advanced Therapy Medicinal Products (ATMPs) into healthcare; a range of strategic goals (including ecosystem development, healthcare delivery pathways, research capacity, and public engagement); and seeks a whole-system approach involving workforce development, infrastructure, and strategic partnerships to the development of sustainable services. As the host for Advanced Therapies Wales, the WBS plays a central role in enabling this vision, providing the regulatory, scientific and operational foundation required to progress ATMP service provision and positioning the organisation as a key partner in shaping and delivering future advanced therapies across Wales.

Velindre Cancer Services will also work with Health Board Clinical Teams, Primary Care Services, Palliative Care Teams and other partners, to ensure the National Optimal Pathways are fully embedded to realise desired efficiency and effectiveness for patients, and productivity is optimised.

Welsh Blood Service Policy

The service supports 2 policy areas within Welsh Government namely Blood and Tissues Cells and Organs.

Blood

NHS Wales Blood Health Plan Led by the **Blood Health National Oversight Group (BHNOG)**, this plan focuses on safe, evidence-based transfusion practices across Wales. The plan has **3 Strategic Aims**:

- **Support Blood Health & Avoid Unnecessary Transfusion**: implementation of Patient Blood Management (PBM); including embedding anaemia pathways; promoting informed consent and alternatives to transfusion; and addressing inequalities in access for ethnic minorities.
- **Use Data to Improve Practice & Reduce Variability**: benchmarking transfusion data to support improvements; and promotion of audit and continuous improvement.
- **Safety, Quality & Innovation**: standardisation of protocols across Wales; strengthening education and digital systems (e.g. delivery of vein-to-vein tracking; and effective preparation for the future risks).

The Infected Blood Inquiry Report (2024) set out 12 recommendations which the Welsh Government accepted all either **in full** or **in principle**.

It is most important to firstly acknowledge the assessment of Sir Brian Langstaff in the Inquiry report, that men, women and children had been treated by infected blood and blood products from the 1970s to early 1990s this was "the worst treatment disaster in the history of the NHS." As a Trust, we sincerely apologise for the tragic hurt, pain and loss of everyone infected and affected by blood and blood products.

Through the Wales Infected Blood Support Scheme, the Trust supports 250 people either infected or affected by infected blood. Following the publication of the Inquiry report. The Trust alongside Welsh Government and NWSSP colleagues are working to deliver the compensation framework and transition into the Infected Blood Compensation Authority.

Progress against the recommendations is being managed with key stakeholders via the Welsh Government Infected Blood Inquiry next steps working group, and a number of recommendations are either complete or well underway.

Recommendation 7 **relates to improving Blood Transfusion Safety** and has a number of sub recommendations within it. The Welsh Blood Service has a leadership role in progressing these and for 2026-2027 will focus on a digital solution regarding traceability of blood products to the patient bedside with Digital Health Care Wales to map patient outcomes.

In addition, to support a key recommendation the Welsh Blood Service will commission a piece of work with colleagues in Health Education and Improvement Wales to provide a workforce model to support transfusion laboratories and blood banks across Wales.

Tissues, Cells and Organs

WBS continues to play a national leadership role in delivering UK and Wales-wide transplantation policies, ensuring services remain aligned with evolving clinical and strategic priorities. This includes supporting the *Organ Donation and Transplantation 2030* vision and the *Donation and Transplantation Plan for Wales 2022–2026*, both of which drive increased demand for histocompatibility and immunogenetics services and require ongoing workforce, capacity and technological development.

Through the Welsh Bone Marrow Donor Registry, the Service contributes to the UK Stem Cell Strategic Forum's ten-year vision, strengthening donor diversity, enhancing the resilience of the domestic stem cell supply chain and supporting the development of Advanced Therapy Medicinal Products.

The Welsh Blood Service also provides national leadership in pharmacogenomics, with the Welsh Transplantation Laboratory being the only provider of HLA-based drug-suitability testing in Wales, positioning the organisation to support the safe expansion of personalised medicine.

What do our commissioners require?

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales, and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our commissioners, Local Health Boards and the Joint Commissioning Committee, to inform the development of our strategies and this IMTP. The priorities set by our commissioners are included in the plan.

SECTION THREE: OUR PLANS FOR DELIVERING IMPROVEMENTS TO OUR SERVICES 2026-2029

This section of the IMTP sets our plans for the 2026 – 2029. It includes our priorities; the actions we will take; to improve the services we deliver; and the benefits that patients, donors, staff and our partners can expect to gain over the next three years.

This section provides an overview of our plans for years one, two and three (2026-2027, 2027-2028 and 2028-2029) of our IMTP.

The detailed delivery plans are included in **Appendix (2a-2i)** which include the quarterly actions planned in 2026-2027 and 2027-2028, and a summary for the year 2028-2029.

The tables in the following pages 31-41, provides identification of the Trust plans to deliver against the Ministerial Priorities and Enabling Actions.

Ministerial Priority Timely Access to Care	Ministerial Delivery Expectations for 2026-2027	2026-2027 Actions
New 2026-2027	Velindre University NHS Trust delivery of the Cabinet Secretary's Priority - Timely Access to Care Health boards to achieve the suspected cancer pathway target of 75% through implementing the nationally agreed pathways, while reducing the backlog of patients waiting more than 62 days by end of March 2027*	(The quarterly timescales in this table reflect the commencement dates reflected in our plan) VCS Component of FDT delivered within 24 days from date of referral received at VCS by June 2027 *to understand the Velindre role with the SCT, performance against the 75% will be tracked for patients. In addition, Velindre performance on the SCT for patients referred on or before 38days will be reported, to track SCT at Velindre based on shared accountability across the 62day. In SACT we will: - • Implement a new SACT delivery model including demand and capacity modelling and pathway review so that by 2027 care is delivered 10%at home, 45% in nVCC and 45% in outreach settings Q1 - Q4 2026-2027 • Develop a SACT chair utilisation tool to facilitate capacity utilisation Q1-4 2026 -2027 • Develop operational and clinical dashboards Q1 2026-2027 • Implementing Hospital Initiated Referrals across VCS Q1 2026-2027 • Implement a delayed pathways of care dashboard Q2 2026-2027 • Explore integration of Hospital with HBs, led by COO Q2 2026-2027 • Develop a business case to resource treatment capacity gap as required from the demand modelling Q2 2026-2027 • Rollout of SACT patient tracker list Q2 2026-2027 • Implement ePMA and phased implementation of hub & spoke model Q3 2026-2027 - Q4 2027-2028 • Implement phased rollout of funded hub and spoke model Q4 2026-2027-Q1 2027-2028 In Radiotherapy we will: - • Planning for new treatment techniques in IRS for (axilla & partial breast radiotherapy) Q4 2026-2027 • Develop & implement Brachytherapy transition & service plan – Q1 2026-2027 - Q2 2027-2028 • Deploy phase 3 of the IRS programme to achieve full implementation Q3 2026-2027 - Q2 2027-2028 • Commissioning of new LINACS in nVCC Q3 2026-2027 - Q2 2027-2028 • Implement Hypersight capability on new LINACS in nVCC Q3 2026-2027 - Q2 2027-2028

Ministerial Priority Timely Access to Care	Ministerial Delivery Expectations for 2026-2027	2026-2027 Actions
		(The quarterly timescales in this table reflect the commencement dates reflected in our plan) - Implementing a new treatment solution to treat a larger cohort of patients with neurological cancer with Stereotactic Radiosurgery Q4 2026-2027-Q1 2027-2028 In our Outpatients Service we will: - - Complete a baseline assessment of workforce – skills and capability Q1 2026-2027 - Implement a revised Standard Operating Procedure for patient flow Q2 2026-2027 - Implement the delayed pathways of care dashboard Q2 2026-2027 - Pilot digital patient check in Q2 2026-2027 - Implement a digital patient record Q2 2026-2027 - Implement a new model of patient administration Q2 2026-2027 - Implement a 'shared care approach' to SCP breach reporting with UHB's Q2 2026-2027 - Scope development for remote monitoring and digital PROMS Q2 2026-2027 - Undertake a workforce redesign / OCP Q3 2026-2027 In our Pharmacy we will: - - Plan for the development of a shared pharmacy technical service (aseptic service) for Wales. Q1-Q4 2026-2027 - Implement Electronic Prescribing and Medicines Administration (ePMA) Q3 2026-2027 Quantified Impact of Actions Achieve the VCS element of 75% of patients receive FDT within 62 days. VCS component FDT delivered within 24 days from date of referral received at VCS (local target). Baseline Jan 39% to 75% Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.
	Number of patients waiting more than 8 weeks for a specified diagnostic – target zero	Out of scope – no primary diagnostics within VUNHST Clinical Services. Velindre University NHS Trust contributing to the wider system requirements VUNHST is supporting improvements towards this target as part of the South East Wales Regional Radiology Programme to improve diagnostic performance. We will: -

Ministerial Priority Timely Access to Care	Ministerial Delivery Expectations for 2026-2027	2026-2027 Actions
		(The quarterly timescales in this table reflect the commencement dates reflected in our plan)
		- Participate in the establishment of diagnostics pathways for the Community Diagnostic Hubs Q 1 2026-2027 - Provide workforce and demand and capacity data to support development of regional reporting models and workforce plans Q2 2026-2027
	No patients waiting more than 104 weeks for referral to treatment.	Out of scope – No RTT Pathways in Clinical Service - patients timely access to care, managed through SCP or SACT/RT measures included in this plan
	Ensure no ambulance patient handover waits over 45 minutes Ensure no patient spends 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge.	Out of scope - no major or minor emergency care facilities

Population Health & Prevention	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
New 2026-2027	Reducing inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and diabetes prevention and care. Increase the proportion of children in Wales who are a healthy weight by halting the rise and contributing to a year-on-year decrease in the levels of overweight and of obesity, as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged. (out of scope) At least 90% of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans.	Out of scope – these services are not within the scope of our Clinical Services Velindre University NHS Trust contributing to the wider system requirements We will: - Undertaking an equity audit of access to specialist treatments by geography, deprivation ethnicity & tumour site – Q2 2026-2027 - Improve access and equity in the completion of the nVCC and our hub and spoke model of care Q4 2026-2027 - Continue to support donors to refer to GP support with any screening identified issues and concerns about their health - Our core services refer patients and donors to our wellbeing and prevention information - these include our psychology and wellbeing services and Maggie's

Community by Design	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
New 2026-2027	Deliver a 12-month reduction trend in both the number of people who are delayed in hospital and the total days delayed for these patients, as measured by the Delayed Pathways of Care dashboard.	Out of scope – not include within our Care Pathways. Palliative Care and End of Life Patients may be delayed. Therefore, our actions are targeted on this cohort of patients. Velindre University NHS Trust contributing to the wider system requirements

Community by Design	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
	Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024-2025 and greater where possible. (out of scope)	We will: • Develop a 7-day sustainable fully funded palliative care service by March 2027 Q1 - Q4 2026-2027 • Implement Palliative Care and End of Life framework and national specification Q1-Q4 2026-2027 • Develop a business case to support extended working hours Q2 2026-2027

Mental Health Access	Ministerial Delivery Expectations for 2026-2027	2026-2027 Actions
New 2026-2027	Implement and evaluate Open Access Mental Health Support by March 2027. Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027. (out of scope) Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.	Out of Scope – no direct Mental Health Access service provided in the Trust. Velindre University NHS Trust contributing to the wider system requirements. We recognise the holistic needs and also significant mental-health burden sometimes experienced by our patients. We are committed to strengthening identification of need, improving referral pathways, and collaborating closely with providers of holistic and psychological needs. We will: - • Maintain and promote our Psychologists and Counselling service: a small team who work with Inpatient and Outpatient patients and can help people who are experiencing emotional or personal difficulties relating to their cancer, both during and after their illness. • Maintain and promote our Supportive Care Team: which offers support and information in areas of welfare and benefits, discussions with children, and organising transport. • Maintain and promote our Chaplaincy Services: which offers access to a multifaith chaplaincy service to support patients with their spiritual needs. • Continue to promote access to 'Maggie's' services

Women's Health	Ministerial Delivery Expectations for 2026-2027	2026-2027 Actions
	Further expansion of the Women's Health Hub model in each health board area by March 2027 (aligned to the Women's Health Plan) Improving the quality of our maternity services by reducing peri natal mortality rates.(out of scope)	Out of scope – we do not have Women's Health Hubs or maternity services within our Clinical Services. Our contribution to delivery of the Women's Health Plan Appendix 8 and Page 110 . Velindre University NHS Trust contributing to the wider system requirements. The details of The anaemia rates for patients undergoing major elective surgery of which the incidence rate of anaemia is twice as high in women than men (39% vs 19%). We will: - - Review of our anaemia management post operative pathway Q1 -Q4 2026-2027 The anaemia workstream aligns with five of the eight priority areas, menstrual health, endometriosis and adenomyosis, preconception health, menopause and ageing well. - Collaborate with UHB colleagues at Muti-Disciplinary Meetings to increase identification and referral for cancer patients to genomic testing recommendations for precision medicine Q1 – Q4 2026-2027 - Lead training by our specialists in women's cancer to raise awareness and offer genomic testing as appropriate Q1 – Q4 2026-2027

Quality and Safety	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
	Days of safe care delivered since the last never event, monitored using SPC T-Chart	We will: - - Develop SPC data capture for utilisation should a 'never event' occur Q1 2026-2027 - Maintain Trust delivered 'proportionate investigation training' to ensure staff awareness or never events, and risk of under reporting Q1 – Q4 2026-2027 Quantified Impact of Actions SPC T-chart in place
	Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027	The number of complaints dealt with via early resolution in VUNHST as at Q3 2025-2026 is: WBS 94.4% and VCS 71.4%. This is significantly above the national target and fluctuates month on month due to relatively low volumes.

Quality and Safety	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
		VUNHST will: - - Continue with monthly monitoring of delivery against quality indicators and this measure Q1-Q4 2026-2027 - Planning for the implementation of the new Listening to People Process to be enacted in April 2026 Q 1 2026-2027 Quantified Impact of Actions We have set a local target to maintain WBS early resolution at 90% or above and VCS at 65% or above. We consider this to be an optimum level – some complaints will always require full investigation.
	The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35 days of identification, ensuring timely and accurate data quality improvements across all health boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.	Timeliness of Coding: 95% completed within one reporting month of discharge Velindre Trust continues to consistently achieve this target month on month. Based on current performance and available resources. We will remain compliant with this target during 2026-2027. We will: - - Explore the utilisation of AI to maintain performance whilst improving efficiency Q3 2026-2027 Error Correction: 90% corrected within 35 days of identification Velindre Trust continues to consistently achieve this through robust processes already in place that identify coding errors prior to national submission. Any errors detected are corrected well within the 35-day timeframe, ensuring timely and accurate data quality improvements. We will: - - Maintain existing processes to ensure performance is sustained and improved Q1-Q4 2026-2027 Quality and Specificity: 10% year-on-year increase in depth index Velindre Trust clinical coding team already capture all documented comorbidities in full accordance with national standards. We will: - - Collaborate with DHCW and Welsh Government colleagues to resolve current challenges with the applicability and validity of this newly proposed measure. Quantified Impact of Actions Maintain compliance on depth index: Velindre record a mean average of 9 codes per episode (approx. 6 diagnosis codes and 3 procedure codes per episode). All co-morbidities documented are coded as a routine Timeliness of Coding 99.8% for YTD as at Dec 2025 (latest available figures)

Quality and Safety	Ministerial Delivery Expectations for 2026-27	2026-2027 Actions
		Error Correction 97.7% for YTD as at Jan 2026
	Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.	Out of scope – development of mortality metrics reflected in VCS plan. Readmission rates not applicable to our clinical service provision

New Actions for 2026-2027	Ministerial Enabling Actions for 2026-2027	2026-2027 Actions
Productivity	Health boards to ensure utilisation of the total factor productivity model and set out the actions and quantified productivity impact that will increase total productivity in 2026-2027 from the baseline position.	Out of scope - The Trust has its own programme for productivity and efficiency detailed in this plan and in Appendix 6.
Mental Health	Health boards to implement actions to deliver a material reduction in the number of out-of-area placements in 2026-2027, and associated costs.	Out of scope - this service is not within the remit of our clinical service provision.

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions for 2026-2027	2026-2027 Actions
Timely Access to Care	Improvement in the implementation and delivery of High Volume Low Complexity Theatre lists, with an initial focus on - Cataract 90% of lists to have 7 Cataracts per list by end of Q2, Arthroplasty 90% of lists to have 4 Primary joints per day and 90% of time achieve at least 6 HVLC General Surgery procedures on an all-day list made up of hernias/gallbladders by end of Q2	Out of scope – these services are not within the remit of our clinical service provision
Building Community Capacity	Support the implementation and roll-out of the NHS Wales app for maximum impact and benefit to include the uptake of its use for repeat prescriptions	Out of scope – the Trust does not issue repeat prescriptions Velindre University NHS Trust contributing to the wider system requirements The rollout of EPMA will support the use of WP10 HPS for community pharmacies to dispense prescriptions issued at VCS. We will: - - continuing to collaborate with UHB and DHCW colleagues on the NHS Wales App and its role in relation to nVCC Q1 –Q4 2026-2027 - Implement electronic prescribing (EPMA) to support digital management of prescriptions Q3 2026-2027

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions for 2026-2027	2026-2027 Actions
Maximising Value for Money	Non-Pay - ensure implementation of Value & Sustainability Board recommendations, which includes local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value.	Out of scope – see Medicines Management below. Velindre University NHS Trust contributing to the wider system requirements We will: - Continuing to educate, motivate and incentivise staff to undertake Value Based Health Care projects Q1-Q4 2026-2027
	Estate - ensure strengthened actions are taken to improve estate utilisation including the appropriate repurposing & disposal of under-utilised estate.	We will: - Plan the management of Whitchurch Land and decommissioning of VCC.Q1-Q4 2026-2027
	Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the programme areas.	The Trust is represented at the Value & Sustainability Board at Executive level. Through this leadership role the Trust ensures specific 'value' opportunities are reviewed and implemented in the Trust as appropriate. We will: - Reduce expenditure on high-cost drugs through the implementation programme of All Wales Blueteq System Q3 2026-2027 Quantified Impact of Actions Based on the latest NHS Wales Medicines Value & Sustainability report (August 2025), the All Wales full year opportunity from maximising biosimilar use, switching to generics, and restricting low value prescribing is £2.81m. Applying a conservative attribution based on Velindre's relative medicines spend (~3.5%), this represents an estimated medicines savings opportunity of approximately £0.10m per annum for Velindre Trust.
	CHC - ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care.	Out of scope – not within our Clinical Services VUNHST does not commission 'packages of care'.
Improving Value, Optimising Outcomes, & minimising Variation	Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Bone Health	Out of scope – not within our Clinical Services. VUNHST contributing to the pathway for Sarcoma patients incorporated into pathway work in VCS plan.
Workforce Productivity	Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2026 and aligned to service demand and capacity plans.	Trajectory is on target to achieve compliance by Q2 2026-2027

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions for 2026-2027	2026-2027 Actions
		The new VCS structure has delegated management of job planning through the new Directorates. We will: - • Monitor completion rates and maintaining effective scrutiny of compliance through Executive Management Board (88% compliance at Jan 2026) The WBS compliance rate is consistently maintained at 100% through existing governance structures.
Workforce Productivity	Continue to deliver a further and sustained reduction in agency expenditure, with a target 30% reduction in 2026-2027 from 2025-2026 outturn and ensuring no off-contract expenditure.	Agency reduction target achieved in 2025 -2026 We will: - • Monitor ongoing decision making and expenditure utilising recruitment scrutiny and financial review process in place to achieve target of further 30% reduction in 2026-2027 Quantified Impact of Actions The forecast 2025-26 outturn agency expenditure is £350k. A 30% reduction target in 2026-27 delivers a recurrent cash releasing saving of £105k
Workforce Productivity	Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular	We will: - • Monitor ongoing decision making and expenditure utilising recruitment scrutiny and financial review process in place to achieve target of further 30% reductions • Policy group established Priority areas identified agency reduction programme requires two main areas of focus: • enhanced NHS workforce supply – to incentivise workforce to deliver the additional flexible hours that we need to deliver a safe and efficient service in more safe, transparent and cost-effective ways • improved control framework for agency deployment to reduce agency • maintain scrutiny at finance and establishment reviews Q1-Q4 2026-2027 • continue our work with HEIW on workforce supply and commissioning Q1-Q4 2026-2027
	Organisations who have achieved a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to maintain that position. Organisations yet to deliver that position to deliver zero by 30th September 2026.	Reduction Target achieved – we will maintain performance as above

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions for 2026-2027	2026-2027 Actions
	Ensure a reduction in sickness absence in 2026-2027 in comparison to 2025-2026, through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.	VUNHST achieved a reduction in sickness absence from 5.7%-5.1% in 2025-2026 We have set a target to at least maintain the current sickness absence rate of 5.1% (or better) acknowledging our experience and workforce research that sickness absence usually increases during periods of major change. To mitigate risk of increasing sickness we will: - • Monitor trajectory at Divisional Management and Executive Management Board • Maintain control and challenge through Trust governance structures • Implement attendance management plan and monitor absence management triggers points and review meetings are conducted effectively and timely to support staff to return to work • Raise awareness of employee support and assistance programmes (Our People) Q1-Q4 2026-2027 Quantified Impact of Actions Utilisation of the additional productivity achieved through the reduction in sickness absence achieved in 2025-26. Applied across the Velindre University NHS Trust workforce (1,703 WTE), this equates to approximately 6.8 WTE of additional capacity.

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions with newly defined actions	2026-2027 Actions
Timely Access to Care	Ensuring the full implementation of the National Optimal Pathway (NOPs) in Cancer	Out of scope – the NOP's apply to the pathway prior to VCS referral. VUNHST contributing - All our plans for SACT, Radiotherapy and Outpatients will support delivery of the National Optimal Pathways in Cancer.
	Theatre session utilisation is improved to achieve GiRFT standard of 85%- late starts (>15 mins), early finishes (>60 minutes) and overall utilisation are reported as key KPIs to underpin the 85% standard	Out of scope – VCS does not have theatres.
	Consistent clerical and clinical validation should be in place using the national SOP - any patient waiting greater than 26 weeks should be validated. Volumes of non-admitted closed pathways will be monitored as proxy supported by National Programme team visits	Out of scope – not within our Clinical Services
	Each Health Board should see a referral return rate of 20+% and/or a reduced referral rate per 100,000 population by December 2026 - utilising Health Pathways optimally.	Out of scope - not within our Clinical Services

Actions to be rolled over New Actions for 2026-2027	Ministerial Enabling Actions with newly defined actions	2026-2027 Actions
	Through effective streaming of patients on arrival at the front door allied to a focus on safe, efficient and early discharges, deliver all ambulance patient handovers within a maximum of 45 minutes, aiming for achievement of >90% in 15 minutes by the end of 2026-2027	Out of scope - not within our Clinical Services
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme Optimal Hospital Flow Framework with a focus on 7-day working with leaner acute hospital processes and more efficient discharge transport services to facilitate earlier discharges and increasing weekend discharges.	Out of scope - not within our Clinical Services. Velindre University NHS Trust contributing to the wider system requirements As set out in VCS plan for acute service transformation.
	Deliver medical same day emergency care (SDEC) and acute frailty services at the front door of hospitals in line with all principles set out in national SDEC policy and strategy documents, and the six goals for urgent and emergency care programme Front Door Acute Frailty Service (AFS) Framework for Acute Hospitals.	Out of scope - not within our Clinical Services. Velindre University NHS Trust contributing to the wider system requirements As set out in VCS plan for acute service transformation
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme community-based falls response framework and, in support, implement a focus on prevention and early intervention in line with the policy statement on population health management.	Out of scope - not within our Clinical Services. Velindre University NHS Trust contributing to the wider system requirements We will support delivery of the Six Goals Framework through our pathway work. (See VCS plan)
	Deliver, as a minimum, all principles set out in the six goals for urgent and emergency care programme single point of access (SPOA) framework to ensure people with urgent care needs receive timely and appropriate support, minimising unnecessary escalation to emergency ambulance conveyance or hospital admission. Prioritise tailored interventions for frail and older adults, scaling up “call before convey” as a business-as-usual model and referrals to community nursing services enabling urgent response. Strengthen integration with key system partners, including WAST and Local Authorities, to deliver coordinated and effective care across the urgent care pathway.	Out of scope - not within our Clinical Services. Velindre University NHS Trust contributing to the wider system requirements We will support delivery of the Six Goals Framework through our pathway work. (See Velindre Cancer Service plan)
Population Health & Prevention	Ensure progress of the focused Diabetes High Value High Impact pathway	Out of scope
Improving Value, Optimising Outcomes, & minimising Variation	Eradicate unsupported systems and devices and ensure a clear cyber response plan for the organisation.	VUNHST has a Cyber Response Plan in place. The Trust has identified as series of actions which require further investment to deploy the required actions on Windows 10-11 migration, backup, infrastructure, virtualization and firewalls. We will: - Develop a case for investment for additional resources for the Cyber team Q1 2026-2027

WELSH BLOOD SERVICE 2026 – 2029

Where are we now: what has been achieved by March 2026

The Welsh Blood Service continues to deliver on its strategic ambition outlined in *Blood and Transplant Services for the Future*, which concludes in 2027–2028. As we enter 2026–2027, our strategy is being refreshed to ensure it remains aligned with emerging priorities and future service needs. This refreshed approach is anchored in our four core service offers, transfusion services, transplantation services, diagnostic testing, and wholesale supply, ensuring we continue to provide safe, sustainable and high-quality services for donors, patients and NHS partners across Wales.

Over the past year, significant progress has been achieved in developing safe, high-quality services across Wales, with a strong focus on safety, donor experience, operational efficiency, and innovation. The Welsh Blood Service maintained exceptional service reliability throughout the year, issuing no alerts to customer hospitals, reflecting our ongoing commitment to safety, quality, and operational resilience. The following section summarises the key achievements and milestones delivered during this period.

The logos at the top of each objective, programme, priority or change activity highlight which of the Trust's Well-being Objectives it aligns too.



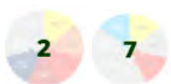
Safety and Quality

- Duty of Candour and national standards fully embedded, strengthening governance and patient safety.
- Implementation of a new microbiological Nucleic Acid Testing platform and procurement of Haemoglobin S Testing analyser to enhance blood safety.
- National rollout of self-administered G-CSF to support stem cell preparation for transplantation, enabling donors to complete safely at home, improving donor experience and strengthening the efficiency and effectiveness of transplantation pathways.
- A pre-operative anaemia pathway has been rolled out nationally, reducing the prevalence of anaemia ahead of surgery and improving patient outcomes.
- Enhancement of the Genetic Haemochromatosis pathway, supporting improved patient outcomes, while enabling more individuals to be monitored and managed outside the hospital setting — reducing pressure on secondary care and improving patient experience through more accessible, community-based care.
- Implemented phase 1 of a new Laboratory Information Management System for the Welsh Histocompatibility and Immunogenetics Service, to improve quality, safety and efficiency for service users and patients.



Donor Engagement and Experience

- Increased donor numbers and diversity, with new recruits from ethnic minority backgrounds, reflecting the communities we serve.
- Improvements in booking, screening, and donation processes for a seamless experience.
- Development of a Donor & Advocate Forum, providing a structured platform for donor voices to help shape service improvements.
- Introduction of enhanced haemoglobin testing on donation clinics to support donor safety and improve the quality of the donation experience.
- Introduction of mobile donation tours across North Wales, allowing blood donation teams to provide an increase in access to communities, increasing visibility, accessibility, and engagement.



Innovation and Transformation

- Migration of the Prometheus Donor Matching System to enhance the accuracy, efficiency and reliability of donor–recipient matching, strengthening the safety and effectiveness of transplantation services.
- Improved Welsh Histocompatibility and Immunogenetics Service Human Leucocyte Antigen Typing service to streamline testing performed, while maintaining highest quality test results for patients.
- Development of the Welsh Bone Marrow Donor Registry 5-Year Strategy to strengthen stem cell provision, positioning Wales at the forefront of donor registry innovation and future readiness.
- Formal approval of the Platelet Operational Plan, establishing a standardised approach to production, stock management, reducing waste, and clinical supply, alongside the development and implementation of a new Platelet Planning Tool, enabling improved forecasting, inventory management, and clinical responsiveness across Wales.
- Developing new blood components and participating in national and international collaborative studies.
- Working in close partnership with leading aviation and technology organisations to advance autonomous drone delivery across Wales. Through the UK-funded Dragon's Heart initiative we are helping to design and test a fully automated, safety-assured drone network that supports the practical needs of frontline healthcare teams.



Efficiency and Continuous Improvement

- Embedded improvement culture through initiatives such as the internationally recognised *Five-Minute Improvement Programme*.
- Adoption of a Toyota Lean Management approach, supported by Welsh Government programmes, delivering measurable improvements in Red Cell Immunohaematology laboratory turnaround times.
- Secured funding to progress the recovered plasma programme, supporting the development of future pathways for the safe and effective use of recovered plasma in Wales.
- Adopting software support when screening donors for travel to improve efficiency and safety of blood donation.



Infrastructure and Sustainability

- Outline Business Case submitted to Welsh Government in March 2026 for the refurbishment of the Talbot Green site, creating a high-quality, low carbon facility to support services for the next 50 years.
- Business case for fleet modernisation was submitted to Welsh Government, setting out the investment required to transition to a more sustainable, and resilient vehicle fleet that aligns with organisational carbon-reduction commitments and supports the safe, reliable delivery of services across Wales.
- Business Case for the Blood Establishment Computer System (BECS) supported by Welsh Government, enabling transformational change and enhancement of service delivery across the Welsh Blood Service.
- Delivered the initial phase of in-house development of a new digital system for UK NEQAS international External Quality Assessment Service, using Microsoft Power Platform.

What do the next 3 years look like: our focus and priorities for 2026 - 2029

The Welsh Blood Service plays a critical national role in securing a safe, sustainable and high-quality supply of blood, blood components, stem cells, organs, medicines and diagnostic services for patients across Wales. As demand continues to evolve, the WBS remains focused on delivering modern, resilient and patient centred- services that support high-quality- clinical care, strengthen donor engagement, and contribute to wider system priorities across NHS Wales. Our work is underpinned by a commitment to innovation, digital transformation, research, sustainability and prudent healthcare, ensuring we continue to meet current and future clinical needs while providing an excellent experience for patients, donors, and partners.

During 2026–2029, we will focus on delivering the remaining priorities within the strategy, while at the same time reviewing and refining our long-term direction to ensure it continues to meet the needs of patients, donors, and services across Wales. Our priorities are:



A continued focus on improving the safety and quality of our services through the implementation of:

- Core blood and transplant regulatory and healthcare standards.
- New screening techniques to improve the safety of blood and transplant services within Wales and across the globe.
- The Infected Blood Inquiry recommendations relevant to transfusion including education, connectivity, laboratory staffing and governance.
- Implementation of X-Ray Technologies for Blood Irradiation in alignment with the UK-wide national initiative.
- Continued delivery of the Blood Health Plan for Wales, strengthening system-wide governance of blood and blood components, improving clinical appropriateness, and supporting prudent, sustainable use across NHS Wales.
- Investigating the feasibility of providing HLA selected red blood cells for solid organ transplant recipients in Wales, to reduce the incidence of immunological rejection and improve patient outcomes.



The continued implementation of our blood donation model to support the provision of safe and high-quality blood, platelets, stem cells to improve clinical outcomes, through the implementation of:

- An enhanced donor portal which enables donors to book online and allows communication with donors in multiple ways, including phone, text message, and a new App.
- A clinically led blood donation model ensuring that blood donation activity is guided by clinical expertise optimising donor safety and improving the quality and consistency of collected components.
- Targeted recruitment of ethnically diverse communities, with a particular focus on donors of Black heritage, to improve the availability of rare and ethnically matched blood components.



The development of a range of new tests and services including:

- Expanding Stem Cell donation services to increase the number of stem cells available for transplant globally, and provision of stem cell processing capabilities to support future advanced therapeutic medicinal product cellular therapy requirements including, the collection and delivery of ATMP starting materials to support clinical research, commercial partnerships and ultimately decentralised therapeutic cell treatment manufacture.
- Support effective organ transplantation by reviewing the antibody testing strategy and introducing new biomarker tests for donor derived cell free DNA.

- Developing a sustainable national capability for the collection and supply of recovered plasma to support the manufacture of lifesaving plasma derived medicines for NHS Wales.
- Implementing a national model for the collection of plasma for fractionation to support Wales and the UK to improve self-sufficiency and supply chain security and resilience.
- Work in partnership with Advanced Therapies Wales, which are hosted by the Welsh Blood Service, to strengthen our Advanced Medicinal Therapy Product (AMTP) capability, supported by an external review undertaken by the Scottish National Blood Transfusion Service (SNBTS).



The continued implementation of our research and innovation including:

- Strengthening our national and international partnerships, enhancing WBS influence across collaborative initiatives, and expanding our portfolio by enabling more colleagues to contribute to research and innovation.
- Building a sustainable and financially robust environment, supported by clear governance and financial frameworks, increased external income.
- Maintain facilitation and support, to ensure specialist advice, compliant delivery and sustainable oversight of activity.
- Scoping a Value Based Health Care (VBHC) project focused on optimising transport logistics across NHS Wales, assessing opportunities to improve efficiency, patient outcomes, and resource utilisation.



The transformation of services through digital technology and innovation, including implementation and embedding of:

- A new Blood Establishment Computer System (BECS) which will support the transformation of our service and providing donors and partners with a world class experience.
- A new computer system for the management and distribution of blood derived medicines/wholesale products.
- The Wales Laboratory Information Management System (WLIMS) which will provide us with a national system to effectively manage the Red Cell Immunohaematology referral services at WBS.
- A new Welsh Bone Marrow Registry digital system to support efficient logistics and enhance clinically informed decision-making across the management of the donor registry.

- Live connectivity with our Blood Establishment Computer System (BECS) on our blood donation clinics.
- Delivery of Phase 2 of the new in-house digital solution to provide an external quality assessment (EQA) service for clinical laboratories supporting organ transplantation, building on the successful completion of Phase 1.
- New integrated donor communication and customer relationship platforms to enhance appointment management, strengthen donor engagement, and improve the overall donation experience.
- Implementation of Phase 2 of the Welsh Histocompatibility and Immunogenetics Service (WHAIS) digital solution, following the successful delivery of Phase 1, to improve data integration, streamline information flows, and enhance digital connectivity across national health systems.

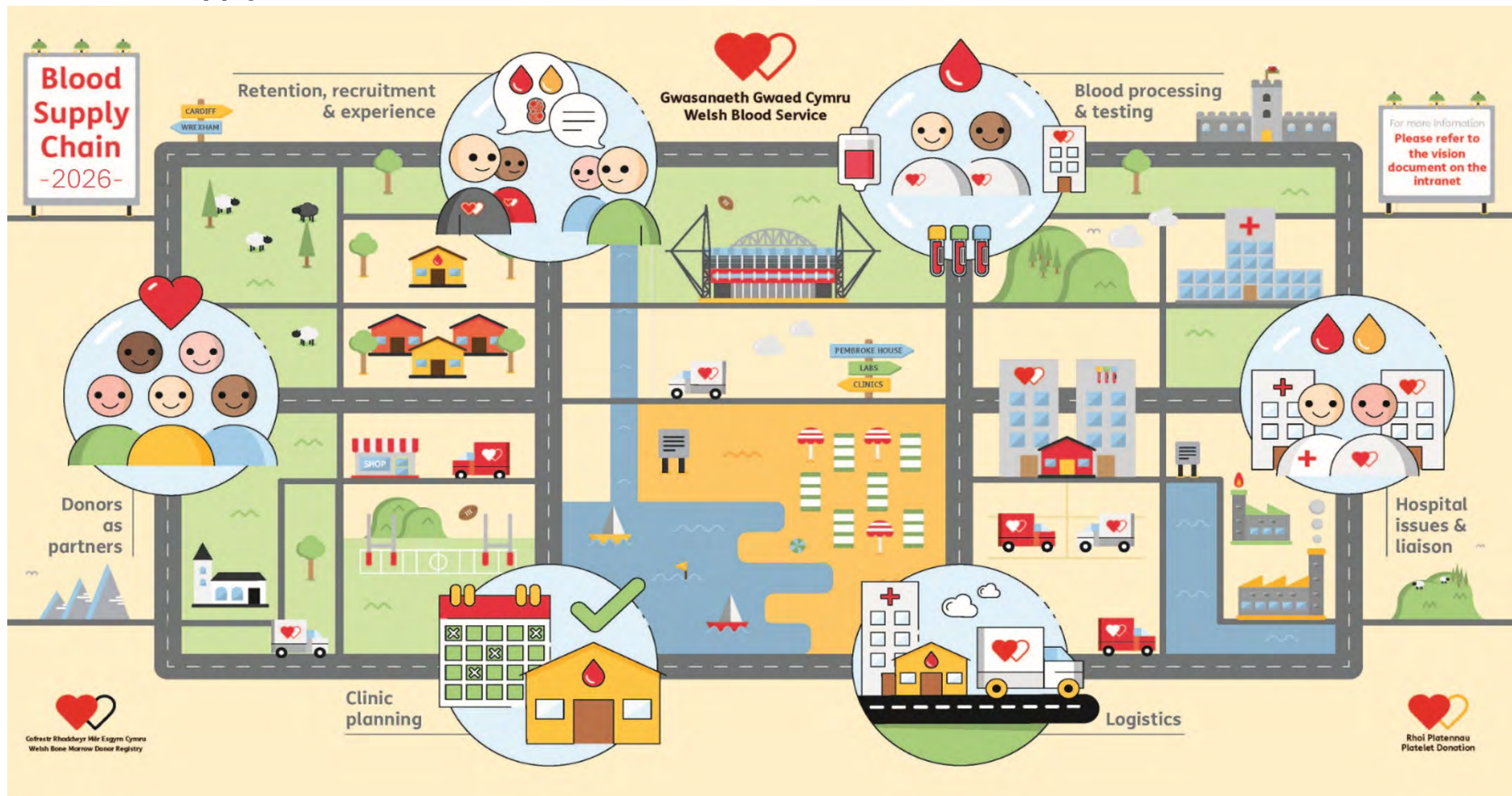


Development of our infrastructure, estate and supporting logistics across Wales to provide sustainable, modern and ‘fit-for-the-future’ facilities from which to donate, manufacture, transport and distribute blood and other lifesaving products

We will:

- Submit a Final Business Case to Welsh Government, to secure approval to commence the refurbishment of the Talbot Green site to deliver a high-quality, low carbon facility fit for the next 50 years.
- Continue to work with our partners to improve the quality of our local blood donation sites across Wales, providing donors with a great experience.
- Continued implementation of our fleet strategy to improve the transportation of blood and products across Wales; and reduce our carbon impact.

Our Blood Supply Chain Model

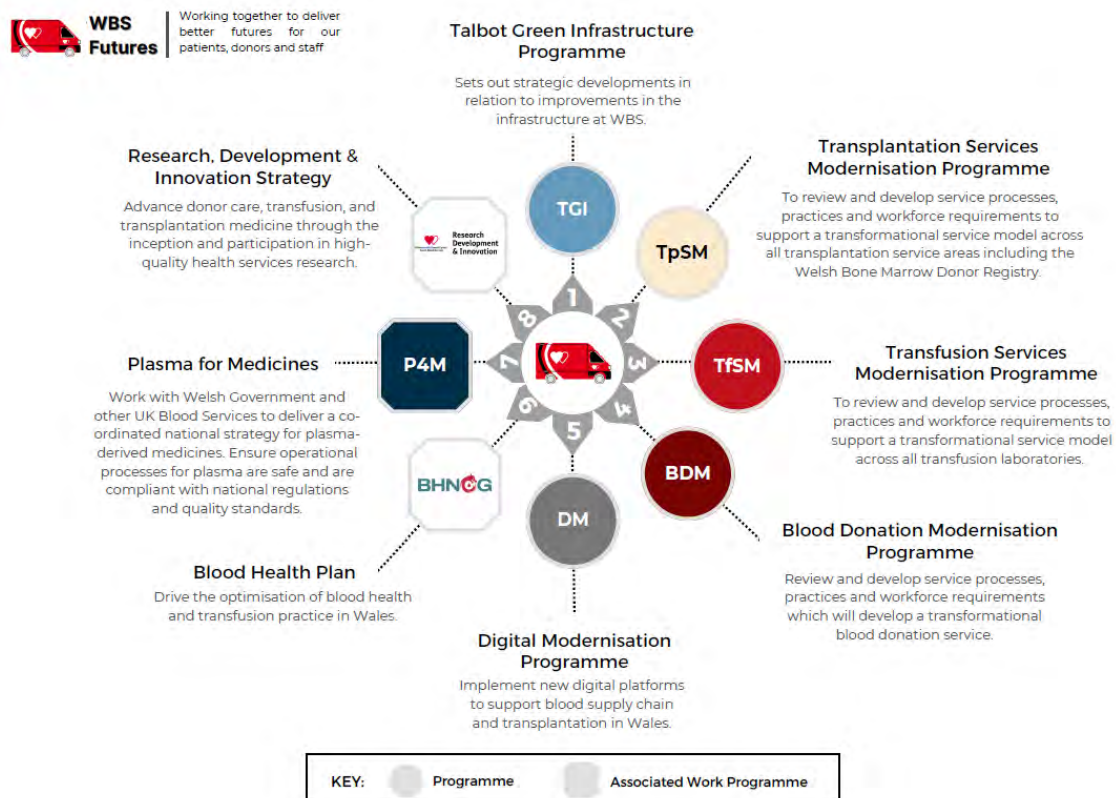


Welsh Blood Service Delivery Plan

Our delivery plan is governed through Welsh Blood Service (**WBS**) **Futures** – our overarching transformation programme that brings together all modernisation activity across transfusion, transplantation, donation, digital systems, fleet and infrastructure. WBS Futures sets out how we will redesign services, adopt new technologies and strengthen our workforce to meet the future needs of NHS Wales. It provides a structured, 5-year programme that will deliver future-proofed services, improve patient outcomes through faster and more accurate testing, enhance donor experience, and build resilience in blood and stem cell supply. Through WBS Futures, we will turn our ambitious vision into a coordinated, deliverable plan for sustained improvement and innovation.

The WBS Futures portfolio is structured around a series of key programmes that together will modernise and strengthen every aspect of our service. Each programme provides a clear framework for how we will redesign processes, introduce new technologies, enhance clinical and donor services, and build a resilient infrastructure capable of meeting future demand. The following sections set out the high-level aims, scope and anticipated benefits of each of these programmes, demonstrating how they collectively deliver the transformation required to support high-quality, safe and sustainable blood and transplant services for NHS Wales.

The Detailed Delivery Plan, included as Appendix 2a, sets out the outputs, benefits and timelines associated with each programme outlined below.



Demand Assumptions for 2026–2029

Demand for blood and blood components has remained stable, with no significant growth projected over the 2026–2028 period. Demand forecasting continues to be informed by the daily Resilience meetings and monthly Blood Supply Chain Planning Group meetings, drawing on utilisation trends, clinical practice changes and national system pressures to maintain a safe and efficient supply position.

Platelet demand is modelled separately using the last six weeks of issuing data, supplemented by a 1 to 2 standard deviation buffer to ensure operational resilience and reduce the likelihood of supply disruption. The development of the platelet planning tool during 2025-2026 has significantly improved the accuracy and reliability of platelet demand forecasting, enabling more refined predictions.

This work forms part of ongoing efforts to enhance forecasting methodologies across all components, strengthen data insight, and ensure alignment with wider UK blood supply planning frameworks.

WBS is also supporting the delivery of the Blood Health Plan for Wales, which is strengthening understanding of blood use, variation and clinical demand across the system.

Stem cell transplantation related activity continues to demonstrate sustained growth and increasing complexity. Donor matching demand is forecast to increase by approximately 5% across UK and global transplant centres, with the University Hospital of Wales activity showing higher growth, including a 41% increase in stem cell product imports in 2025 compared with 2024. Stem cell collections are projected to increase by 29% in 2025-2026. This level of increase is not expected to be sustained in 2026-2027; however, a further 13% increase is anticipated. Increasing donor search complexity is driving higher verification typing and antibody testing workload per patient for the laboratory.

In solid organ transplantation, national strategy (Organ Donation and Transplantation 2030: Meeting the Need) sets a target 15% increase in transplants per year by 2028-2029 to address record national waiting list levels. Locally, planning assumptions indicate an estimated 10–15% increase in transplants, with laboratory work to support (e.g. antibody monitoring) already demonstrating upward trends during 2025-2026.

Disease association testing demonstrates stable upward trends, supporting an overall forecast of 3-5% increase per year, reflecting sustained referrals and emerging pharmacogenetic testing indications.

WBS will continue to work closely with commissioners and Welsh Government to develop an agreed long-term strategy for achieving partial self-sufficiency in plasma derived medicines.

Key Programmes:



Transfusion Services Modernisation Programme

Modernise and future-proof our Transfusion Services by introducing new technologies, strengthening laboratory capability and creating a more resilient, efficient and clinically responsive service for NHS Wales. Key projects within this programme include:

- Automated Blood Processing Solutions**
 Modernising manufacturing workflows to improve efficiency, reduce variation and enhance resilience across transfusion laboratories.
- Implementation of X-Ray Technologies for Blood Irradiation**
 Improving turnaround times and strengthening the safety and reliability of component preparation.
- Review and Optimisation of Red Cell Immunohaematology (RCI)**
 Enhancing service sustainability through updated service models, workforce development and greater use of automation.
- Wholesale Product Management System**
 Implementing a modern IT system to streamline product data, improve operational efficiency, and ensure accurate inventory and pricing for blood-derived medicines and other wholesale products.

Success will be demonstrated through the sustained delivery and continued improvement of performance against WBS Performance Management Framework indicators:

KPI Ref	Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Nov 2025 Actual
KPI.18	Timely	Turnaround Times – Antenatal	Quarterly	90%	95%
KPI.23	Timely	Turnaround Times – Red Cell Reference Serology	Monthly	90%	97%
KPI.30	Safe	Number of SABRE/SAEAR incidents	Monthly	n/a	n/a
KPI.36	Safe	Overdue SABRE/SAEAR actions	Monthly	<5%	3.2%
KPI.04	Effective	Clinical demand for red cells met	Monthly	100%	103%
KPI.05	Effective	Clinical demand for platelets met	Monthly	100%	131%
KPI.07	Effective	Stock stability (O/A/B+ below 3 days)	Monthly	0	0
KPI.25	Effective	Time expired red blood cells	Monthly	1%	0.02%
KPI.26	Effective	Time expired platelets	Monthly	10%	14%



Transplantation Services Modernisation Programme

Modernise and strengthen our Transplantation Services by expanding digital capability, enhancing genomic and stem cell services, and building a resilient, future-focused programme that meets the evolving needs of NHS Wales. Key projects within this programme include:

- Implementation of a New Welsh Bone Marrow Donor Registry (WBMDR) Digital System**
 Modernising donor registry processes, improving data quality and strengthening our ability to match donors efficiently across UK and international registries.
- Expansion of Stem Cell Services**
 Increasing capacity to meet growing clinical demand for transplantation and advanced therapies, with improved pathways for donation, processing and clinical collaboration.
- National Integration of Cell Free Foetal DNA Testing**
 Delivering consistent, high quality genomic screening services across Wales and strengthening WBS's role within national diagnostic pathways.
- Development of National External Quality Assessment Service (NEQAS) Digital Capability**
 Modernising external quality assurance systems to support standardisation, improved benchmarking and enhanced laboratory quality.
- Development of Welsh Histocompatibility and Immunogenetics Services**
 Reviewing antibody testing strategy, investigating provision of Human Leucocyte Antigen (HLA) matched red blood cells and introduction of new biomarker tests to improve outcomes for transplanted patients in Wales.

Success will be demonstrated through the sustained delivery and continued improvement of performance against WBS Performance Management Framework indicators:

KPI Ref	Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Nov 2025 Actual
KPI.23	Timely	Turnaround times – Foetal RHD Screening	Quarterly	90%	100%
KPI.83	Timely	Turnaround times - deceased donor typing for NHSBT-Organ & Tissue Donation & Transplantation (OTDT)	Quarterly	90%	100%
KPI.13	Effective	Stem Cell collections (apheresis & bone marrow)	Monthly	3	4
KPI.20	Effective	New stem cell volunteers	Monthly	333	1286

KPI Ref	Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Nov 2025 Actual
KPI.45	Equitable	Register: % of volunteers from ethnic minority groups	Quarterly	6.2%	4.2%
KPI.45	Equitable	New volunteers: % from ethnic minority groups	Quarterly	12.4%	16.6%
KPI.30	Safe	Number of SABRE/SAEAR incidents	Monthly	n/a	n/a
KPI.36	Safe	Overdue SABRE/SAEAR actions	Monthly	<5%	3.2%
KPI.47	Person Centred	Stem cell donors that rate their experience as excellent	Quarterly	95%	100%



Blood Donation Modernisation Programme

Modernise our Blood Donation Services to create a clinically led, technology enabled and accessible donation model that enhances donor experience, strengthens supply resilience and supports the growing demand for blood, blood components and plasma across Wales. Key projects within this programme include:

- Donor Engagement: Donor & Advocate Forum (Donor Voices)**
 Implement a co-design forum that enables donors and advocates, including under-represented groups, to actively shape future donation services, increasing diversity of participation through inclusive design, accessible channels, and targeted outreach so services reflect the needs of all communities across Wales.
- Clinically Led Blood Donation Model**
 Embedding a clinically driven, workforce modelled approach to optimise blood donation activity, strengthen safety, and ensure capacity and skills are aligned to clinical need.
- New Donor App**
 Providing donors with an intuitive digital platform to book, manage and track donations, improving convenience and engagement.
- Fleet Strategy Implementation**
 Modernising transport capability to improve access to blood donation services and the movement of blood and products across Wales while reducing carbon impact.
- Live Connectivity on Clinic**
 Enabling real-time access to systems and data on mobile and static clinics to support safer, more efficient collection processes.

Success will be demonstrated through the sustained delivery and continued improvement of performance against WBS Performance Management Framework indicators:

KPI Ref	Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Nov 2025 Actual
KPI.04	Effective	Clinical demand for red cells met	Monthly	100%	103%
KPI.05	Effective	Clinical demand for platelets met	Monthly	100%	131%
KPI.07	Effective	Stock stability (O/A/B+ below 3 days)	Monthly	0	0
KPI.27	Effective	New whole blood donors	Quarterly	2750	1862
KPI.20	Effective	New stem cell volunteers recruited	Monthly	333	1286
KPI.44	Equitable	Donor panel: % of donors from ethnic minority groups	Quarterly	6.2%	2.39%
KPI.44	Equitable	New donors: % from ethnic minority groups	Quarterly	12.4%	6.76%
DIG.71	Efficient	% of donors booking online	Monthly	80%	83%
KPI.09	Person centred	Whole blood donors rating experience as excellent	Monthly	85%	89%
KPI.14	Person centred	Donors failed to donate	Monthly	4.0%	3.32%
KPI.28	Person centred	Donor concerns	Monthly	n/a	3



Digital Modernisation Programme

Modernise our digital infrastructure to create an integrated, reliable and future ready technology environment that supports safe, efficient and data driven services across transfusion, transplantation and donation. This programme will enhance system connectivity, strengthen clinical workflows and improve the quality and availability of information for staff, donors and partners. Key projects within this programme include:

- Blood Establishment Computer System (BECS)**
 Upgrading our core operational system to improve digital workflows, strengthen data integrity and support end-to-end visibility across the donation, testing, manufacturing and distribution process.
- Welsh Histocompatibility and Immunogenetics Service (WHAIS) Information System**
 Implementing modern digital capability to support histocompatibility and immunogenetics services, enabling improved testing efficiency, enhanced traceability and integration with wider laboratory and clinical systems.
- Welsh Laboratory Information Management System (WLIMS)**
 Delivering a next generation laboratory management solution that enables consistent, high quality laboratory processes, improves interoperability across

NHS Wales and enhances the accuracy and timeliness of diagnostic reporting.

Success of the Digital Modernisation programme will be measured through clear evidence that the digital enhancements are improving the safety, efficiency and reliability of our services. We will monitor reductions in errors, improved traceability and stronger regulatory compliance as upgraded systems support more accurate and consistent data handling. We will assess whether automation and better system integration are delivering faster, more reliable laboratory turnaround times, improved stock management and more efficient use of components. In addition, we will evaluate improvements in donor and staff experience, including smoother workflows, fewer process delays and enhanced digital access to information.



Plasma for Medicines Programme

We will develop a sustainable national capability for the donation and supply of recovered plasma to support the manufacture of life-saving plasma derived medicines for NHS Wales. This programme will strengthen the resilience of the UK plasma supply chain, reduce reliance on international imports and enhance Wales's contribution to national self-sufficiency efforts. We will continue to encourage the Welsh Government to approve the apheresis donation of plasma. Key activity within this programme includes:

- **Recovered Plasma Supply**

Expanding and optimising the collection of recovered plasma across Wales to ensure high-quality, safe and reliable plasma is available for fractionation and the production of essential medicines.

Success of the Plasma for Medicines Programme will be demonstrated through the establishment of a robust, scalable and sustainable national capability for recovered plasma collection and supply. In addition, progress will be shown through our contribution to UK self sufficiency efforts, reduced reliance on international plasma imports and readiness to implement apheresis plasma donation should approval be granted.



Talbot Green Infrastructure (TGI) Programme

Transform our Talbot Green site into a modern, sustainable and resilient national facility that supports the long-term delivery of blood, blood components, stem cells, organs, diagnostic tests, medicines and logistics services for NHS Wales. This programme will ensure that our infrastructure is fit for the future, supports service growth and provides the environmental and operational standards required for the next 50 years. Key activity within this programme includes:

- **Final Business Case (FBC) Development and Submission**

Completing and submitting the Final Business Case, following approval of the

Outline Business Case, to secure the investment required to commence major refurbishment and development works at the Talbot Green site.

Success of the Talbot Green Infrastructure Programme will be measured through the delivery of a fully approved Final Business Case and the securing of the investment required to begin redevelopment. This redevelopment will provide the modern, resilient infrastructure needed to secure the long-term future of the Welsh Blood Service, ensuring we can continue to deliver safe, high-quality services for decades to come.



Blood Health Plan Programme

As a key stakeholder of the Blood Health National Oversight Group (BHNOG) we will support delivery of the Blood Health Plan for Wales by strengthening clinical pathways, improving the safe and appropriate use of blood, and supporting national efforts to optimise patient outcomes. This programme enhances our role in system-wide blood management and ensures alignment with national policy, safety expectations and prudent healthcare principles. Key areas of activity within this programme include:

- **Anaemia Management**
Further implementation of the national pathways to improve anaemia diagnosis and management, reduce avoidable transfusions and support better surgical outcomes.
- **Intraoperative Cell Salvage (ICS)**
Ensure equitable and effective use of ICS as a core patient blood management initiative.
- **Genetic Haemochromatosis (GH) Pathway**
Expanding the GH pathway to enable safe, community based management of eligible donors, reducing pressure on secondary care while improving patient experience. Contributing to sustainability by reducing the incineration of blood in hospitals and making it available for patients who need transfusion.

Success of the Blood Health Plan implementation will be demonstrated through clear evidence that activities are advancing patient blood management and delivering on the recommendations of the Infected Blood Inquiry. Progress will be monitored through the Blood Health National Oversight Group (BHNOG) using KPIs for preoperative anaemia pathways, intraoperative cell salvage metrics and blood stock management, while Genetic Hemochromatosis metrics will be overseen through WBS Futures governance. Further assurance will be provided by embedding standardised transfusion education programmes via the BHNOG Education Strategy Group and monitoring transfusion related risk through the BHNOG Transfusion Risk Group. Together, these activities will enable shared learning, reduce variation and lower overall transfusion related risk.

Anaemia Management Programme

Led by the Blood Health Team and reporting to the Blood Health National Oversight Group, the Anaemia Management Programme is coordinating with stakeholders nationally to improve the identification and management of anaemia across our

population. Following the success of the Pre Operative Anaemia pathway the scope of the work is expanding beyond major surgery to include post-operative pathways, women’s health, bowel screening. The team is also available to advice clinical networks beyond these areas as anaemia is a condition that can impact outcomes across a wider range of clinical conditions. A priority for the programme is accessing data relating to use of IV iron treatment and transfusion across all Health Boards. This is in line with the recommendations of the Infected Blood Inquiry and will enable the programme to better monitor impact and identify variation. Wales is at the forefront of blood health management within the UK and working to build on its success to cost-effectively improve outcomes of anaemic patients through early detection and treatment.

Project to pilot the All-Wales Genetic Haemochromatosis donor pathway and increase recruitment of eligible blood donors to the WBS

Establishing a pathway for people with Genetic Haemochromatosis to become donors within the WBS brings many system wide benefits. These include: a reduction on clinical demand for Health Board Clinical Haematology services, reduced waste, increased security of supply of blood products for NHS Wales. For patients, the donor sessions can be scheduled more flexibly with more convenient access than a traditional hospital appointment and the knowledge that their treatment is helping save lives contributes to patient experience. Furthermore, through partnership with CTMUHB, the waiting list for treatment has reduced from 18 months to 6 weeks. This work will be extended for a further year to ensure that the benefits gained are sustained and accessible for GH patients across Wales.



VELINDRE CANCER SERVICE (VCS) 2026 - 2029

Where are we now: what has been achieved by March 2026

The logos at the top of each objective, priority, programme or change activity highlights which of the Trust's Well-being Objectives it aligns to.

Our strategy 'Shaping our Future Together' concludes in 2026 – 2027. A significant amount of progress has been achieved over the last year, in the development of safe, high quality tertiary oncology services across South East Wales. Our key successes are:



Radiation Services

- The Velindre@Nevill Hall Radiotherapy Satellite Unit, Nevill Hall Hospital opened in June 2027. The Unit was supported through a regional business case and was developed in partnership with ABUHB. The unit will provide additional capacity for the treatment of breast, prostate and palliative radiotherapy patients, enabling some patients to be treated closer to home, enhancing patient experience.
- Successfully implemented a new molecular radiotherapy service – Peptide Receptor Radionuclide Treatment (PRRT) following close work with the Joint Clinical Commissioning body (JCC). This has enabled patients in South Wales to access services that in the past, they may have needed to travel outside of Wales to receive.
- The IRS programme has continued through its phased implementation in 2025-2026, with the opening of two new Linear Accelerators (LINACs) at the Satellite Unit in NHH and three new linacs machines upgrades within the existing fleet at VCS, Whitchurch. Phase 3 will see the transfer of the existing three Linacs from VCS Whitchurch to the new Velindre Cancer Centre alongside the installation of an additional five new LINACs in the new cancer centre.
- In line with national programme, VCS has successfully progressed local work to support implementation the new Radiology Informatics System (RISP.) A delay in the National Programme has resulted in a revised Go-Live date of Q1 2026-2027.
- Brachytherapy element of Integrated Radiotherapy Solution programme has been successfully implemented in readiness for transition to the new Cancer Centre Q1 2027.



Systemic Therapies

- The expansion of virtual Assessment prescribing services (VAP) has supported the ethos of care closer to home, with a further move from face-to-face appointments to virtual assessment.
- Implementation of Electronic Prescribing and Medicines Administration System (EpMA) for Velindre Cancer Services has continued to progress locally, although the service reprofiled delivery to align delivery of Chemocare upgrade to support interdependencies, resulting in full implementation now planned for Q3 2026-2027
- VCS has seen a significant increase in activity in Systemic Anti-Cancer Therapy (SACT) treatment to reflect the increase in demand for service due to the new lines of treatment, new novel therapies and people living longer. In February 2026, the SACT treatment service in Aneurin Bevan University Health Board (ABUHB) moved to a new location within Nevil Hall Hospital, which provides capacity to support further expansion of the outreach service in 2026-2027.
- The Chemocare contract has been extended as part of the national upgrade programme with further upgrades planned for 2026-2027.
- In conjunction with Value Based Healthcare Team, there has been successful proof of concept for 'self-administration' of denosumab, enabling patients to manage their own treatment within the vicinity of their own home.



Acute / Inpatient / Palliative Care

- SDEC model was presented to Welsh Government as part of the overview of SDEC services, including the successful 7-day service implemented through the monies received from Welsh Government.
- Work has taken place to develop a service delivery model to support 7-day service for the Ambulatory and Assessment Unit, a key component for the nVCC.
- VCS has been active in its implementation of six goals, including optimal hospital care, patient flow and discharge practice, following the principle of home first.
- Work is continuing to support the introduction of new novel therapies including immunotherapies (BiTE) at VCS. In July the Cancer Service successfully delivered a proof-of-concept pilot for a new bispecific Tebentafusp.



Division-wide

- Implementation of the Integrated Quality Management System (IQMS) commenced in radiation services and pharmacy services. Progressing phasing will take place across the whole of the cancer services by Q2 2026-2027.

What does the next 3 years look like: our focus and priorities for 2026 – 2029

Cancer remains a major public health challenge in Wales, with increasing incidence rates and significant disparities in mortality outcomes. This trend, influenced by demographic shifts, lifestyle factors, and advancements in diagnostics, is putting considerable pressure on the healthcare system (Life Sciences Hub Feb 2025).

Data from Public Health Wales (PHW) Observatory, projects that by 2035 there will be around **24,000 new cancer cases each year** among people living in Wales, up from around 20,000 in 2019, which equates to an increase of **11% over the next decade**, mostly due to the increase in people living longer and cancer more prevalent in older people.

In April 2024, only 53.8% of patients started treatment within 62 days of suspicion, falling short of the 80% target set for 2026. Whilst some tumour sites are already exceeding the 80% target (e.g. skin cancer), certain cancers face more significant delays, with the worst performing tumour sites being head and neck cancers (26%), gynaecological cancers (31%), and lower gastrointestinal cancers (33%). (Life Sciences Hub 2025). Cancer treatment delays are not unique to Wales, as similar trends have been observed across England, Scotland, and Northern Ireland, where all UK nations have struggled to manage diagnostic backlogs and rising referrals (Life Science Hub Feb 2025).

The VCS Strategy is due to be refreshed in 2026 and will look to set the future ambition for the Cancer Service in line with the VUNHST Destination 2033 as a centre of excellence for the people of Wales, providing high-quality, specialist solid-tumour oncology services. This will be underpinned by our strong regional partnerships and cross boundary working alongside major service transformation as the Cancer service transitions to a new state of the art Cancer Centre in Whitchurch.

A key ambition is to incorporate learning from the Federation of Specialist Hospitals review commissioned in 2025 and to further integrate the key attributes into VCS as we move forward providing system leadership as a specialist provider of cancer services. This will realise wider system benefits in increasing efficiency for complex procedures, extending access to clinical trials and research opportunities, and growing the education provided and delivered across Wales, through the Velindre Oncology Academy.

We are at the start of our journey to achieve **Organisation of European Cancer Institute (OEI) accreditation** which will support us in achieving an internationally

externally accredited standard of care, which is recognised as exemplar across the western world.

Demand - National growth assumptions for 2026–2029:

SACT activity	+12–18% cumulative
Immunotherapy	+30–45% cumulative (multiple new indications across lung, GI, GU, melanoma)
Oral anticancer medicines	+20–30% cumulative (increased monitoring burden)
Radiotherapy fractions	+3–6% cumulative (hypofractionation partially offsets demand)
Acute oncology	+12–18% cumulative (toxicity, frailty, multimorbidity)
Supportive care	+10–15% cumulative (bone health, symptom management, survivorship)

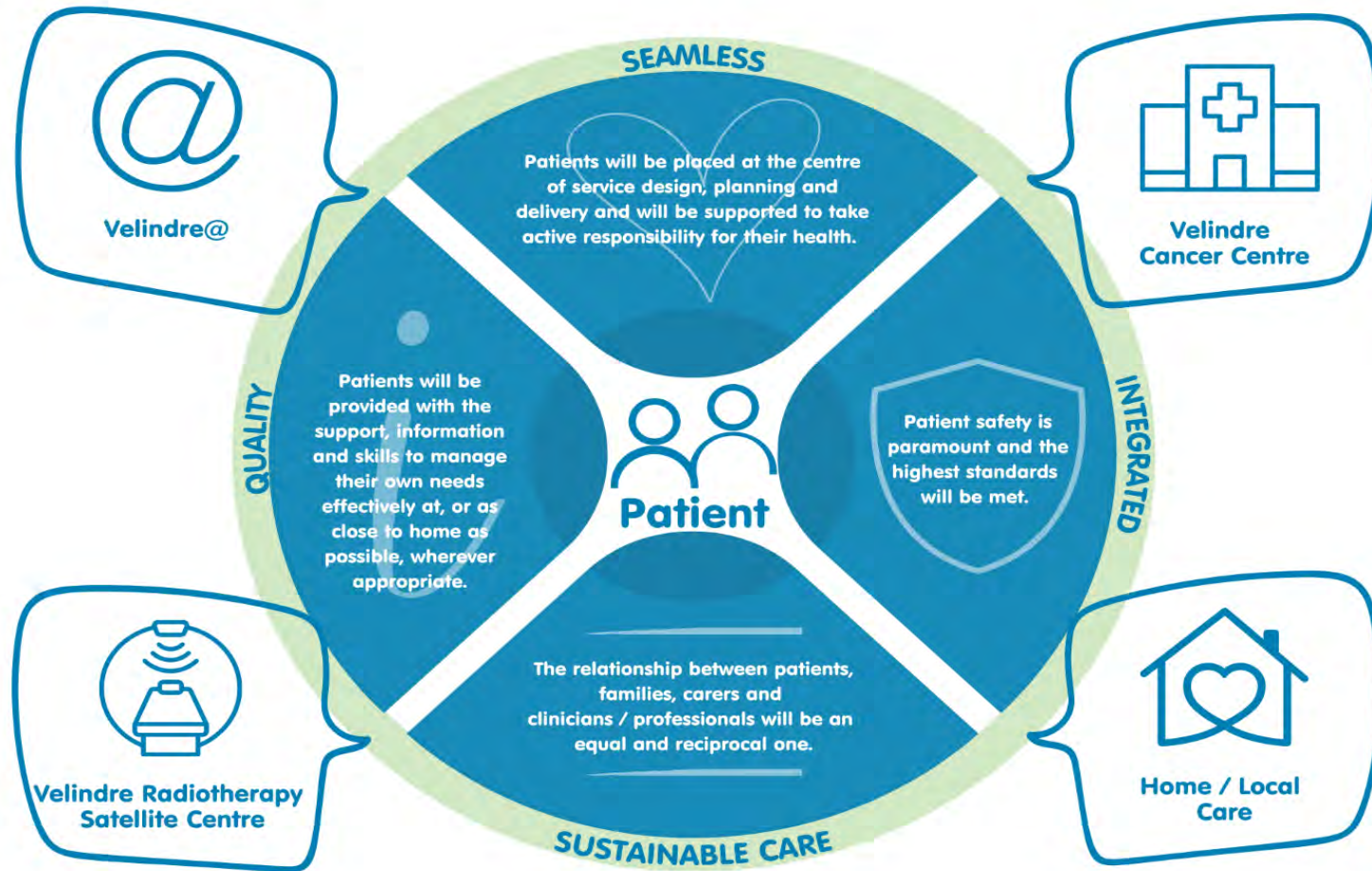
Workforce Requirements

Workforce remains the most significant constraint on service sustainability. Recruitment and retention challenges persist across oncology, cancer pharmacy, radiotherapy, nursing, and AHP professions. The need to increase support to staff through a robust organisational development and training plan as part of the preparation for the move to nVCC is essential for our service. Workforce planning will align with national programmes, including the National Clinical Network workforce strategy and regional training pipelines.

Our Clinical Model

Our delivery plan is governed through Velindre Cancer Services Futures, designed to deliver seamless, integrated, sustainable quality care, whilst moving to a model of care delivered in the community where possible. These plans will be delivered in the context of the Trust realising our ambition to provide collaborative system leadership in cancer services across Wales.

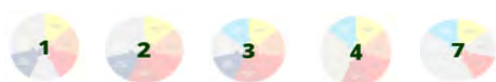
Our Clinical Model



VCS Delivery Plan Priorities

The detailed quarterly delivery plan is included in Appendix 2b.

Priority 1 - Safe and effective transition of services to the new Velindre Cancer Centre (nVCC) site – Timely Care



This delivery plan sets out the organisational roadmap for safely and effectively transitioning Velindre Cancer Centre into the New Velindre Cancer Centre (nVCC); and ensures that Velindre is fully prepared to operate a modern, sustainable, and high quality specialist cancer centre that meets the needs of patients across South East- Wales.

Delivery approach / phasing

- Commissioning and operational readiness - ensuring the nVCC, equipment, digital systems, and clinical environments are fully tested, safe, and ready for patient care.
- Service transformation and pathway redesign - modernising radiotherapy, SACT, acute oncology, supportive care, and multi-disciplinary team (MDT) processes to align with the capabilities of the new centre.
- Workforce, culture and organisational development - preparing staff for new models of care, new technologies, and new ways of working, while supporting wellbeing and retention
- Safe transition and continuity of care - ensuring that the move from the current Velindre Cancer Centre to nVCC is seamless, safe, and centred on patient experience.

2026-2027

- Q1 Programme Mobilisation & Readiness Foundations
- Q2 Commissioning, Digital Build & Pathway Redesign
- Q3 Workforce, Operational Policies & Simulation Planning, Commissioning Testing, Clinical Model Finalisation & Move Planning
- Q4 Full Operational Readiness Testing, Pre-Activation & Phased Service Preparation

2027-2028

- Q1 Transition & Go Live
- Q2 Stabilisation, Optimisation
- Q3/4 Programme Closure

Outcome

- Open purpose-built cancer centre.
- Implemented a future-proofed clinical model that improves access, safety, and patient experience.
- Strengthened workforce capability and resilience.
- Delivered digital systems that support high-quality, efficient care.
- Established a platform for expanded research, innovation, and regional collaboration.

- Effective implementation of the Mutual Investment Model (MIM)
- Fully digitised medical record
- Maintained operational service stability and organisational performance throughout the transition

Priority 2 - Consistent and reliable service delivery across all standards – Timely Care



This plan provides a realistic, phased, and accountable approach to delivering cancer clinical standards. It ensures that the organisation is positioned to deliver high-quality, equitable, and modern cancer care, while contributing to national ambitions for improved outcomes across Wales.

Over the next 3 years, the organisation will focus on four strategic aims:

- Strengthening governance and clinical assurance to ensure safe, high-quality cancer care.
- Improving early diagnosis and pathway performance to reduce delays and support better outcomes.
- Embedding person-centred, equitable care across all tumour sites and treatment pathways.
- Accelerating digital, workforce and innovation programmes to modernise cancer services and support sustainable improvement.

Delivery approach / phasing

2026-2027

Focuses on establishing strong foundations. This includes a comprehensive baseline assessment against national standards, strengthening cancer governance, improving data quality, and initiating targeted improvements in early diagnosis, MDTs functioning, and treatment pathways.

Workforce development, personalised care, and supportive care expansion are central to improving patient experience and safety. Digital upgrades and performance assurance processes will ensure that progress is measurable and transparent.

2027-2028

Our actions focus on embedding improvements and demonstrating measurable impact. This includes sustained improvement in waiting times, early diagnosis, and treatment timeliness; targeted action to reduce inequalities; expansion of research and innovation activity; and strengthened quality assurance through internal audits and external readiness.

2028-2029 - embed in Trust governance monitoring and reporting cycles

Deliverables

- Implementation of integrated performance management framework
- Implementation of waiting list management at VCS with associated operational and clinical dashboards
- Implementation of a patient administration review to align roles and responsibilities to the operational and clinical requirements of the services

- Implementation of electronic referral system into VCS from the Health boards utilising Hospital Initiated Referral (HIR) form
- Implementation of operational cancer management meetings between VCS and Health boards
- Implementation of the shared care approach to SCP breach reporting
- Establish Divisional M&M review meeting

Targets - Ministerial Priority / Enabling Action

- Reduction in the number of patients delayed in hospital as measured by the Delayed Pathways of Care Dashboard by March 2027
- VCS - 75% of patients on an SCP receive first definitive treatment in 62 days by March 2027 – shared breach arrangement for VCS – referral to FDT within 24days (75%)
- Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.

Outcome Measure

- Palliative care assurance framework – national KPI not available yet
- All Wales SACT clinical quality metrics – 50% improvement from baseline January 2026
- All Wales Radiotherapy COSC metrics– 50% improvement from baseline January 2026
- PIFU and DNA/CNA rates fully implemented
- SDEC metrics & patient flow metrics

Priority 3 & 4 - Widening access to treatments available in comparable specialist cancer services



Access to advanced therapies, strengthen networked oncology pathways, and improve the reach and responsiveness of specialist services delivered in partnership with acute providers and maximises the capability and capacity of the new radiotherapy equipment in nVCC.

Delivery approach / phasing

2026-2027

Focuses on establishing new treatment techniques and service models for lung skin and neurological cancers, and the LINAC and Brachytherapy System.

2027-2028

We will embed new treatment capability with new equipment in nVCC to neurological conditions, axilla and partial breast radiotherapy techniques.

2028-2029

Formal closure and benefits realisation of the IRS

Deliverables

- Increase access to specialist systemic anticancer therapies (SACT), including immunotherapy and targeted agents
- Expand radiotherapy capacity and capability, including advanced techniques and hypo-fractionated pathways.
- Strengthen networked oncology models to deliver specialist care closer to home and membership of Federation of Specialist Hospitals.
- Reduce inequalities in access, particularly for underserved populations and those with complex needs.
- Patients able to access high quality, evidenced base treatment locally with no delay through the adoption of new technologies, treatments, drugs, services
- Improve timeliness of treatment, supporting national cancer waiting time standards.
- Enhance research participation, ensuring equitable access to clinical trials.
- PET CT Business Case
- Implementation of prostate SBRT for low/ intermediate risk prostate cancer as per PACE B trial
- Implementation with appropriate funding of partial breast radiotherapy, axillary RT as an alternative to axillary node dissection, Internal mammary node irradiation and simultaneous integrated boost.
- Commissioned Brachytherapy equipment
- Linac transfer and Commissioning plans completed

Targets – Ministerial Priority / Enabling Action

- 12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 75% by March 2027.
- VCS - 75% of patients on an SCP receive first definitive treatment in 62 days by March 2027– shared breach arrangement for VCS – referral to FDT within 24 days (75%)
- Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.

Outcome Measures

- NICE compliance within set timeframes
- Improved PROMS scores for clinical outcomes and reduced toxicity scores for breast cancer patients treated with new radiotherapy techniques
- benefits realised in line with Full Business Case
- nVCC and IRS benefits realised in line with Full Business Case

*Priority 5 - Deliver Improved access to Systemic Anti- Cancer Therapy (SACT)
Pathways and Processes*



Our vision is to deliver a high performing, digitally enable SACT service that will provide timely access to treatment, reduce unwarranted variation, and improves patient outcomes and experience.

The service will deliver:

- Sustainable hub and spoke model supporting care closer to home where clinically appropriate.
- Improved Productivity & Efficiency through workforce development & skills growth.
- Increase in personalised care and digital patient engagement.
- Improved patient toxicity management.
- A sustainable, skilled workforce with expansion of advanced practice roles.

Delivery approach / phasing

2026-2027

Our actions include developing a digital skills foundation relating to SACT, detailed demand and capacity modelling and SACT treatment service capacity utilisation, with implementation of funded hub and spoke model of care.

2027-2028

Our detailed actions realise expanded capacity through our outreach models aligned to nVCC, and workforce expansion of Advanced Clinical Practioner roles; alongside the introduction of remote toxicity monitoring and predictive analytics.

2028-2029

Activity will focus on reviewing predictive analysis model for patient toxicity management and developing lessons learned or further change management plans as required.

Deliverables

- Implementation of chemo care upgrade and system re-procurement
- Deliver measurable improvements in timeliness, safety, and patient experience

Outcomes

- Delivery of SACT clinical quality indicators.

- Introduction of next generation immunotherapies as standard of care increasing treatment options and improving clinical outcomes.
- Expansion of Virtually Assessed Patient (VAP) Clinic Capacity.
- Introduction of new medicines patient self-administration pathways providing patient choice, reducing requirement for patients to attend a clinical setting to undergo treatment and releasing treatment capacity.
- Routine screening for Blood Borne Viruses (BBV) for all patients beginning SACT treatment.
- Implementation of Chemo Care Upgrade and System Re-Procurement
- Implementation of a new prescribing and medicines administration system (EPMA) which will replace existing paper-based systems.
- Implementation of BlueTeq at VCS.

Targets – Ministerial Priority / Enabling Action

- 75% of patients on an SCP receive first definitive treatment in 62 days by March 2027 – shared breach arrangement for VCS – referral to FDT within 24 days (75%)
- Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.

Outcome Measures

- 20% year on year increase in patients commencing treatment within P1, P2 and P3 targets by March 2027
- 100% compliance with 90-day NICE implementation target for newly approved medicines

Priority 6 - Deliver a modern, patient centred, outpatient service that is accessible, efficient and digitally enabled



The vision is to deliver a modern patient centred outpatient service that has:

- A sustainable workforce with advanced practice capability.
- Enhanced toxicity management and reduced emergency attendances.
- Improved patient reported experience and outcomes.
- expanded capacity through extended hours and improved patient flow.

Delivery approach / phasing

2026-2027

The redesign of service will be delivered through detailed actions in readiness for nVCC. Our phased approach ensures early risk reduction while building the infrastructure for long-term transformation. Our actions include:

- detailed demand and capacity modelling;
- introduction of standardised referral triage and clinic templates;
- piloting digital check in and patient information tools;
- expanding virtual, outreach and telephone follow up pathways;
- establishing patient involvement structures;
- Build the workforce foundations for advanced practice roles.

2027-2028

Our detailed actions in 2026-2027 facilitate an effective transition to nVCC.

2028-2029

Full evaluation of the outpatient transformation programme impact.

Deliverables

- Electronic clinic outcome forms in place.
- Consistent compliance with national outpatient standards.
- Strengthened incident reporting, learning, and audit.
- Improvement in patient communication.
- A robust governance framework in place to support continuous improvement.
- Strengthen preassessment and reduce cancellations.

Outcomes

- Development and implementation of Clinic Templates.
- Clinic utilisation optimised.
- Reduction in patient/hospital cancellations.
- Resilient booking and administrative service in place.
- Digital 'front door', self check-in, and optimum treatment pathways in place
- Scheduling optimised.

Targets – Ministerial Priority / Enabling Action

- 75% of patients on an SCP receive first definitive treatment in 62 days by March 2027 – shared breach arrangement for VCS – referral to FDT within 24 days (75%)
- Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.

Outcome Measures

- Delivery of effective outpatients through See on Symptom (SOS) and patient initiative follow up (PIFU) by default

- Reduction of 20% in DNA/cancellation by March 2027
- 15% Increase in Virtual consultations by March 2027
- Percentage of patients seen within hub and spoke model
- Achieve 70% of patients accessing correspondence electronically
- Patient communication – 2-day turnaround post implementation of digital solutions by March 2027
- Civica patient experience -100% increase in patient responses by March 2027

Priority 7 - Deliver a resilient, patient-centred oncology acute care service that delivers safe, timely and equitable care



Our plan will deliver

Delivery approach / phasing

The vision is to create a high performing, digitally enabled, 7day Acute Oncology Service that delivers:

- Rapid specialist assessment for all oncology emergencies
- Early access to specialist expertise in the management of immunotherapy and new therapy toxicities
- Reduced avoidable admissions through strengthened ambulatory and community pathways
- Improved survival and safety, including faster time to antibiotics for neutropenic sepsis
- Enhanced patient experience through personalised care and improved communication
- A sustainable workforce model with advanced practice roles and clear development pathways
- Integrated digital systems that support proactive, data driven care

2026-2027

Our plan is to build on and develop regional governance structures to fully deliver the six goals models of best practice, deliver improvements in care and respond swiftly to changes and developments in treatment advancements.

The model of care is for patients to be treated in the right place at the right time. Eligible acute oncology patients will be treated at VCC or nVCC as appropriate. Effecting a move away from local health board accident and emergency departments.

2027-2028

The plan delivers full implementation of a robust regional model of care.

2028-2029

Review service model to assess any further changes to optimise care.

Deliverables

- Delivers safe alternatives to hospital admission - treatments that otherwise would require a hospital bed (IV, steroids, fluids, biologics etc).
- Rapid specialist response during clinical deterioration.
- Reduced pressure on acute hospitals by managing cancer-related emergencies within oncology.
- An expanded Acute assessment service 7/7

Outcomes

- Improved access to expert acute oncology services (AOS) for patients with cancer in south-east Wales including delivery of VCS elements of AOS regional business case.
- Resilient and sustainable clinical flow models across the acute pathway.
- Provide the right care, first time by giving patients direct access to oncology specialists via a same-day ambulatory service 7/7.
- Sustainable model for the management of immunotherapy toxicities
- Design and Implementation of enhanced care capability offer at VCS and in readiness for nVCC.
- Strengthen regional collaboration and cross sector pathways.
- Cardiac base-line testing for patients receiving immunotherapy treatments.
- Strengthening links with palliative care and survivorship services

Targets – Ministerial Priority / Enabling Action

- deliver a 12-month reduction trend in both the number of people who are delayed in hospital and total days delayed for the patients as measures by the Delay Pathways of Care Dashboard

Outcome Measures

- Annual reduction in number of inpatient admissions related to cancer / oncology treatment toxicities.
- Annual reduction in number of unwell patients transferred to acute secondary care settings.
- 100% compliance with NICE guidance at audit.
- SDEC data quality framework by March 2027
- >90% compliance with neutropenic sepsis antibiotic timing

Priority 8 - Implementation of National service specific for Wales: Palliative and end of life care



We will deliver Palliative and End of Life Care Services which:-

- Strengthen integration between Velindre, primary care, acute hospitals, and community services.
- Enhance symptom management through earlier intervention and proactive supportive care.
- Increase advance care planning (ACP) and shared decision making.
- Improve equity of access, particularly for underserved groups and those with complex needs.
- Expand psychological, spiritual, and family support as part of holistic care.
- Embed digital tools to support communication, monitoring, and coordination.
- Strengthen workforce capability in palliative and end of life care across the Trust

Delivery approach / phasing

2026-2027

Our actions are focused on review of the National specification and All Wales Palliative Care Framework to identify areas for improvement or service redesign, including development of a business case for service change.

2027-2028

Our plan relates to the roll out of the Verifications of Expected Death - All Wales policy and education programme.

2028-2029

Assess the potential to further extend PROMs in End of Life and Palliative Care Services

Deliverables

- The national specification for Palliative Care including a sustainable delivery model for extended hours of working
- Reduced variation in symptom management and end of life support.
- Pilot complete for All Wales Civic feedback questionnaires to inform service delivery
- DNACPR Competency Framework implemented for Nurses and AHPs
- Quality Statement for Palliative and End of Life Care

Targets – Ministerial Priority / Enabling Action

- Increase in capacity at weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024-2025 and greater where possible

Outcome Measures

- Implementation of national KPI framework and national dashboard (subject to formal issue)

- 85% of Nurses & AHPs to complete DNACPR Competency Framework by 2029
- Sustainable service delivery model and formal extended working days/weekend by March 2027

Priority 9 – Pharmacy Modernisation



The Oncology Pharmacy Transformation Programme will deliver a modern, stabilised, and expanded pharmacy services that support systemic anticancer therapy (SACT), acute oncology, acute and outpatient cancer pathways.

Delivery approach / phasing

2026-2027

Our actions include developing a digital skills foundation relating to SACT, detailed demand and capacity modelling and SACT treatment service capacity utilisation, with implementation of funded hub and spoke model of care, ePMA and BlueTeq.

2027-2028

Our detailed plans include the transition to a new aseptic facility at nVCC, including utilisation of new robotic equipment and new predictive analytic tools for toxicity management, and digital PROMs for toxicity monitoring and personalised care.

2028-2029

Undertake review of digital patient toxicity management and develop improvement plan / lessons learned

Deliverables

- Implementation of EPMA (general medicines)
- Increased use of outsourced products to at least 70% as part of the nVCC transitional plan
- Implementation of BlueTeq
- Pharmacy robot commissioned
- A sustainable workforce with advanced practice capability
- Successful transition to a new aseptic unit at nVCC
- Full implementation of EPMA (general medicine)
- Enhanced toxicity management with pharmacy led and toxicity review clinics to reduce emergency admissions
- Strong governance with real time safety and performance monitoring

Targets – Ministerial Priority / Enabling Action

- 75% of patients on an SCP receive first definitive treatment in 62 days by March 2027 – shared breach arrangement for VCS – referral to FDT within 24 days (75%)
- Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.

Outcome Measures

- 100% compliance with VCS SACT protocols.
- 100% compliance with 90-day implementation target for newly approved medicines
- 30% in-house pharmacy production within the aseptic unit by June 2027
- Increased number of patients receiving medication close to home by March 2027

Priority 10 - Accreditation of OECl



Purpose

Achieve Organisation of European Cancer Institute (OECl) accreditation to demonstrate the cancer centre meets internationally recognised standards across governance, clinical care, research, education and patient involvement, and provide external assurance of service quality and outcomes.

Delivery approach / phasing

2026-20227

Preparation & Self-Assessment

- Complete organisational gap analysis against OECl v4.0 standards
- Establish governance, datasets and evidence framework
- Undertake full self-assessment and readiness review

2027-2028

Peer Review & Improvement Planning

- Submit accreditation documentation and host external peer review
- Agree improvement action plan and integrate into organisational priorities

2028-2029

Implementation & Embedding

- Deliver improvement actions and demonstrate measurable quality improvement

- Embed standards into routine governance and prepare for accreditation award

Deliverables

External peer review completed

Organisation-wide quality improvement plan implemented

OEI standards embedded into clinical, research and governance processes

Sustainable accreditation governance framework in place

Targets – Ministerial Priority / Enabling Action

International accreditation achieved by 2028

Accreditation actions incorporated into organisational planning and performance reporting

Outcome Measures

Demonstrable improvement in quality indicators and pathway governance

Independent external assurance of cancer service quality

Continuous improvement cycle aligned to future accreditation review

Performance Measures

Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Current position January 2026	Year end
Timely	75% of SCP delivered within 62 days from POS to FDT (HB target)	Monthly	75%	28%	75%
Timely	75% of SCP 62 day pathway: VCS component FDT delivered within 24 days from date of referral received at VCS (local target) Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway.	Monthly	75%	39%	75%
Timely	Scheduled Radiotherapy Patients Treated 100% within 21 Days	Monthly	100%	79%	100%
Timely	Urgent Symptom Control Radiotherapy Patients Treated 100% within 7 days	Monthly	100%	71%	100%
Timely	Emergency Radiotherapy Patients Treated 100% within 2 days	Monthly	100%	100%	100%
Timely	Elective delay Radiotherapy Patients Treated 100% within 14 Days	Monthly	100%	95%	100%
Timely	100% P1 Emergency SACT patients treated with 2 days	Monthly	100%	100%	100%
Timely	20% year on year increase on patients commencing treatment within P2 and P3 targets by 2027	Monthly	20%	New measure baseline at 31/03/2026	
Safe	30 Day Mortality Benchmark SACT** • Curative • Palliative	Monthly	2%	0.192% 1.14%	position maintained
Safe	30 Day mortality benchmark RT	Monthly	DCP	Not available	
Safe	Number of 'Never Events' recorded	As appropriate	0	0	0
Effective	Number of Pathway of Care Delays***	Monthly	0	Not available	0

Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Current position January 2026	Year end
Person Centred	100% of letters on DMS consistently approved & sent within 30 working days of patient appointment	Monthly	100%	100%	100%
Safe	The development of 15 steps assurance framework to include magnet methodology to actively capture staff feedback on psychological safety via regular audits.	Bi Monthly	Qualitative measure	New measure	6 audits undertaken
Person Centred	fully implement 'Call for Concern' in Velindre Cancer Service.	Monthly	0	New Measure	0
Safe	Ensure that 100% of bloods taken within Velindre Cancer Service are reviewed within 48 hours	Monthly	100%	Not yet available	100%
Person Centred	Develop and implement inclusive feedback methods to improve representation in all Wales CIVICA feedback	Monthly	30%	3%	30%
Efficient	Implementation of LPF and shift to Early resolution from formal concerns with reduction in formal concerns	Monthly	20%	Average 12 concerns per month	20%
Person Centred	Embedding the People's Experience Framework	Monthly	Qualitative measure	New measure	Qual measure
Safe	90% of patients with neutropenic sepsis identified and treatment started within required timeframe	Bi Monthly	90%		90%
Safe	Reduction in number of patients transferred to secondary acute care from VCS	Bi Monthly	20%	New Measure	20%
Timely	12 month reduction in delays in hospital measured by the delays in pathways of care dashboard	Monthly	10% reduction from baseline	2	10% reduction
Effective	Embed all Wales palliative care framework with the roll out of verification of expected death policy and DNACPR competency framework	As appropriate			
Safe	Reduction in the number of avoidable Pressure areas grade 2-4 by 25% from baseline 2025-2026 through improved risk assessment, enhanced protocols	Monthly	25% reduction from baseline	3 per month	25% reduction

Quality Domain	Key Performance Indicator (KPI)	Reported	Target	Current position January 2026	Year end
	and increased staff training on prevention.				
Safe	Reduced number of medication safety incidents resulting in patient harm by 20% from baseline by March 2027 through full implementation of ePMA and establishment of a medication safety group and medication safety group 'druggles' stepped up when incidents happen to allow live feedback and learning	Monthly	20% reduction from baseline		20% reduction from baseline

**** December position. Reporting month behind due to delays reporting deaths.**
*****reporting to commence February 2026 (1PoCD)**

RESEARCH DEVELOPMENT & INNOVATION 2026 - 2029

The Trust's strategic vision is to be a beacon for research, development, and innovation. Research and Development plays a central role in advancing healthcare at Velindre through high-quality clinical trials, translational research, and multidisciplinary collaboration, ensuring that research is a core part of how care is delivered.

Welsh Blood Service (WBS)

The Welsh Blood Service plays a central role in ensuring a safe, sustainable, and innovative blood and transplantation service for the people of Wales. Research, Development and Innovation (RD&I) is integral to this mission, enabling the Service to advance transfusion science, transplantation support, and operational innovation through collaborative research, translational development and evidence-based service improvement across the whole service. This activity is closely connected to operational services including blood component manufacturing, donor services, transplantation laboratory support, and service innovation across the Welsh Blood Service.

Welsh Blood Service will continue to build on the Research, Development and Innovation strategy (2024) and commits to seven missions embedded across the service.

Mission One: Centres WBS on improving patient and donor care through research that benefits both patients and donors.

Mission Two: Advancing Blood Components.

Developing knowledge and innovation that improves the processing, storage and clinical effectiveness of blood components.

Mission Three: Advancing Transplant Research in Wales.

Strengthening Wales' contribution to transplantation science and supporting improved transplant outcomes.

Mission Four: We will use Innovation and Value-Based Healthcare to improve our services and performance.

Applying innovation and value-based approaches to improve service delivery, efficiency and long-term sustainability.

Mission Five: Using Collaboration to Sustain our RD&I.

Building partnerships with universities, healthcare organisations and industry to sustain a strong research portfolio.

Mission Six: Serve the people of Wales by supporting international initiatives.

Contributing to international research programmes and collaborations that advance transfusion and transplantation science.

Mission Seven: Enhance the impact of RD&I and celebrate success.

Sharing the outcomes of research and innovation through publication, presentation and wider engagement.

Through RD&I activity, the Welsh Blood Service contributes to improvements in patient and donor care, advances in blood component science, and the development of new approaches that strengthen the resilience and sustainability of national blood services, while supporting the translation of research findings into operational practice. This work takes place through a

combination of internally led research, collaborative programmes with academic and clinical partners, and participation in national and international research networks.

As part of this Plan, the Welsh Blood Service will continue to strengthen the credibility, sustainability and impact of its RD&I activity. This includes supporting staff to participate in research, growing the organisation's research portfolio, and ensuring that collaborative activity is supported by robust governance, costing and risk-sharing frameworks. These arrangements enable the Service to engage confidently with universities, research organisations and industry partners while protecting core service budgets and ensuring appropriate cost recovery or underwriting arrangements where required.

The overarching objective is to ensure that research and innovation directly support the improvement of patient and donor outcomes, the advancement of transfusion and transplantation practice, and the long-term sustainability of the Welsh Blood Service. This includes embedding research within operational services, supporting staff engagement with innovation and evidence generation, and ensuring that research activity contributes to national priorities for healthcare improvement and scientific advancement.

A central feature of this approach is the strengthening of national and international collaboration. The Welsh Blood Service will continue to contribute actively to UK and global research initiatives, including participation in programmes such as the BEST Collaborative and other multicentre studies. Through these partnerships, the Service aims to enhance Wales' contribution to transfusion and transplantation research while strengthening its visibility and credibility as a research partner.

Between 2026 and 2029, the Welsh Blood Service will move into a new phase of RD&I maturity, in which research activity is more clearly integrated with operational services, supported by sustainable funding mechanisms, and enabled through stronger partnerships across academia, healthcare systems and industry. This includes clearer portfolio management, stronger translational pathways from research to service implementation, and improved visibility of RD&I activity across the organisation.

Strategic Priorities for Welsh Blood Service Research Delivery

To support this approach, RD&I activity within the Welsh Blood Service will be structured to provide a consistent framework for planning, delivery and assurance.

Strengthening national and international collaboration, increasing the visibility and contribution of the Welsh Blood Service across UK and global transfusion and transplantation research partnerships.

Building sustainable and financially responsible research partnerships, supported by clear governance, costing and risk-sharing frameworks that protect core service resources while enabling collaborative research.

Growing the Welsh Blood Service research portfolio, supporting successful grant applications, developing commercial research opportunities and enabling partnership ventures that generate additional income for reinvestment in RD&I capability.

Embedding a strong culture of research and innovation across the organisation, enabling more staff to participate in research activity, supporting new project ideas aligned with the RD&I Strategy, and strengthening organisational engagement with innovation and evidence generation. These priorities ensure that RD&I activity remains closely connected to the operational mission of the Welsh Blood Service, supporting improvements in patient and donor care while strengthening the Service's role within the wider research system.

Milestones for Welsh Blood Service research

Over the period 2026–2029, the Welsh Blood Service will demonstrate clear progress in the maturity and sustainability of its RD&I activity through a series of measurable outcomes.

- A stable and active research portfolio across transfusion, transplantation and service innovation, with sustained participation from multiple departments across the organisation.
- Increased participation of Welsh Blood Service staff in research and innovation activity, supported through improved organisational communication, training and engagement.
- Strengthened national and international research partnerships, including continued participation in collaborative research programmes and multicentre studies.
- Growth in external research funding through successful grant applications, commercial research activity and collaborative ventures that support reinvestment in RD&I capability.
- Clear governance and financial frameworks supporting research partnerships with universities and research organisations, ensuring that collaborative research is sustainable and aligned with service priorities.
- Enhanced visibility and impact of Welsh Blood Service research through publications, conference presentations and dissemination of findings across the healthcare system.

Cancer

As part of this Plan, the Trust will further strengthen its research capacity, credibility, sustainability, and delivery performance in a way that aligns with Welsh Government priorities for evidence-based healthcare, innovation, and sustainable research growth. This includes the effective and responsible use of commercial research and other income to support long-term capability, infrastructure, and workforce resilience.

The overarching objective is to improve patient outcomes by embedding research within routine clinical practice, increasing access to appropriate studies, and ensuring that growth in research activity – particularly commercial research – directly supports service sustainability and system resilience. This approach ensures that eligible patients have an opportunity to participate in research, while maintaining delivery credibility and protecting patient experience.

The Trust will continue to build on the Overarching Cancer Research and Development Ambitions 2021–2031. A particular focus for 2026–2029 is on improving the reliability, consistency, and credibility of cancer research delivery. This means ensuring that research activity genuinely supports patient care, clinical services, and national expectations, and that it can grow in a controlled way without increasing risk at the same rate.

At the heart of this approach is a shared understanding that cancer research delivery is a whole-system activity. Successful delivery depends not only on the Research Service, but on close coordination with Velindre Cancer Service, Clinical Directorates, Site Specific Teams (tumour groups), and a wide range of internal and external support services and partners. Between 2026 and 2029, Velindre University NHS Trust will therefore move into a new phase of cancer research delivery, strengthening how research is selected, agreed, delivered, and kept under active control so that it remains reliable, integrated with clinical services, and sustainable over time.

Strategic priorities for cancer research

To support this approach, the Trust's cancer research priorities will continue to be structured around four clear strategic themes. These themes provide a consistent framework for planning, delivery, and assurance, and reflect both the Trust's long-term ambitions and the practical requirements of delivering high-quality cancer research:

1. **Driving forward the Cancer Research and Development Ambitions**, building on established strengths to deliver high-impact research that benefits patients in Wales.

2. **Strengthening clinical trials and research infrastructure**, ensuring that facilities, workforce, and systems can support increasingly complex research in a safe and reliable way.
3. **Maximising national and international research collaborations**, positioning Velindre as a credible and valued partner across academia, industry, and the wider research system.
4. **Embedding a strong research culture within the organisation**, so that research is part of everyday clinical practice and supported across the workforce.

These priorities will be delivered through enhanced integration with Velindre Cancer Service, Clinical Directorates, Site Specific Teams, and the internal and external support services that are essential to effective research delivery.

Milestones for cancer research

The Trust's milestones for cancer research over the 2026–2029 period describe what will be demonstrably different as a result of this approach. Supported by a dedicated transformation plan, they focus on maturity, consistency, and sustainability, rather than activity volume alone:

- **Sustained improvement in patient access to cancer research** across Velindre Cancer Service and South-East Wales, with access patterns visible, understood, and explainable at Board level.
- **A balanced and credible cancer research portfolio**, with growth in study activity aligned to clinical priorities, delivery capacity, and patient benefit.
- **Strengthened early-phase, radiotherapy, and translational research capability**, including delivery through the Cardiff Cancer Research Partnership and appropriate outreach settings.
- **A stable and capable research workforce**, with strengthened clinical academic leadership and delivery supported through clearly defined roles and planned capacity.
- **Controlled growth in commercial cancer research activity**, increasing the proportion of commercially sponsored trials within the cancer research portfolio to approximately 70% by the end of financial year 2028/29, contributing to infrastructure strength, workforce resilience, and long-term financial sustainability.
- **Stronger, deeper and more mature partnerships** across academia, industry, and the wider health system, supporting Wales-wide cancer research capability and system leadership.

To support national expectations for increased participation in commercially sponsored research, Velindre University NHS Trust will increase the proportion of commercially sponsored interventional cancer trials within the active cancer research portfolio to approximately 70% by end of the financial year 2028–29.

This change represents a rebalancing of the research portfolio rather than a reduction in non-commercial research activity. Commercial trials often provide patients with earlier access to innovative therapies while generating income that supports research infrastructure, workforce capacity, and long-term sustainability of the research service.

Delivery of this shift will be achieved through strengthened portfolio oversight, improved feasibility and study selection processes, closer coordination between research delivery teams and clinical services, and proactive engagement with commercial sponsors and research networks.

		Key actions		
Delivery Priority	Objective	2026-2027	2027-2028	2028-2029
Driving Forward the Blood and Transplant Research and Development Ambitions	Strengthen national and international blood and transplant research partnerships.	We will continue national and international partnerships and strengthen national presence and partnership working WBS visibility and contribution across UK and international research collaborations, including active participation in BEST Collaborative studies and joint programmes with partners in Wales, the UK and internationally.	WBS plays a visible role in leading or co-developing blood and transplant research studies with partners across the UK and internationally	WBS is recognised as a trusted partner and contributor to international blood and transplant research collaborations and programmes
Driving Forward the Blood and Transplant Research and Development Ambitions	Establish sustainable governance and financial frameworks for blood and transplant research collaborations.	Sustain financially protected partnerships by implementing clear governance, costing and risk-sharing frameworks that enable the Welsh Blood Service to collaborate confidently with universities and research organisations, while protecting core service budgets and ensuring full cost recovery or agreed underwriting arrangements.	Financial and governance frameworks enable stable collaboration in blood and transplant research while protecting service budgets.	Blood and transplant research collaborations operate on predictable and sustainable financial arrangements that support long-term partnership working.
Driving Forward the Blood and Transplant Research and Development Ambitions	Grow investment and income supporting blood and transplant research and innovation.	Increase our research budget by supporting successful grant applications, developing commercial research opportunities and building partnership ventures that generate additional	Income from grants, partnerships and commercial activity contributes to a growing blood and transplant	Blood and transplant research funding streams support sustained investment and reinvestment

		income for reinvestment in RD&I.	research budget.	into RD&I capability.
Driving Forward the Blood and Transplant Research and Development Ambitions	Expand the Welsh Blood Service blood and transplant research portfolio.	Grow the WBS research portfolio by enabling more colleagues to undertake research within their roles and by supporting the development of new project ideas that align with the RD&I Strategy.	The blood and transplant research portfolio grows with increased projects.	Blood and transplant research activity is embedded within roles across services and contributes to a stable and diverse research portfolio.
Driving Forward the Blood and Transplant Research and Development Ambitions	Increase staff engagement with blood and transplant research and innovation.	Increase staff engagement in research and innovation through enhanced organisational communications that integrate Blood and Transplant research and innovation	Staff participation in blood and transplant research and innovation initiatives increases across departments.	Engagement in blood and transplant research and innovation is embedded as part of organisational culture and professional development.
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Improve equitable patient access to cancer research	Patient access to research is reviewed routinely using existing recruitment and portfolio information. - Differences in access across tumour groups and pathways are visible and discussed through established governance. - Clinical teams and the Research Service jointly agree where variation is appropriate and where improvement is needed. - Access considerations are	Access considerations are embedded into routine portfolio planning and study commitment decisions, including coordination with outreach and satellite services where appropriate.	Access to research is consistently planned as part of service delivery, with patterns explainable at tumour-group and Trust level.

		reflected in portfolio planning discussions		
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Operate a controlled and shared system for cancer research delivery	A shared delivery model is agreed and in use across Velindre Cancer Services and the Research Service. - Portfolio, commitment, and delivery control are applied consistently when considering new and ongoing cancer studies. - Roles in decision-making and escalation are clearer across clinical services and research delivery teams. - Learning from benchmarking with critical friends (e.g., Clatterbridge) inform how controls are applied.	The shared system is embedded and operating consistently across directorates, tumour groups, and support services.	The delivery system is stable and predictable, supporting growth without increasing risk at the same rate.
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Improve reliability and consistency of study set-up and delivery	Study set-up is approached as a whole-system activity involving clinical teams, research delivery teams, and support services. - Key dependencies (clinics, workforce, pharmacy, radiotherapy, laboratories, data) are identified earlier in the set-up process - Variability in set-up timelines is understood and discussed through routine governance.	Set-up and delivery timelines are more consistent across tumour groups, supported by alignment between services and clearer escalation routes.	Study set-up and delivery are dependable and explainable, with reduced variability and fewer late-stage issues.

		• Escalation routes for set-up issues are clearer and used more consistently		
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Strengthening integration between research and clinical services	Research planning and review are more closely aligned with Clinical Directorates and Site-Specific Teams. • Tumour groups have clearer visibility of research commitments and delivery impact on services. • Research is considered alongside clinical pressures when agreeing new studies. • Shared ownership of research delivery between clinical services and the Research Service is more explicit.	Joint ownership of research delivery is embedded across clinical services and tumour groups.	Research is fully integrated into routine clinical pathways and service planning.
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Strengthen early phase, radiotherapy, and translational research capability	Trust priorities for early phase, radiotherapy, and translational research are clarified and agreed. • Decisions about complex studies reflect delivery capability and service readiness. • Learning from benchmarking and peer organisations informs how complex research is supported. • Coordination across sites and services is	Delivery models for complex research are operating reliably, including through the Cardiff Cancer Research Partnership and relevant outreach settings.	Capability is aligned to future service configuration, including the new Velindre Cancer Centre.

		strengthened where required.		
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Support sustainable growth in commercial cancer research	Commercial research activity is reviewed alongside non-commercial studies as part of portfolio oversight. • VPAG objectives are applied to ensure commercial activity supports sustainability and reinvestment. • The impact of commercial studies on clinical services and research delivery is more visible. • Decisions about commercial growth are linked to capacity and delivery credibility.	Controlled growth in commercial research is embedded within portfolio and delivery governance, supporting workforce and infrastructure resilience.	Commercial research operates as a sustained contributor to long-term capability and system resilience.
Driving Forward the Velindre Cancer Services Research and Development Ambitions	Build a stable and capable cancer research workforce	Research roles and responsibilities across clinical services and the Research Service are clearer. • Training and regulatory expectations are reviewed and maintained. • Support service input to research delivery is better aligned to portfolio demands. • Pressure points are more visible and discussed.	Research delivery is supported through clearly defined roles and planned capacity across services.	Workforce capacity and capability are matched to portfolio ambition and VCS / Research service configuration.
Driving Forward the Velindre Cancer Services Research and	Strengthening partnerships and system leadership in cancer research	Existing partnerships with academia, industry, and NHS partners are actively supporting research delivery. • Collaboration arrangements are	Velindre's role as a credible research partner is reinforced through consistent	Velindre is recognised as a system leader in cancer research delivery, contributing to

Development Ambitions		clearer and better aligned to delivery priorities. • Roles within regional and national research structures are more explicit. • Learning from partners informs local improvement	delivery and collaboration.	Wales-wide capability.

Innovation

Innovation is a core enabler of Velindre University NHS Trust's ambition to deliver world-class, compassionate, and sustainable cancer and blood services for the people of Wales. As the health and care landscape continues to evolve, the Trust recognises that structured, evidence-based innovation is essential to improving patient outcomes, enhancing donor experience, strengthening service resilience, and accelerating the adoption of new technologies and models of care.

Through a growing portfolio of programmes and strategic partnerships, Velindre is developing the organisational capability, culture, and governance required to deliver transformation at scale. This includes embedding innovation principles within everyday practice, supporting staff-generated ideas, and collaborating with national and international partners to translate research, digital solutions and emerging technologies into measurable impact.

The Innovation function also supports the Trust's commitment to value-based healthcare by enabling new approaches that improve clinical effectiveness, streamline pathways, and address pressures on workforce and resources. The development of our formal Innovation Management System, aligned to the ISO 56001 international standard for innovation, further strengthens our ability to prioritise, manage, and evidence innovation activity in a systematic, auditable and sustainable way.

Our Vision: To be an International Beacon for innovation in Cancer and Blood Services.

Our Mission: To drive continuous improvement and breakthrough innovations in cancer and blood services by fostering a culture of innovation, creativity, collaboration, and excellence.

Our Strategic Objectives for Innovation:

1. **Enhance Patient Outcomes and Improve patient and donor Experience:** Develop and implement innovative treatments and care pathways that improve patient survival rates, quality of life, and overall experience for patients and donors.
2. **Improve Operational Efficiency:** Utilise innovation to streamline processes, reduce costs, and improve the efficiency of service delivery.
3. **Strengthen Collaboration:** Build strategic partnerships with academic institutions, industry, third sector, government / governmental support organisations and other healthcare organisations to accelerate innovation.
4. **Cultivate an Innovation Culture:** Encourage a culture of innovation among staff through continuous learning, incentives, and support for creative initiatives.

Implementation Themes

Our 10 implementation themes below provide us with the framework for our activities to support the delivery of our objectives.

1. **A Collaborative Innovation Ecosystem:** Our vision includes building a collaborative innovation ecosystem where staff, healthcare providers, researchers, academia, industry, patients, donors and community partners work seamlessly together to drive innovation, address healthcare disparities, and create healthier communities. We are building an ecosystem that supports and strengthens the capability and capacity for the Trust to innovate. We will further embed the ISO 56001 (International standard for Innovation) to provide a framework for our innovation ecosystem to thrive. We want to improve whole system cancer care through collaboratively accelerating cancer research, innovation education and involvement. Providing a virtual and physical space to encourage creativity, collaboration, and knowledge exchange

with practical and positive impact on cancer care for all those involved. The Collaborative Centre will strengthen the innovation infrastructure and ecosystem for the Trust.

2. **A Culture of Innovation:** We are dedicated to fostering a culture where every member of our organisation is empowered, informed, and supported to innovate, experiment, and embrace change, making innovation a way of life rather than an isolated event.
3. **Clear Communications and Recognition:** We are committed to delivering clear communications to support the capability and capacity building for Innovation within the Trust. Recognising the efforts of our staff, patients, donors, community, funders partners and stakeholders; and reinforcing our Trust culture of innovation. This includes :
4. **Patient and Donor Centred Excellence:** aspiring to redefine patient and donor centred care, placing patients and donors at the heart of every decision, ensuring their voices are heard, and tailoring healthcare experiences to their unique needs and preference.
5. **Leadership and Role modelling:** As a University Designated Organisation – Senior Leadership are committed to sponsoring key initiatives and novel projects and ensuring that Innovation, Research, Development, Learning and Education opportunities are enabled and reflected in job roles and responsibilities and provide the support and resources needed to drive innovation.
6. **Advancing Technology Integration:** Our approach is to harness the power of cutting-edge technologies, including artificial intelligence, telemedicine, wearable devices and data analytics, to optimise treatment, experiences, inform diagnostics and preventative care, with the aim of making services more accessible and efficient.
7. **Data Driven Insights:** Leveraging data as a strategic asset, using it to inform our innovation activities and efforts.
8. **Health Equity and Inclusion:** Our commitment extends to achieving health equity and inclusion for all with a focus on disparities in healthcare access and outcomes. Our innovations will strive to remove barriers to care and promote health equity.
9. **Empowerment and Autonomy:** Empowering employees by giving them autonomy to propose and implement innovative ideas within their areas of expertise.
10. **Training and Development:** Innovation training is key to building the capability and capacity of the innovation infrastructure for the Trust. It will equip staff with the knowledge, skills and mindset necessary to drive innovation, improve patient and donor care, and adapt our delivery approaches to the changing innovation landscape. It helps create a culture where innovation is not just encouraged but also effectively implemented for the benefit of our patients and donors.

Future Focus for Innovation 2026 - 2029

Over the next three years, the Trust will continue to deliver and strengthen a system-wide approach that enhances patient and donor outcomes, improves operational efficiency, deepens collaboration and embeds a culture of innovation. Building on the foundations established through ISO 56001 and

the maturing Innovation Strategy, the programme will prioritise activity that delivers measurable impact, supports strategic alignment, and accelerates the adoption of beneficial innovations across clinical and corporate services.

Over the IMTP period, activity will be underpinned by clear, measurable KPIs to ensure demonstrable progress, transparency, and impact.

1. Enhancing Patient Outcomes and Improving Patient & Donor Experience

A key future focus will be on increasing the visibility, impact, and measurement of innovation activities that directly improve the patient and donor journey. This includes expanding the systematic collection of patient-reported outcome measures (PROMs) and experience data across relevant innovation projects to strengthen evidence-based decision-making and value-based healthcare delivery. The programme will also continue to promote innovation engagement at the frontline, such as through staff and patient-facing innovation stands at VCC enabling greater awareness, insight exchange and local problem-solving. This work will be supported by strengthened monitoring of innovations that contribute to patient safety and environmental sustainability, including the reporting of carbon reduction benefits delivered through specific innovation initiatives.

2. Improving Operational Efficiency

The Trust will strengthen governance and prioritisation processes to ensure projects fully align with Trust objectives and the Long-Term Plan. Regular portfolio analysis will maximise the value of the innovation pipeline, minimise duplication, and support the progression of high-impact opportunities. Operational efficiency will be enhanced through the continued roll-out of Bright Ideas across VCS and WBS, enabling staff to identify efficiency improvements and reduce waste.

Capability building will remain a core focus through the delivery of the ISO 56001 awareness module and embedding innovation expectations into mandatory training. Maintaining ISO 56001 will ensure a consistent, systematic and efficient approach to innovation management. The sustainability of the innovation function will be supported through strong governance, embedded processes and a maturing organisational infrastructure.

3. Strengthening Collaboration

The Trust will widen its collaborative footprint through structured horizon scanning, expansion of external partnerships and increased presence at sector-wide events. Collaboration with Cardiff Health Partners (CHP), Industry and academic partners and other NHS organisations will be strengthened through co-designed projects, shared innovation forums and participation in major events such as the NHS Wales Innovation Symposium. Communication channels including the Innovation newsletter will continue to showcase partnership outcomes, case studies and impact stories.

4. Cultivating an Innovation Culture

Embedding innovation as an organisational competency is a central component of the future focus. The Trust will continue expanding its network of Innovation Champions, with annual recruitment targets and retention expectations to ensure sustained, distributed leadership. Innovation responsibilities will be further embedded within job descriptions, appraisal processes and core behavioural frameworks, ensuring innovation becomes integral to every role across the organisation.

A structured programme of internal communication, including monthly updates on progress and achievements, will support staff engagement and promote transparency. Recognition mechanisms such as submissions to the MediWales Innovation Awards will continue to celebrate staff contributions and reinforce a positive, forward-looking culture. By mainstreaming innovation education supported through the Innovation Toolkit, Bright Ideas roll-out, and ESR training the Trust will cultivate a confident, empowered workforce capable of delivering continuous improvement and transformative change.

OUR PEOPLE 2026 – 2029

Our people

The Trust employs HC 1,978 whole time equivalent (WTE) 1,761 (December 2026) excluding hosted organisations and bank and agency staff.

Our People Strategy sets out our vision to be an 'Employer of Choice'. This is supported by our Workforce Planning and Culture programmes which set out the actions that we will take to attract, develop and retain the right workforce, with the right skills, to deliver the best care possible.

Staff Survey: Developing insight

We undertook the NHS Staff Survey in 2023-2024 and 2024-2025 which had a response rate of 34% and provided us with a great deal of insight which has been used to shape change at Trust and Divisional levels. Three topics were identified for focus for 2025-2026 as clear issues arising from staff feedback and providing the best options for improving the experience for staff in the workplace. These topics align with Accountability, Caring and Respect.

1. PADR, so that the Trust achieves 85% compliance by March 2026 and maintains and improves in 2026-2027.
2. Creating time and support for Team discussions, so that staff are working in supportive environments where they can plan, review and discuss their work openly.
3. Countering bullying, harassment and discrimination through focusing on the Trust Values, so that staff feel increased psychological safety at work.

These themes will be reviewed on receipt of the next report in January 2026 and updated as required.

Monitoring Progress

We have made good progress over the last three years in developing our workforce and culture; as noted in our previous IMTP, attracting, training and retaining our workforce has been a key challenge for the Trust and our People Strategy has supported mitigating these risks, which are exemplified in our key metrics over this period: -

Attraction

- We have a dedicated attraction and resource action plan, with an emphasis on modern marketing methods for hard to fill roles and a widening access programme to support socio-economic development.
- Workforce resource across the Trust has grown from 1491.36 WTE to 1751.48 WTE, with the largest growth in our registered nursing and medical and dental workforce at 27% and 26% respectively.

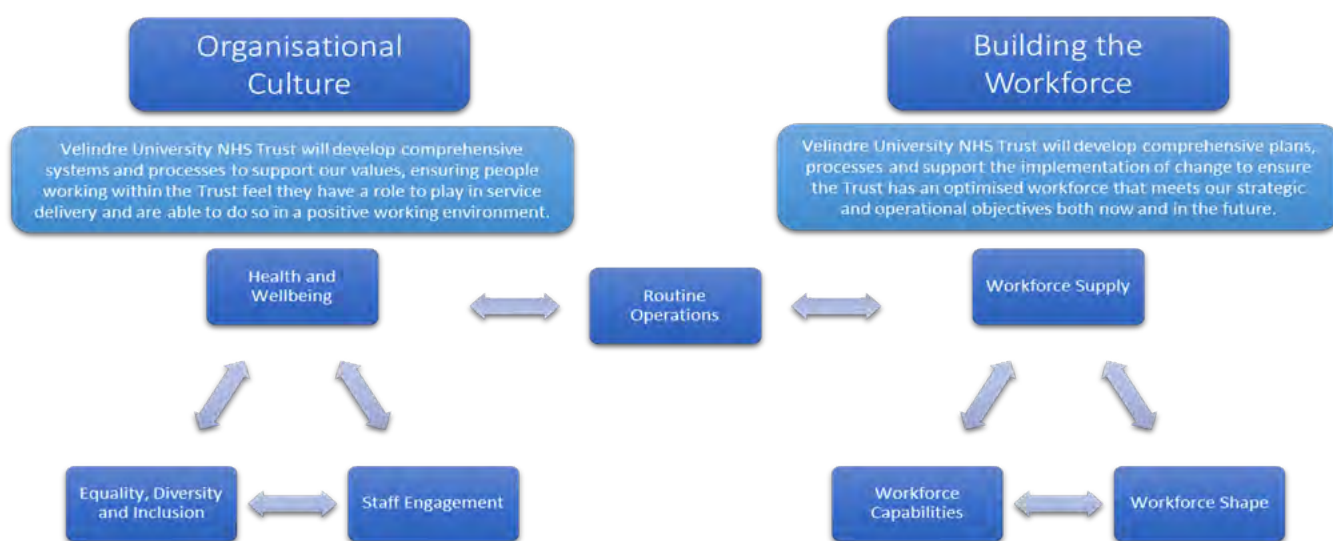
- Our recruitment time to hire remains consistently below the NHS Wales target of 71 days at an average of 57 days across the Trust.

Training

- We have developed a new policy and process for regular performance reviews within the Trust which has seen the Performance Appraisal and Development Review (PADR) completion increase from 71.23% to 80.6%.
- Improved compliance in Medical and Dental Job planning by investing in medical leadership, taking compliance from 64.71% to 73.17%.
- Across the three years Statutory and Mandatory training has remained above target and continues to rise from 86.22% to 88.88%.
- Developed the Welsh Language Clinical Plan and increase the Welsh Language awareness compliance from 79.81% to 91.99%.

Retaining our Workforce

- Turnover dropped from 13.85% to 9.38% in the same period with the implementation of dedicated retention programmes across the Trust.
- We have piloted a staff wellbeing service supporting the overall reduction in absence from 5.73% to 5.1%
- Implementing more robust measures on agency spending has supported an overall reduction, target of 30% reduction on course to complete for 2026-2027 workforce.



Our Priorities for 2026 - 2029

We will build upon the progress we have made in previous years. Our People and Culture plan sets out our priorities for this period, which are aligned with the national workforce developments being taken forward by Health Education and Improvement Wales (HEIW).

Organisational Culture



We will: -

- Commission a programme of culture and leadership support which will provide in-person development to staff across the Trust from Senior Leaders to all front-line personnel
- Strengthen the connection between our Wellbeing work and the building of psychological safety
- Follow up on the Harassment, Bullying and Discrimination data with specific actions at Trust and Divisional level (through the Staff Survey plans)
- Develop the inclusive culture through building the Staff Networks to Advocate, Educate and Influence
- Refresh our governance arrangements

Building the Workforce – Objectives 2026-2027

- Workforce planning support to all Trust divisions to co-develop resource and operational workforce plans that strengthen recruitment, enhance development and Welsh language capability, and improves retention across the organisation.
- Lead and facilitate the Trust's development of a comprehensive strategic workforce plan that reflects labour-market intelligence and incorporates best practice in blood and cancer care to ensure a sustainable, future-ready workforce:

We will: -

- Build and embed workforce planning capability at all levels across the Trust by educating and equipping teams to confidently undertake resource, operational, and strategic workforce planning that supports evidence-based, sustainable decision-making
- Deliver a comprehensive labour productivity assessment that aligns with the wider Welsh workforce efficiency agenda while meeting recognised health-industry standards and regulatory requirements to drive evidence-based workforce optimisation across the Trust
- Design and implement a user-friendly, easily accessible workforce dashboard that strengthens management accountability by clearly displaying key workforce KPIs to support timely, evidence-based decision-making across the Trust
- Develop and enhance the Trust's education and learning offer by strengthening internal programmes and leveraging external partnerships to equip staff with the skills and capabilities needed for current and future service demands

The Future NHS Workforce Solution

Our workforce management will be supported by the Future NHS Workforce Solution, (which will succeed the Electronic Staff Record (ESR)). The new workforce solution will support the Trust and our employees by providing a complete employment lifecycle platform, generating significant benefits for the NHS over the 15-year contract duration. The system will provide everything from recruitment and onboarding to career development, workforce management, payroll and retirement.

The implementation of the new system will require resource and planning from both finance and workforce teams, ensuring that there is effective engagement in the design and delivery of the programmes as well as skills to later deliver training and engagement to staff on using the system.

The system will provide benefits for the Trust through: -

- Increased functionality and improved user experience,
- Access to timely data and insights to facilitate informed decision making
- Streamlined business processes, which
- Reduces administration burden and releasing People Services to further support frontline colleagues in continuing to deliver high-quality care
- Reduced expenditure on third party contracts and other workforce solutions.

The new workforce solution will be implemented through the Trust Portfolio approach to optimise efficiency and appropriately manage resources and other Trust Portfolio and Programme interdependencies.

Workforce Mental Health and Wellbeing



Wellbeing of staff is central to the vision for the Trust. The People Strategy has a part of its vision: Healthy and Engaged People: of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity.

- Maintain the sickness absence rate at 5.1%, as achieved during 2025-26. This to be achieved through the use of SMART actions at divisional level as reflected throughout this plan.
- Through the NHS Staff Survey Group, agree changes with staff to minimise Harassment, Bullying and Discrimination at work.
- Develop infrastructure for Employee Voice, including reviewing processes for Speaking Up Safely.
- Introduce e-learning for Sexual Safety at Work in partnership with NHS Wales colleagues.
- Establish a procedure and guidance for departmental interventions that have high mental health, stress and other related sickness.
- Establish support for managers to confidently and safely steer positive changes. Change is constant and can be rewarding and bring about opportunities for career development and quality in service provision.

The goals will form part of the Trust Health and Wellbeing Plan and will be monitored via the Healthy and Engaged Steering Group

Milestones:

1. The People and Organisational Development Team will support the Trust to develop a workplace culture for our people that is truly inclusive by developing compassionate frameworks aligned to statutory requirements for improving equality and diversity within Wales. This will connect to the culture programme of work and measurement in this plan.
2. We will support the Trust to develop workforce plans, both strategic and operational based on the changing needs of the labour market and service delivery. Divisional plans will ensure detailed analysis of key workforce data ensuring any actions implemented will bridge gaps and challenges within the workforce.

3. We will continue to utilise the success of the employer branding and attraction campaigns to engage the future workforce, develop effective career pathways and improve workforce diversity through our widening access programmes. We will develop and implement a comprehensive talent attraction and retention programme. This will include design and roll out of employer branding and attraction campaigns, development of career pathways and supportive access to work initiatives that improve workforce diversity as well as dedicated retention plans where needed within hard to fill roles.

		Key actions		
IMTP Priority	Objective	2026-2027	2027-2028	2028-2029
Skilled and Developed Workforce	Roll out new Performance Appraisal and Development Review process with aim of 85% participation Working with medical colleagues to ensure a robust and effective process for job planning that is built into our workforce plans	New PADR process in place Job Planning process in place	Maintaining process and monitoring outcomes	Targets achieved Workplan highlights a changed workforce
Workforce Mental Health and Wellbeing Safely and Working Together engagement sessions	Maintain current performance and sickness level of 5.1% (or better)during our significant change programmes	Sickness plans in place and monitoring ongoing	Targeted interventions as required	Monitoring
Healthy and Engaged Workforce	Creating time and support for Team discussions, so that staff are working in supportive environments where they can plan, review and discuss their work openly.	Culture plan developed Business case for wellbeing service Speaking up safely infrastructure in place	Culture plan monitored with measures in place	Improving staff survey/exit interview /pulse survey outputs

IMPROVING ACCESS, EQUALITY, DIVERSITY AND INCLUSION



Welsh Language

The Trust continues to embed the importance of bilingual services for patients and donors in all that we deliver.

The Active Offer dominates our plans, and it will continue to do so into 2026-2027. The simple concept remains central to our bilingual provision and supports our actions around the Welsh Language Standards and the More than just words framework.

Our actions for 2025 have strengthened our approach, with staff training increasing skills and our in-patient pathway; now being supported by a newly developed Clinical Plan focussing on Welsh language consultations for patients and donors.

We continue to research ways to streamline our telephony process, and this priority is a focus within the developments for the new Cancer Centre, however our telephony services at the Welsh Blood service continues to investigate ways to enhance the bilingual process of donating blood. We have this year agreed a Welsh language streamlining telephony service that complements our English language approach. We now have a fully bilingual donor telephony screening service giving equality to both languages from the outset.

Similarly, we have updated our Complaints process to include a more detailed Welsh Language section. We have updated our Equality Impact Assessment process ensuring discussions around Welsh Language needs and rights are at the forefront of the process.

Priorities for 2026 onwards include:

- Working in partnership with Coleg Gwent and the National Centre for learning, staff training to continue to be provided free of charge. This will continue to strengthen our ability to provide bilingual services with a focus on increasing staff confidence and embedding a positive approach to all levels of Welsh language skills.
- We will continue to plan for the Welsh Language tutor post. This role is crucial to continue our Trust specific training in support of the national training availability.
- We will investigate the opportunity of providing clinical terminology training for our blood donation service staff to ensure we support staff with our expectations of providing Clinical Consultations.
- Embedding the Trust's Clinical Consultation plan will be central to Welsh Language priority setting. Working in partnership with the Welsh Language Commissioner has enabled us to approach standard 110 with a realistic and achievable action plan that will be updated regularly. Our divisions are heavily invested in this plan and will support its delivery through their Welsh Language groups.
- Our new recruitment process will take time to embed but this again aligns with the need to ensure we have the right people in the right place for our bilingual services.
- Workforce planning and Welsh Language skills will also be a priority, and we continue to ensure our collection of staff Welsh Language skills stay above the 90% to give us a clear picture of who we have currently and what skill we need moving forward. We will be developing a workforce plan where Welsh Language awareness, recruitment and training are considered and can complement the clinical needs of our services.
- We will continue to monitor our internal structures with mystery shopper calls in line with the Welsh Language Standards and our divisional working groups will embed further their ambitions for a truly bilingual provision, Trust wide.
- Moving from a reactive approach to bilingual provision to proactive planning continues and we welcome a more partnership approach in all that we do. Strengthening our discussions

with the Welsh Language Commissioner and the priorities set by Welsh Government drives our thinking as we look forward to 2026 and beyond.



Health Inequalities

As part of our specific duties under the Equality Act 2010 and Regulations in Wales, the Trust is required to develop and publish a Strategic Equality Plan and its strategic equality objectives every four years, and our current plan is set for 2024-2028. This has been monitored through our quarterly performance and improvement meetings with the Welsh Government. In 2026-2027 we are moving to the Maturity Matrix model of assessment, monitoring and improvement as we further embed our equality objectives.

1. Fairness and Respect

This will be a core component of our organisational culture and leadership programmes, sponsored by our Board. This will work on a number of priorities including ensuring compassionate leadership, that we live our values and tackling poor behaviour. A milestone plan has been shaped, and we will co create the action plans with our Trade unions. As part of this programme of work, we will look for opportunities to increase workforce diversity and inclusion and eliminate Pay Gaps. We would like the workforce to better reflect the diverse nature of the communities that we serve, and to ensure that there is no systemic pay disparity between people of different genders, races or disability.

Key Milestones:

- Develop a positive organisational culture, across all training and communication mechanisms.
- Implement the Trust's Widening Access Plan.
- Implement the second phase of the Wales Anti-racist Action Plan.
- Implement the LGBTQ+ Action Plan.

2. Engagement

As well as continuous engagement with staff regarding the culture and leadership programme, we will engage with the community to ensure that we are providing services that our patients and donors want and need. It is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways. This is led by our clinical service connecting with patients and donors as reflected in their delivery plans.

Key Milestones:

- Increase the number of donors across specified target groups in line with the Welsh Blood Service 5 Year Strategy.
- Use Equality Impact Assessment process to prepare cancer services for the move into new Velindre Cancer Centre.

3. Accessibility

Communicate with people in ways that meet their requirements. We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.

Milestones:

- Any legislative changes in British Sign Language are translated into service plans.
- Implement the Welsh language clinical consultation plans 2026-2027
- Any regulatory changes regarding accessibility are translated into service plans.

DEVELOPING OUR INFRASTRUCTURE TO SUPPORT HIGH QUALITY CARE 2026 – 2029



Our strategic priorities for Estates for this Plan are:

- A safe and high quality estate which provides a great experience
- Healthy buildings and healthier people
- Minimising our impact
- Use our estate to deliver the maximum benefit and social value to the community.

Summary of the major estates projects:

Talbot Green Infrastructure – further detail below

- Year 1 - Progress, depending on Welsh Government approval process, works to complete Enabling Works scope and work to complete FBC for whole programme.
- Delivery in 2028/9.

Estates and Facilities transition and readiness for new Velindre Cancer Centre – further detail below

- Year 1- Target Operating Model, Organisational Design and Development, Readiness and Testing.
- Year 2 and 3 – Operating

Readiness for post construction management of Mutual Investment Model – further detail below

- Year 1- Target Operating Model, Organisational Design and Development, Readiness and Testing
- Year 2 and 3 – Operating.

Old Velindre Cancer Centre – Decommissioning/ Conversion for future use

- Year 1 – Business Case completed and submitted
- Year 3 – Work completed

Old Whitchurch Hospital disposal

- Year 1 - Disposal process complete, subject to market

Health Safety and Fire

The objective of this Plan is to continue to implement an effective Health and Safety Management System, based on best practice. The first year of implementation in 2025/6 included the delivery of the first three Principles. For this plan:

- Year 1:
 - o P4 Risk and Opportunities
 - o P5 Learning from Events
 - o P6 Occupational Health
 - o P7 Asset Management
- Year 2:
 - o P8 Contractor and Supplier management
 - o P9 Communication
 - o P10 Emergency Preparedness
 - o P11 Measuring Performance

Well-being of Future Generations Act

The objective for this plan is the more effective embedding of the Act into the refreshed Trust Strategy by end of Year 1.

Sustainability

- **Travel Plan** - Year 1 - Refresh the Trust Travel Plan (2028)
- **Climate Adaption** - Year 1 - Continue delivery on climate adaption risks, working with the Climate adaptation leads across NHS Wales.
- **Energy** - Year 3 - Remove gas from all sites and invest in renewable energy for all sites
- **Sustainable funding model for change** - Year 2 - Model for funding streams and management of savings, building on Site Improvement Plan approach.

Talbot Green Infrastructure (TGI) Programme

The Welsh Blood Service – Research, Development & Innovation Strategy (Dec 2024) will guide the Welsh Blood Service's research activities and partnerships with academia and NHS organisations, linking to funders, industry partners and educational leaders in the supporting infrastructure to perform research, development and innovation (RD&I) with the aim of improving the lives of people in Wales. Its implementation will ensure the research, development and innovation objectives of the *Welsh Blood improvement strategy* and *Velindre University NHS Trust Destination 2033* are further defined and met.

- The mission that supports this strategy and vision are:
- Centred on improving patient and donor care
- Advancing blood components
- Advancing transplant research in Wales
- Using Innovation and Value-Based healthcare to improve services and performance
- Using collaboration to sustain RD&I
- Serve the people of Wales by supporting international initiatives
- Enhance the impact of RD&I and celebrate success

The TGI business case therefore sets out the investment, help and support required to provide the technical infrastructure, systems and expertise to deliver a sustainable and future-proofed service that will enable the strategic objectives of the WBS and VUNHST to be realised whilst delivering the 7 strategic themes and service development plan of the WBS.



This project will support the aims and objectives of the Trust and WBS by also:

- Improving the quality and quantity of research undertaken by the Trust/ service
- Providing donors with the best care and experience possible and ensure they continue to feel fully valued
- Providing an opportunity to promote blood donation to grow the donor pool via improvements in infrastructure for efficiency and data integration
- Improving donor care through the development of research activity at the Welsh Blood Service and utilise research and development activity to support the delivery of evidence-based care.
- Supporting the Plasma for medicines Programme
- Supporting development in the Advanced Therapies arena

The Talbot Green Infrastructure project is listed as a key deliverable within the Transplantation Services Modernisation Programme and seeks to transform our Talbot Green site into a modern, sustainable and resilient national facility that supports the long-term delivery of blood, stem cell, laboratory and logistics services for NHS Wales. This programme will ensure that our infrastructure is fit for the future, supports service growth and provides the environmental and operational standards required for the next 50 years. Key activity within this programme include:

- Outline Business Case (OBC) Development and Submission March 2026
- Business Justification Case (BJC) Advanced Works Development and Submission March 2026
- Final Business Case (FBC) Development and Submission commencement September 2026

Conclusion and approval of the various stages of business case will pave way for a construction programme that will realise the purchase of Welsh Wound Innovation Centre (WWIC) aimed to support the WBS long term strategies included plasma for medicines and apheresis, while acting as much needed decant space to support a 42 month construction programme, with works concluding in the quarter 2 of 3032.

Support Services and Mutual Investment Model (MIM) Readiness for the new Velindre Cancer Centre (nVCC)

The Operating Model is designed to enable the objective of the nVCC: “To provide a state-of-the-art, patient-centred facility focused on delivering high-quality cancer treatment and research, while also prioritising sustainability and a positive patient experience”.

Deliverables

Design of the MIM Operating Model

- Operational Term Governance
- Oversight and Strategic Management through the Senior Responsible Owner
- Contract Commercial Management (Finance)
- Contract Operational and Compliance Management (Estates and FM)
- Enabling Workstreams:
 - o Systems
 - o Data and Reporting
 - o Resources
 - o Handover and Training
 - o Benefits Realisation
 - o Communications

Key Milestones

- Establish Project management arrangements – Q1 26/7
- Project Plan – FEBRUARY 2026 – COMPLETED
- Principles Paper – Q1 26/7
- Draft Project Agreement Handbook (Part B) – Q1 26/7
- Enabling workstreams Plan – Q1 26/7
- Draft Contract Management Plan – Q1 26/7 2026
- Final PA Handbook (Part B) – Q2 26/7

Portfolio Management

The Trust has been incrementally implementing Portfolio Management across the organisation, in order to effectively prioritise across the whole portfolio of change, manage resources effectively and further sharpen our effectiveness of delivery and implementation, and strengthen Trust wide controls in reporting, scheduling and risk management.

The **Portfolio Management integration into our Trust Board**, Executive Board and into our Trust Board decision making and assurance processes is being effectively utilised to support our major capital infrastructure programmes.

A Community of Practice has been established to promote professional development for Portfolio, Programme and Project staff. The Trust has also become corporate member of the Healthcare Projects and Change Association (HPCA).



PARTNERSHIPS

Building strategic partnerships in an NHS Trust means aligning its mission, priorities, and resources with external groups—such as healthcare providers, local authorities, voluntary organisations,

research institutions, and industry—to benefit patients, staff, and the broader health system. The following are the main objectives of our partnership strategy:

- 1. Enhance Patient Outcomes and Experience
- 2. Enable System-Level Integration
- 3. Accelerate Innovation and Research
- 4. Build Organisational Resilience and Capacity
- 5. Promote Sustainability and Value
- 6. Strengthen Governance, Transparency, and Compliance
- 7. Engage Stakeholders and Communities

Overview:

Key priorities	What we expect the plan to deliver ?
Cardiff Health Partners	• Health innovation, anchored in Cardiff, connected for global impact. • The model reduces barriers through shared governance, streamlined research delivery, and federated data access. • It is health improvement and economic growth and regeneration, delivered together. • Significant progress on a long-term strategic partnership for cancer therapies. Year one will include an investment strategy.
South East Regional Joint Committee	• The Trust is an active participant in the newly established South East Regional Joint Committee. The Regional Joint Committee's purpose is to enhance collaboration, reduce inequalities, and promote sustainable healthcare services across the region, marking a step toward integrated regional health governance. Year one to include an agreed workplan and delivery of the Trust's role in contributing to the wider regional health system.
South East Wales Regional Cancer Programme	• The Programme's overarching aim is to improve cancer prevention, early detection, treatment, and palliative care, delivering services that are high quality, equitable, and centred on patient needs for the population of South East Wales. The Programme Board provides strategic oversight, guiding the design, implementation, and evaluation of the programme to ensure these objectives are achieved. All projects and change initiatives within the programme are aligned to the individual cancer strategies of partner organisations, while also prioritising areas where regional collaboration delivers added value and strengthens outcomes across South East Wales. • Products/Actions/ Deliverables

	• Support consistent approach to MDTs across SEW by supporting implementation and spread of NHS P&I's MDT Charter and associated 'Bridging Document' to be published March 2026. • Year 1 delivery – Q4. • Impact - Consistent approach and standards across all MDTs which are auditable and support identification of resource gaps. • Regional Oncology workforce plan • Year 1 delivery – Q4 • Impact - Establish a regional oncology workforce baseline with an associated Workplan Plan to address any gap identified. • Shared Patient Treatment List (PTL) established • Year 1 delivery – Q4 • Impact - Cancer patients tracked in real time across their pathway with all the relevant demographic, referral, clinical and operational data visible to those responsible for patient care. Hospital Initiated Referral (HIR) from Individual HBs into VCS will also provide an in-built validation to the PTL
Cardiff & Vale UHB Executive Partnership	Cardiff & Vale University Health Board and Velindre University NHS Trust share a long-standing partnership that has been central to delivering high-quality cancer services for the population of South East Wales. In 2025/26, this relationship was further strengthened through the establishment of a formal partnership programme designed to support a unified strategic response to an increasingly complex and rapidly evolving oncology landscape. The partnership aims to ensure both organisations can meet the challenges and opportunities created by rapid innovation in oncology, including the emergence of Advanced Therapy Medicinal Products (ATMPs). These treatment advances offer significant potential to improve outcomes but require new delivery models, enhanced acute management pathways, and closer integration across provider boundaries. Guided by an Executive Partnership Group, the collaboration focuses on joint strategic planning and the development of sustainable models of delivery for complex oncology and advanced therapies. This work aims to streamline patient journeys and improve patient experience, ensure timely access to appropriate care, and maximise the use of combined expertise and estate across both organisations.

	As we look ahead to 2026-27, the partnership will turn its strengthened foundations into a coordinated and deliverable programme of work. Key priorities include: • Developing a shared partnership vision and future model of care. This will provide the strategic framework for decision-making and support the development of a phased delivery plan and mobilisation of key workstreams. • Reviewing the options for the shared delivery of lower-acuity haemato-oncology services. This work offers a practical and manageable starting point for testing joint ways of working and establishing the foundations for shared service delivery across both organisations. • Providing a coordinated provider planner input into the Advanced Therapies Wales Therapeutic Apheresis Project. Priority action We will develop and mobilise a coordinated programme of joint service planning across oncology, haemato-oncology and advanced therapies with an agreed future model of care, defined workstreams, and a phased delivery plan in place. Key Milestones Joint Model of Care - o Develop and agree Vision for the Partnership and delivery 'Roadmap' Q1 - o Model of Care enabling workstreams established Q1 - o Develop and agree phased delivery plan Q4 Haemato-Oncology Project - o Agreed service specification for low-acuity haemato-oncology services developed Q2 - o Baseline assessment and demand capacity analysis of lower-acuity haemato-oncology services undertaken and gap analysis undertaken Q2 - o Develop and agree preferred Model of Care for low-acuity haemato-oncology services Q4 • As part of the ongoing partnership between Cardiff & Vale UHB and Velindre University NHS Trust, strategic cancer prevention has been identified as a key area where collaborative working can deliver greater impact than independent efforts. • Scoping sessions have been held between Velindre and CAVUHB colleagues confirmed a shared commitment to strengthening the prevention agenda. Both organisations recognise the opportunity to

	maximise research, development and innovation (RD&I) potential and to embed prevention more systematically across services. Milestones for delivery Q2 2026: • Reviewing primary care cluster profiles to identify areas with the greatest potential impact. • Reviewing the MECC training offer across both organisations. • Developing a draft high-level plan to guide early collaborative activity
Welsh Blood Service RD&I Partnerships	The Welsh Blood Service – Research, Development & Innovation Strategy (Dec 2024) will guide the Welsh Blood Service's research activities and partnerships with academia and NHS organisations, linking to funders, industry partners and educational leaders in the supporting infrastructure to perform research, development and innovation (RD&I) with the aim of improving the lives of people in Wales.
Sustainability Driven Partnerships	Impact will continue to be evidenced in sustainable outcomes by end of year one through the following partnerships: • All Wales Walking Aid Recycling scheme • Climate Adaptation Leads across NHS Wales collaborate through regular meetings and shared platforms to align actions, reduce duplication, and share best practice • Genetic Hemochromatosis pathway
Hefyd Partnerships	Impact will continue to be evidenced in patient, staff and community outcomes by end of year one through the following partnerships: • Arts in Health Programme • Nature-Based Social Prescribing • Sustainable Jamborees
Industry partners	We are developing and strengthening our relationships with industry partners to support our research and innovation plans, with Varian, Acorn and Pfizer and others, to improve access to new and emerging treatments and therapies for our patients and donors.
National Leadership	Our Chief Executive Officer is a member of the NHW Wales National Cancer Leadership Board and Cancer Reference Group to provide system leadership in the governance structures to improve Cancer Service delivery in Wales; with detailed delivery managed through our role in the South East Wales Regional Programme. Welsh Blood Service continues to play a key leadership role in the Blood Health National Oversight Group (BHNOG).

Our work with Cardiff Health Partners, Health Boards, and Hefyd are examples of our contributions to developing Integrated Care Systems, and our support to the principles of Community by Design.

Women's Health

The Trust recognises the importance of the Women's Health Plan for Wales launched in December 2024. Dr Seema Arif, a Velindre Oncology Consultant, is the clinical lead of this national programme.

Key matters for the Trust in contributing towards improving healthcare for women:

Blood Service

The Blood Health National Oversight Group is responsible for ensuring delivery of the NHS Wales Blood Health Plan, a key workstream of which is anaemia management that which is now working in alignment to the Women's Health Plan. The anaemia rates for patients undergoing major elective surgery of which the incidence rate of anaemia is twice as high in women than men (39% vs 19%). The anaemia workstream aligns with five of the eight priority areas, menstrual health, endometriosis and adenomyosis, preconception health, menopause and ageing well.

Cancer Services

The Women's Health Plan highlights that as part of National Cancer Recovery Programme, as part of Planned Care on the five cancer types with the poorest cancer waiting-time performance. Two of the five chosen cancer types primarily affect women, (gynaecology and breast), as well as inequalities of outcomes also in the three other pathways, (skin, lower gastrointestinal (GI) and urology cancer). One year survival outcomes for women with bladder cancer, for instance, is significantly lower than men (75% v 59%). 47 It also highlights the impact of intersectionality and vulnerability, on outcomes in cancer care and survival. There is published research that shows that increased intersectionality leads to worse patient outcomes with respect to cancer.

Key Aspects of Cancer Service Provision for Women's Health:

Contraception and Fertility

Benefits and risks of medical treatment are discussed with the patient prior to treatment start. This is typically undertaken by the patient's consultant, and the patient will be supplied with resources such as appropriate MacMillan Cancer Support booklets and Cancer Research UK material.

Menopause

All patients treated with pelvic radiotherapy and/or brachytherapy are seen in post-treatment, nurse led follow-up clinic 6-weeks post-treatment. Hormone profile testing is undertaken to identify premature, radiotherapy induced menopause. Where appropriate, use of Hormone Replacement Therapy is discussed with patient. Alternative treatments are also considered, particularly in the case of endometrial cancer patients who, typically, cannot receive Hormone Replacement Therapy following radiotherapy induced menopause. Alternatives include anti-depressants, acupuncture and herbal supplements.

Pelvic health and Incontinence

Patients are provided with access to specialist knowledge and expertise at post-treatment follow-up clinic. Tolerance of treatment is actively assessed and awareness of potential toxicities highlighted. Patients are sign-posted to other Velindre cancer services, for instance, late effects gynaecological clinic, clinical psychology, dietetics support, Maggie's.

Violence Against Women, Domestic Abuse, Sexual Violence

The Trust delivers Violence Against Women, Domestic Abuse, Sexual Violence training across the trust and has identified champions. The Trust is committed to support the development of an NHS sexual safety process.

Digital Services

'Digital Excellence 2033', is the digital vision and strategy for Velindre University NHS Trust. Digital technology, data and services provide us with the opportunity to make a real shift in the relationship between health and care professionals, the people we serve and the healthcare services we provide. We need to ensure we address the fundamental challenges of modern and accessible cancer and blood services which requires high quality data; and accessible information to enable effective clinical decision making.

We are now two years into our journey of designing services in partnership with staff colleagues, patients and donors, which will ultimately allow us to reimagine services and provide a more personal experience enabled by digital technology.

There are six core digital themes, guiding our transformation and delivery of connected, people focused, personalised and sustainable services.

The development of these core foundations must be achieved to support the development and deployment of new technologies and capabilities such as robotic processing automation; artificial intelligence; and wearables.

We, together with the wider NHS are faced with workforce challenges. In a competitive employment market for digital specialists, we need to ensure we can develop the capability and capacity of our digital teams to both ensure our essential services are maintained alongside the opportunities to be pioneers in digital health care in Wales.

Since 2022, following the launch of our digital strategy, the Trust has made good progress against all the strategic themes, and the infographic below highlights key progress. These have digitally enabled new key healthcare services, such as the successful opening of the Velindre @ Nevill Hall radiotherapy centre, a new paperless and cloud-hosted Integrated Radiotherapy Solution (IRS), a new digital Patient Reported Outcomes Measures (PROMS) solution for cancer service users and clinicians, and a new user-centred donor appointment booking system for the Welsh Blood Service. Further, the Trust continues to build on its data and insight capabilities, through both Services and its Value Based Healthcare approach, and set the foundations for the wider adoption of Artificial Intelligence. AI is already in use for key systems such as IRS, and CoPilot for 200 staff. Trust AI strategy and policies have been developed and through the plan we will continue to support NHS initiatives including using AI for clinical coding.



Digital is a key part of the how the Trust is driving forward its strategic objectives. The nVCC is positioned as an exemplar SMART hospital, intended to accelerate digital transformation across NHS Wales and serve as a model for future infrastructure projects. This will act as a showcase for NHS Wales with services including a "Digital Front Door", location and asset tracking built into the fabric of the building and ambient voice AI capabilities. This IMTP plan includes the nVCC Digital programme which will enable nVCC. Velindre Cancer Services are also taking a system leadership role through the implementation of advanced Cancer Patient Tracking Lists (PTL) and the IMTP will establish how these can be used to improve SCP pathways across the region.

The Welsh Blood Service has several new digital capabilities enabled in the IMTP, including a new Blood Establishment Computer System, the continued digital transformation of the transplantation service, introduction of the new national LIMS system for blood transfusion and building the business for digital transformation of the Welsh Bone Marrow Donor Registry. A new 20-year partnership for the supply of an overall Blood Establishment Computer System has been procured and will be implemented over the next three years including transformation digital capabilities such as Donor Relationship Management and is planned for go-live 2027-2028.

Good progress continues to be made against the **Ministerial priorities** as set out at the National Digital, Data and Technology (DDaT) Leadership Board. The Trust has been fully engaged with the development of the National Target Architecture and is using this as the basis for decision making in the IMTP, is actively using the National Data Resource (and provides chairs for two of the NDR governance groups). The Trust is also actively engaged with the NHS App team, and the plan would focus on opening up appointment and referrals in the App and the integration of the nVCC 'Digital Front Door' into the App. Electronic Prescribing and Medicines Administration is underway, in collaboration with Better Meds, and is due to go-live in Oct 2026.

Velindre Trust is actively contributing to the National Target Architecture and National Data Resource programmes as they offer a clear route to strengthening interoperability, improving data quality, and enabling more consistent, modern digital services. By adopting shared national standards and platforms, we can reduce duplication, enhance security, and unlock better insights to support clinical care and strategic decision-making, positioning the Trust to benefit fully from national

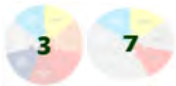
solutions and faster system-wide innovation. For example, we are fully engaged in the NDR proof of concept to develop AI tooling for Clinical Coding. As a high performing coding unit that is meeting current quality and performance measures, we recognise that we need to embrace innovation to maintain that performance whilst continuing to offer a thriving environment for our coding professionals.

Whilst the pursuit of Digital Excellence continues at pace, the digital agenda remains challenging in several areas which are recognised in Trust level risks. The capacity and capability of the Digital Services team to deliver the full digital agenda is constrained so choices and priorities continue to be necessary, a diagnostic is underway to address this challenge. The Trust relies, in large part, on the delivery of National Programmes through Digital Health and Care Wales and there are timeline challenges with the Radiology Information Systems Programme (RISP) and Laboratory Information Management System (LIMS) on which the Trust is dependent. Digital Excellence also requires an integrated approach across local, regional and national systems and the Trust is expecting the new National Target Architecture to make improvements in this area. The final area of digital challenge for the Trust is Digital Inflation in the underlying costs of infrastructure and systems which need to be catered for in plans.

Cyber security remains a key priority for this plan, and we will continue audits through the Cyber Resilience Unit to inform our Cyber Improvement Plan which is assured at Board Committee level. Legacy infrastructure continues to be actively managed down, although will still be a key capital item for the IMTP period. As an example, the Trust has now completed device moves from Windows 10 to 11, well ahead of other NHS Wales bodies. Continued focus in the ongoing place is placed on educating staff with statutory training ahead of the 85% target and regular Phishing simulation exercises undertaken. The improvement plan also includes regular testing of cyber resilience, and the Trust will continue to participate in National testing exercises.

Recognising that Digital Excellence is not about just technology the Trust has achieved accreditation against the Digital Inclusion Charter for Wales managed by Digital Communities Wales (DCW). This marked a significant milestone in its commitment to digital equity and innovation. This prestigious recognition celebrates Velindre’s efforts to embed digital inclusion across all levels of its organisation, from strategic planning to frontline service delivery. DCW praised Velindre’s approach as a “model of best practice,” highlighting its ambition, innovation, and people-centred ethos. Continued work on digital inclusion in our digital activities is a key part of the IMTP.

In particular the digital elements of the IMTP will take forward our Digital Excellence through:



Ensuring our Foundations

Brilliant Basics are the things that we need to have in place to ensure our services are based upon robust and stable foundations. These are the areas which impact on the digital experience of our patients, donors, partners and staff. We are committed to a number of key improvements including a single log-on for our clinical/professional staff; provision of a Digital Front Door for patients and donors to access our services; and provision of high-quality devices and equipment for our staff; who can access clinical and administration systems from anywhere as we continue to move to cloud based solutions. We will support our drive for improved efficiency through the implementation of modern digital system and scaling of the use of robotic process automation and artificial intelligence.



Digital Inclusion

We will support people to become more digitally confident, included and connected. Our patients, donors and staff need easy access to our services 24/7, from any location across Wales in support of our clinical services for cancer and blood which will see us providing more care at home; locally within Health Board/community settings with people only having to travel for highly specialist services. We will create a Digital Front Door for patients and donors where they can access our services; enable the use of hand-held devices to allow easy use; and provide staff, patients and donors with education and support in using technology to access services. We achieved the Digital Inclusion Charter in 2025 and will continue to progress our work in this area to further enable the communities we serve.



Safe and Secure Services

We will secure our data and information through an effective approach to general data protection and cyber security, working in collaboration with the Cyber Resilience Unit and the National Cyber Security Centre. This will include a refresh of our infrastructure network and software to ensure compliance with Network Information Systems Standards; education and training for staff; and routine testing exercises and learning.



Working in Partnership

We are working with a range of people to develop and deploy technology which provides better services; and makes Wales an attractive place to partner with to innovate. We will continue to work with the local universities and commercial partners to identify how we can use digital technologies, such as artificial intelligence, to solve some of the challenges we face. We will use our existing Innovation Network and the Centre for Collaborative Learning and Innovation, opening in the new Velindre Cancer Centre in April 2027, to co-ordinate activities.



A Digital Organisation

We are working with patients, donors, staff and partners to create a service culture that embraces the use of digital technology to offer the best quality services. We will support the development of 'digital first culture' by supporting clinical, nursing and scientific staff to become digital leaders; continuing to invest in our staff through formal education programmes and opportunities to learn. We will see a significant step towards becoming a paperless organisation through the digitisation of all of our cancer service records and the implementation of a paperless radiotherapy system; electronic prescribing and by refreshing our Blood Establishment Computer System and Laboratory Information Management System. These are pre-cursors whilst we await Welsh Government policy on a move to a Once for Wales Electronic Health Record platform.



Insight Driven Services

This is a key area of the digital strategy and also threads throughout all of our service delivery and the IMTP. Data, information and insight plays a vital role in supporting effective decision-making and service delivery which supports a quality driven, clinically led and population/value focussed approach. We are developing individual-level clinical insights which will help us to support individual performance and development of our people and progress our plans to build internal data science

capabilities through the development of our data repository/platform; improving our reporting dashboards; and developing our analytical capability through investment in our staff.

We will continue to work with DHCW and our Local Health Boards, to take full advantage of the National Data Resource; sharing of clinical information which supports our collective ability to deliver high quality operational and patient experience insights and improved clinical outcomes and population health.

Our immediate focus for the next three years is to accelerate the development of our range of quality measures; increase data sharing across NHS Wales and build our internal capacity and capability to enable our staff to confidently self-service their data needs. We have recruited a number of key roles including information security, data governance and analytics and will continue this investment in the coming years.

In line with the Trust's portfolio management strategy the digital IMTP initiatives in the table below are recognised as being Tier one for size and scale.

		Key actions		
IMTP Priority	Objective	2026-2027	2027-2028	2028-2029
nVCC Digital	Digitally enable the new Velindre Cancer Centre and support the transition of the VCS service model into nVCC	Planning and Implementation Sep '26 Beneficial Access – infrastructure commissioning	Apr '27 – nVCC opens Day + 1 optimization	Day + 1 optimization
WHAIS	Digital Transformation of the Welsh Histocompatibility and Immunogenetics Service	Phase 1 go-live and stabilisation	Phase 2 scope Transfer to Business as Usual	
Radiology Informatics System Programme (RISP)	Establish a new Radiology/PACS system on the National RISP platform.	Readiness for Service (Apr ' 26) Stable Operations (May '26)	Optimise system Transfer to Business as Usual	
Welsh Laboratory Information System (WLIMS 2.0)	Precursor for digital connectivity for the Infected Blood Inquiry digital solutions.	Blood Transfusion Module go-live in WBS and HBs	Digital Connectivity scoping for IBI	Digital Connectivity implementation for IBI
Blood Establishment Computer System (BECS)	Establish a new BECS for the Welsh Blood Service by Oct '27.	Scope Minimum Viable Product Implementation, Configuration	Testing, Validation Oct '27 go-live for Minimum Viable Product	Additional BECS modules including: Hospital ordering; Donor relationship management



Value Based Healthcare

Funded by the Welsh Government, the Value Intelligence Centre works across the organisation to enable the optimisation of care through Value Based Healthcare. The team works closely with the Value Transformation directorate and Value Based Healthcare teams across Wales to share best practice.

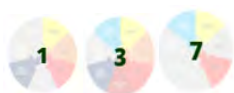
Our vision is to enable clinical and operational teams to deliver exceptional services, using linked datasets to identify and deliver continuous improvements that maximise the value, quality, safety, and efficiency of the care our patients and the service our donors receive.

The programme is structured around the following workstreams:

- **Training, Engagement and Communication:** Creating, sharing and delivering developmental information to staff at all levels to build confidence and incentivise uptake of VBHC projects. This includes publishing case studies, participating in webinars and conferences.
- **Technical Development:** Developing tools to enable linked data sets (e.g. activity, outcomes and use of resources) to be accessible to services to inform decision making. An example of this is the SST dashboard which is now live and has supported teams to identify and address unwarranted variation. It is regularly iterated to meet service needs. The team will facilitate the Cancer Service to benchmark performance (resource efficiency, waiting times, quality) with peer organisations in England. This recognises the unique challenges that Velindre faces in comparing organisational effectiveness within Wales.
- **Data Maturity:** Working to ensure that the accuracy and completeness of data within patient IT systems is sufficient to enable meaningful analytics. Priorities are agreed through working with service areas to identify and resolve the most impactful issues. The work here aligns with the Women's Health Plan (improving capture of Breast patient metastatic status) and Marmot Principles (tackle the inequitable distribution of power, money, and resources, through conducting an assessment of the digital PROMS (patient reported outcome measures) access and response status. This work will identify where we have inequity in the capture of PROMS (digital health assessments) across key demographic characteristics. This will inform work to address this inequity.
- **Data Driven Sense Making and Action Planning** Supporting the operational teams to improve the value of the services provided with project management input.
 - enabling patients to self-administer treatment (where licenced) to improve the conditions of daily life and social value of care,
 - assessing the impact that Frailty has on Velindre patient outcomes and use of resources,
 - collating Transport arrangements in place for blood products with WBS and the Health boards to identify inequity,
 - implementation of PIFU-enabled pathways (patient initiated follow-up) to enable patients who are not under active treatment to continue to access clinical input if and when needed without the need for ongoing follow up appointments
 - Supporting ongoing work to enable people with Genetic Haemochromatosis to donate blood as part of their ongoing treatment (see below).

- **Digital PROMs Platform:** Velindre Cancer Service now has an active Digital Health Assessment system that is operating across 5 services, with plans in place to implement across all pathways over the next 2-3 years. This enables the service to capture PROMs, conduct symptom monitoring and pre-SACT checks digitally. Roll out will include work to support patients that are not familiar with using their phones in this way, and use of a tablet on site for those who don't have this technology to hand. Analysis of access and response rates to understand any inequity is scheduled for next year. The Cancer Service is actively working with the Welsh Cancer Network to gain agreement on national sets of PROMs and with international organisations for agreement for a set for Bladder Cancer. Uniquely, the system will be used to capture outcomes from donors via the Welsh Bone Marrow Donor Registry. These outcomes will supplement the regular health checks carried out for this cohort of donors. Associated activity to enable clinicians to easily access and analyse the responses will take place in parallel with the system implementation.

Funded by the Welsh Government, the Value Intelligence Centre works across the organisation to enable the optimisation of care through Value Based Healthcare. The team works closely with the Value Transformation



Velindre Oncology Academy

The Velindre Oncology Academy has been established to provide non-surgical specialist oncology training, along with other related education, to multi-professional staff across Wales (and beyond).

Ambition:

To continue the expansion of the Velindre Oncology Academy's training prospectus to meet oncology workforce development needs across Wales, and to secure the long-term success of the Academy. By March 2027, we will develop and implement a three-year strategic plan that includes clearly defined KPIs for learner progression, programme quality, and financial sustainability.

The Academy will offer both university-accredited and non-accredited training programmes, positioning itself as the oncology training provider of choice for Health Education and Improvement Wales(HEWI), NHS Performance and Improvement(P&I) and NHS Wales partners.

End Quarter 1 2026-2027:

Level 4 Cancer HCSW qualification tender process - by May 2026, complete and submit a high-quality tender ensuring all requirements are met, stakeholder input is incorporated and bid is quality assured through internal processes

Operational delivery of 'Communication and Psychological Skills' module Target of 20 students with 100% student places filled by start date

Measures:

- Timely submission with 100% of QA compliance completed prior to submission
- 100% student places filled by start date of 14th April

End Quarter 2, 2026-2027:

- Increase reach and reputation - By September 2026, increase the academy's visibility by continued delivery of the marketing and communication plan and a 50% increase social

media and website engagement metrics by 50%, as well as present and exhibit the academy's work at a minimum of 2 national/international events

- Operational delivery of 'Immunotherapy' module – Module start date of September 7th. Target of 20 students with 100% student places filled by start date
- Operational delivery of 'Leadership and Quality Improvement' module – Module start date of September 1st. Target of 20 students with 100% student places filled by start date
- Operational delivery of 2 day 'Advanced Communication' course to be run tri-annually – first course to be delivered in September. Target of 8 students per course with 100% student places filled by start date

Measures:

- Academy expansion - by September 2026, increase learner enrolment by 50%
- Increase the Academy's visibility – Achieve 50% increase in social media and website engagement metrics
- Presenting/exhibiting at least two national or international events by September 2026.
- 100% recruitment into the 'Leadership and Quality Improvement' and 'Immunotherapy' module
- 100% recruitment onto the 'Advanced Communication' course.

End Quarter 3, 2026-2027:

Curriculum development - by December 2026, design and launch an updated curriculum framework that includes new and revalidated short courses/accredited modules based on stakeholder feedback, evaluations and horizon scanning. Increase learner enrolment

Measures:

- Updated curriculum framework - completed and approved by December 2026 with 100% of framework components delivered
- Module launches – by December 2026, delivery of 4 new modules

End Quarter 4:

- Operational delivery of 'SACT' and 'Acute Oncology' module – Exact Module start dates to be confirmed. Target of 20 students with 100% student places filled by start date
- Increase in short course offerings – new short course to be developed on operational throughout quarter 4. Subjects currently being determined through horizon scanning, benchmarking and stakeholder engagement. Will be announced in new curriculum launch in Q3

Measures:

- **Successful operational delivery of the 'SACT' and 'Acute Oncology' module - 100%** recruitment. Commencement of teaching on the planned start dates (to be confirmed)
- **Successful operational delivery of short course** – new curriculum to launch in Q3.

Efficiency & Productivity

Performance & Productivity

Following the assessment and report from the Ministerial Advisory Group on Performance and Productivity for NHS Wales, Velindre has focussed on efforts to benchmark performance and productivity against peer organisations with similar services. However, this has been difficult given the lack of available data and peer groups in Wales.

While the Trust is progressing multiple accreditation efforts which could lead to international benchmarking – for example, from the International Cancer Benchmarking Partnership (ICBP) and Organisation of European Cancer Institutes (OECI) – these are longer term initiatives with unclear benchmarking information; therefore, they cannot help with immediate improvement planning.

We do have however, an opportunity in the short-term to leverage data from cancer services in England. There is an opportunity to drive a rapid benchmarking initiative that can help Velindre leaders and front-line clinicians identify and align an effective improvement programme for results in 2026-2027.

1. Metrics categories, data definitions and time horizon

This work must be multi-disciplinary by default; therefore, we are leveraging the following data sources (Model Hospital System; publicly available NHSE datasets; annual reports; and board papers) to extract relevant metrics regarding:

- Workforce effectiveness
- Operational effectiveness
- Quality and clinical effectiveness
- Financial effectiveness

Through this work, we will include data definitions, which will help us identify which metrics are comparable between Wales and England, either as-is or through derived calculations or other methods of reconciliation.

We will also aim to collect the most recent data available (e.g. 2024-2025 or 2023-2024), and where available we will collect 2019-2020 data for a pre-Covid productivity baseline assessment.

2. Productivity and Efficiencies

The Trust is reviewing its productivity & efficiency using measures comparing:

- its specialist cancer services peer organisations in England – The Clatterbridge Cancer Centre, The Christie, Royal Marsden and Mount Vernon using Model Health System to identify areas of improvement
- its specialist Blood & Transplant services using the European Blood Alliance existing benchmark participants.
- Trust VCS & WBS productivity performance over time

The Trust has established an enablers Workforce Planning working group to review and shape workforce re-design to ensure the best use of staffing resources.

3. An integrated productivity programme for Cancer Services

Velindre has a number of boards, committees and working groups throughout the Trust, for planning and performance. Benchmarking performance and productivity work will be embedded within the existing organisational governance, following the benchmarking analysis and improvement planning milestones.

The work will include a mapping exercise to connect specific benchmarking metrics to the most appropriate governance structures, segmenting by metric category and nature of proposed actions. Our plan is a 10-week programme of work to undertake benchmarking analysis, improvement planning and integrated productivity programming

Set-up and metrics alignment		Benchmarking analysis and findings	Improvement plan design and confirmation	Productivity programme launch
Estimated Duration	2 weeks	3 weeks	3 weeks	2 weeks
Key activities	- Finalise scope, milestones and key touchpoints - Schedule key meetings - Explore, refine and finalise metrics list for benchmarking - Identify early hypotheses for improvement plan areas	- Conduct data collection of metrics list for Velindre and comparison set - Provide weekly review and refinement touchpoints - Iterate benchmark findings document	- Connect productivity findings to top areas for improvement plan - Engage with Velindre colleagues to explore current state in select areas - Finalise improvement plan	- Shape the integrated productivity programme - Finalise governance and linkage across Velindre - Embed ways of working internally for traction
Key meetings	▲ Kick-off meeting with project board ▲ Initial data and metrics discussion with Ops leads and D&I lead	▲ Weekly sessions with project board ▲ Validation of specific metrics with Data & Insights as required ▲ Initial benchmarking findings workshop	▲ Weekly sessions with project board ▲ Early testing of data/reporting needs with Data & Insights ▲ Improvement plan prioritisation workshop	▲ Weekly sessions with project board ▲ Data and insights in-housing plan session for ongoing reporting ▲ Productivity programme working group launch
Outputs	- Validated project plan - Validated stakeholder list with key project touchpoints - Finalised metrics list	Benchmarking analysis report with underlying data and any prompts created - Productivity findings and implications for Velindre	Paper for EMB on a recommended improvement plan Memo on maturing the benchmarking programme	Integrated productivity programme structure report Productivity programme roadmap and initial priorities - Handover documents

4. Initial Baseline Assessment of VCS Productivity Trend 2019-2020 to 2025-2026

Metric	2019-20	2025-26	% Change / Index
Activity	202,378	267,476	+32.2%
Expenditure (£) (Exc. NICE/HCD)	£53.6m	£67.1m	+25.2%
Workforce (WTE)	709	925	+30.5%
Outputs per WTE (Av. Labour Productivity)	285.5	289.1	+1.3%
Marginal Labour Productivity			301 episodes / additional WTE
TFP Index (£ input)	—	—	1.056 (+5.6%)
Avg. Productivity (ONS)	—	—	+0.9%/year

Summary of Interpretation

- **VCS has achieved real productivity gains:** Output is rising faster than both workforce and expenditure, meaning the service is delivering more for each unit of input.
- **Efficiency improvements are modest but positive:** Most output growth is matched by increased inputs, but there is still a measurable improvement in how efficiently those inputs are used.
- **Sustainable growth:** The ability to increase activity at a faster rate than costs suggest VCS is on a sustainable path, provided quality and outcomes are maintained.
- **Outputs per WTE (Av. Labour Productivity)** increased from **285.5 to 289.1** (+1.3%), indicating a modest but positive gain in efficiency per staff member.
- **Marginal Labour Productivity** shows each additional WTE contributed **301 extra episodes of care over the period**

- **Total Factor Productivity (TFP) Index (using expenditure): 1.056**
 - o VCS delivered **5.6% more output per £ spent** in 2025-26 than in 2019-20 i.e. **average of 0.93% p.a.**
- **ONS Growth Accounting Framework (annual average productivity growth): 0.9% per year**
 - o This demonstrates sustained efficiency improvements over the period.

5. 2026-2027 Productivity Quantifiable improvements

- Labour Productivity (Outputs per WTE) growth a minimum of 1% with a stretch target of 1.5%
- TFP growth a minimum of 1% with a stretch target of 1.5%
- ONS productivity growth a minimum of 1% with a stretch target of 1.5%

OUR FINANCIAL PLAN 2026 - 2029

Overview of our Financial Plan – 2026-27 – 2028-29

The Trust has had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced out-turn position annually, whilst maintaining or improving the quality of our services, meeting the rising demand and delivering agreed performance measures.

This section sets out our Medium Term Financial Plan from 1st April 2026 to 31st March 2029. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated growing demand for services whilst dealing with significant financial challenges due to a number of major strategic developments as part of the Trust's transformation programme. In addition, there are other significant cost and service pressures as well as the cost of implementing additional capacity to deal with rising demand, which will need to be funded by the Trust, Commissioners and Welsh Government in 2026-27.

As outlined in the Health Board Allocations 2026-27 document issued by Welsh Government, the Trust understands that a 1.11% uplift to Recurrent Discretionary Allocations will be provided in 2026-27. In line with the financial planning framework, we recognise that the funding settlement is intended to support inescapable demand and unavoidable core cost inflationary pressures. Further, the Trust recognises Welsh Government's expectation that an equivalent 1.11% allocation will be passed through to Provider organisations by Commissioners.

The Trust financial plan assumes that its Commissioners pass the 1.11% uplifts to the Trust via its Long Term Agreements (LTAs), which is clearly articulated in the allocation letter, which together with a 2.5% savings target, is a fundamental assumption in enabling the Trust to develop a balanced financial plan in 2026-27.

The Trust is expecting to deliver a balanced financial position over the 3-year IMTP period, however there are challenges and risks in achieving this.

The financial plan for 2026-27 consists of three distinct parts:

Core Plan -

Brought Forward Position:

- The Trust brought forward a balanced position into 2025-26, and despite the challenges from emerging cost pressures and service investment requirements, managed to maintain this position to enable a balanced position to be carried into 2026-27, however, there are risks associated with this.
- The Trust received significant challenge during 2025-26 from some of its commissioners in relation to the pass through of discretionary income from WG which resulted in the Trust agreeing to a non - recurrent reduction in NICE / High Cost Drugs income of £0.825m with Hywel Dda

(HD) UHB to reflect resources consumed rather than historic shares. This was managed in year on a non-recurrent basis by the Trust through a combination of increased savings target and reducing or mitigating cost pressures and reducing investment decisions.

- The Trust Finance Team have been in regular dialogue with our Commissioners regarding the Trust income assumptions. In order to reach agreement with Hywel Dda on LTA principles the Trust has had to agree a recurrent reduction based on the historic share's activity baseline funding of in 2026-27 which is on top of the £0.825m the Trust lost in 2025-26.
- The Trust has faced further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding, prior service development support and the National Discretionary uplift which total £0.605m (as at 2024-25) and are provided to the Trust via the LTAs as per the Trust funding model. Discussions are ongoing regarding the historic ring fenced allocations with a current gap in the position between Velindre and Hywel Dda of £0.290m. However, there is agreement from Hywel Dda UHB that on the Trust providing evidence to support these funding arrangements that Hywel Dda UHB will settle the full cash allocations.
- During 2025-26 Radiotherapy performance underachieved the income growth target set by £0.500m that was made to support capacity within VCS. A further risk is in addition to the £0.500m crystallized in 2026-27.

Growth Pressures:

- The 2026-27, 1.11% core discretionary uplift funding will be required to fund the significant underlying cost pressure caused by inescapable demand and unavoidable core cost inflationary pressures.
- The Trust Commissioners did not agree any additional funding in 2025-26 above the 1.77% general uplift, for either WBS or VCS to support service developments. Commissioners have also confirmed that no additional funding will be provided during 2026-27.
- Any marginal income growth during 2026-27 will be used to support the Trusts current underlying cost pressures meaning that there is no support for investment in Capacity.
- Divisional cost pressures above those recognised in the IMTP Financial Plan at this stage will either need to be mitigated, funded from existing budgets in service divisions or require additional savings above the £2.6m (2.5%) target already identified.

Savings Plans:

- The following table summarises the level of savings the Trust is planning to deliver during 2026-27 which will be required to support the level of investment decisions and cost pressures within the system.

Savings Plan	2026/27 £m
CIP Planned Savings	1.4
Income Generation	1.2
Total Savings / Income Generation	2.6
CIP % (of Core LTA values)	2.5%

Financial Plan

The plan aims to provide services with sufficient capacity to meet demand, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national targets and / or professional performance standards. In terms of efficiency the Trust has set 2.5% savings target of £2.6m in 2026-27.

In addition to this internal savings target and the associated savings schemes the Trust is leading on a number of all Wales service developments that are currently leading to, or will lead to, capacity release, cost avoidance and cost reduction in Health Boards.

The proposed financial plan has been developed using the latest assumptions regarding the Trust’s expected income from Commissioners and Welsh Government, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving and control potential of our services.

These assumptions have been discussed and planning principles agreed with Commissioners and Trust Board through the IMTP engagement process.

Whilst the Trust is submitting a three year balanced financial plan there is significant financial risk and challenges to deliver this plan particularly in the first year, whereby the Trust will need to hold any investment into Velindre Cancer Services and set a fairly ambitious savings target of 2.5%. However, the current expectation is that the Trust will maintain a balanced recurrent underlying position over the course of the three year IMTP period.

The formal agreement of the Trust income planning assumptions will be summarised within respective Commissioner Long Term Agreements for 2026-27 with planning principles having been agreed by the 28th February 2026 with a view to formally sign all agreements by May 2026. A summary financial plan reflecting the marginal revenue and cost impact for period 2026-27 to 2028-29 is presented in the following table:

Summary of Financial Plan 2026-29	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000
Underlying Core Position b/f	0	0	0	0	0	0
b/fwd. underlying deficit	0	0	0	0	0	0
Revenue						
<u>Anticipated Commissioner Income:</u>						
LTA Core Uplift (1.11% 26/27 assumed 1% for 27/28 & 28/29)	1,141	1,141	1,028	1,028	1,038	1,038
VCS & WBS LTA Income Growth for NICE / Blood Products	11,200	11,200	11,728	11,728	12,336	12,336
VCS LTA Service Growth Investment	485	485	6,937	4,525	172	172
VCS LTA Marginal Income for Service Capacity Investment	1,135	1,135	1,000	1,000	1,000	1,000
<u>Anticipated WG Income:</u>						
New VCS MIM ASP Payments and Infrastructure Support	0	0	34,991	34,991	0	0
WG AME & Non Cash (Includes Accelerated Depreciation, Impairment Charge and IFRS 16)	14,784	0	11,521	0	7,721	0
Total Revenue	28,745	13,961	67,205	53,272	22,267	14,546
In year Changes to Operational Cost Base						
VCS LTA Service Growth Investment for IRS, AO, RSU, nVCC	(485)	(485)	(41,928)	(39,516)	(172)	(172)
VCS NICE Drug Growth	(7,678)	(7,678)	(7,678)	(7,678)	(7,678)	(7,678)
WBS Blood Derived Products Growth	(3,522)	(3,522)	(4,051)	(4,051)	(4,658)	(4,658)
VCS LTA Marginal Income for Service Capacity Investment (Held 2026-27)	0	0	(1,000)	(1,000)	(1,000)	(1,000)
National / General Cost Pressures	(1,571)	(623)	(1,433)	(337)	(1,526)	(275)
Trust / Divisional Cost & Service Pressures	(3,352)	(2,916)	(2,280)	(2,098)	(2,186)	(2,243)
WG AME & Non Cash (Includes Accelerated Depreciation, Impairment Charge and IFRS 16)	(14,784)	0	(11,521)	0	(7,721)	0
Total In Year Changes to Cost Base	(31,392)	(15,224)	(69,891)	(54,680)	(24,942)	(16,026)
Net Opening Balance before Savings	(2,647)	(1,263)	(2,686)	(1,408)	(2,674)	(1,480)
Savings Plan 2.5%	2,647	1,263	2,686	1,408	2,675	1,480
Net Opening Balance	0	0	0	0	0	0

MANAGING THE DELIVERY OF OUR PLAN 2026 - 2029

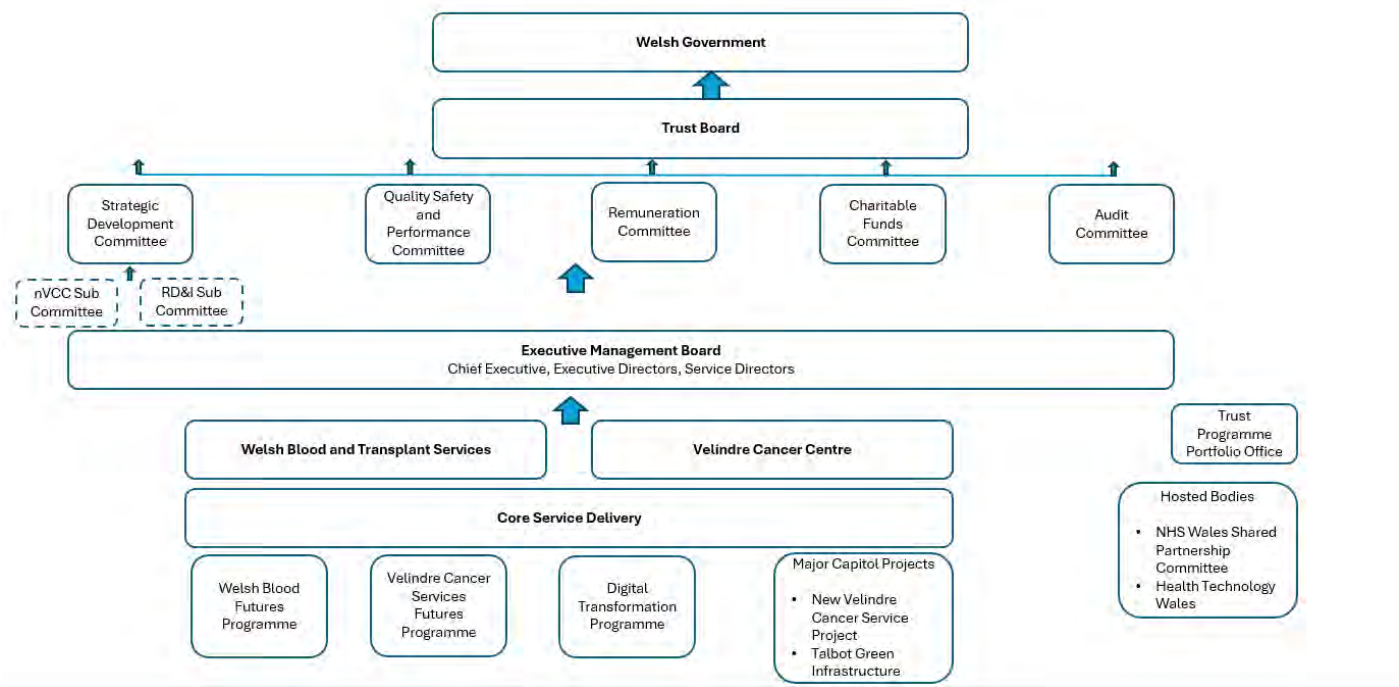
The Trust Board is accountable for the delivery of the Trust’s IMTP and long-term strategic plans (Destination 2033; Velindre Cancer Service ‘Shaping our Future’ and Welsh Blood Service - Blood and Transplant Services for the Future). They are supported by the Committees of the Trust Board who provide scrutiny and assurance to the Trust Board on all of the Trust's services and activities including the delivery of the IMTP. Further assurance on delivery is provided through the Board Assurance Framework (BAF). The Executive Management Board, chaired by the Chief Executive Officer and consisting of all Executive Directors and Directors, provides the leadership, monitoring and oversight of delivery of the IMTP, ensuring implementation is achieved; that the identified service improvements are achieved; and that patients, donors, staff and partners get the expected benefits.

The Executive Management Board is supported by the Portfolio Programme Office which provides oversight on the progress of the Trust transformation programmes (Velindre Cancer Service Futures; Welsh Blood Service Futures; Digital Transformation programme; and major capital projects (the Integrated Radiotherapy Solution; the new Velindre Cancer Centre; and the Welsh Blood Service Talbot Green site refurbishment).

The Trust Board is held to account for the delivery of the IMTP and its long-term strategic plans by the Welsh Government. The Trust routinely provides a range of information to the Welsh Government and a range of other external bodies/regulators. The Welsh Government holds the Trust to account for delivery via two main mechanisms: -

- the Integrated Quality, Planning and delivery meetings (quarterly forums)
- the Cabinet Secretary led Performance and Accountability Reviews

These arrangements are set out below.



Trust Governance

In 2025-2026 the Trust has reviewed the existing governance and Board and Committee structures. We will implement new governance structures in 2026-2027 to optimise arrangements to deliver alignment of accountability, risk domains and assurance routes. This will strengthen the Trust position within the Welsh Government Assurance Accountability Framework and revised risk based meeting cadence, to enable the Trust to operate effectively with the Four Domains' - Quality, Workforce, Finance, Delivery/Performance; underpinned by the Foundation Domain of Leadership; and will support the Trust's role to meet our ambitions in system leadership, innovation, and successful growth of major programmes for the public we serve.

This will be provided as a separate document due to the file size.

Appendix 2a:

2a Trust Delivery Plan – Welsh Blood Service

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1-5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performance indicator (how the improvement will be routinely measured)	G Target Performance for 2026- 2027 (what we expect the plan to deliver)
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSPLANTATION MODERNISATION PROGRAMME Welsh Bone Marrow Donor Registry (WBMDR) Digital Project Implement a digital system within the WBMDR that meets current and future service needs, including enabling seamless connectivity between global registries.	Complete supplier engagement. Develop an outline business case for the procurement of the digital solution for WBMDR.	Procure digital solution for WBMDR.	Award contract.	Phased implementation of the digital solution.	Phased implementation of the digital solution.	Phased implementation of the digital solution.	Phased implementation of the digital solution.	Phased implementation of the digital solution.	n/a	Global integration for better patient outcomes. Future-ready infrastructure. Operational efficiency. Improved service experience. Strategic insight and reporting.	Number of stem cell collections supported.	Modernise donor registry processes. Improved data quality. Strengthened our ability to match donors efficiently across UK and international registries.
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSPLANTATION MODERNISATION PROGRAMME Expanding Stem Cell Services Project To expand Stem Cell collection services and explore opportunities for collection services for aligned registry services, Welsh transplant centres, other UK/International registries, and Advanced Therapy Medicinal Products (ATMP's).	Develop a collection model to include opportunities external to the registry. Commence implementation of phase 1 provision of services for third parties.	Continuing implementation of phase 1 provision of services for third parties.	Continuing implementation of phase 1 provision of services for third parties.	Continuing implementation of phase 1 provision of services for third parties.	Scope further phases.	Scope further phases.	Implement further phases.	Implement further phases.	Implement further phases.	Secure ATMP collections, increase in scope of services provided by the Registry by 2028. Increase Stem Cell collections to pre covid levels by 2028. Financial and reputational benefit, generating revenue via collections.	Number of stem cell collections supported. Number of ATMP collections.	Increased capacity to meet growing clinical demand. Improved pathways for donation, processing and clinical collaboration.
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSPLANTATION MODERNISATION PROGRAMME Integrated Cell Free Foetal DNA Testing Project	Implement Phase 2: Go Live of national services integration.	Continuing implementation of Phase 2: Go live of national services integration.	Close project.	n/a	n/a	n/a	n/a	n/a	n/a	Improved accuracy. Faster turnaround times.	Turnaround Times for Foetal DNA screening.	Delivering consistent, high-quality genomic screening services

		National integration of the Foetal D screening digital reporting solution.										Enhanced patient safety.		across Wales. Strengthening WBS's role within national diagnostic pathways.
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Quality, safety and value: doing it right, first time	TRANSPLANTATION MODERNISATION PROGRAMME National External Quality Assessment Service Project (NEQAS) Implement an in-house digital solution to provide an external quality assessment service for clinical laboratories supporting organ transplantation.	Implementation version 1.1 of new digital solution. Implement version 1.2 (outstanding works and bug fixes).	Phase 2 development.	Phase 2 development	Phase 2 Implementation (Go Live)	n/a	n/a	n/a	n/a	n/a	Improved digital system allowing UK NEQAS to maintain and grow participants. Meet expectations of stakeholders e.g. customers and accreditors. Maintenance of accreditation.	Number of participants. Improved participant feedback rating.	Modernised external quality assurance system to support standardisation Improved benchmarking. Enhanced laboratory control.
Outstanding for Quality, Safety and Experience An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Quality, safety and value: doing it right, first time Sustainable services that deliver the greatest value to our communities	TRANSPLANTATION MODERNISATION PROGRAMME HLA-Selected Red Cells for Solid Organ Transplant Recipients - Feasibility Assessment Project To assess the feasibility of providing HLA-selected red cells for solid-organ transplant recipients in Wales, including evaluating donor panel size and suitability, cost-effectiveness, clinical demand and operational impact.	Begin feasibility assessment. Initial modelling of donor panel size required and costing.	Further modelling. Review outcome data from NHSBT pilots. Assess risks and regulatory issues.	Begin development of options appraisal.	Decision on whether to proceed to business case development. Close feasibility project.	n/a	n/a	n/a	n/a	n/a	Potential reduction in transfusion-induced complications for transplant recipient, supporting graft survival and improved clinical outcomes. Strengthened collaboration with clinical transplant units.	Transfusion induced complications for transplant recipients.	Review of antibody testing strategy, investigating provision of Human Leucocyte Antigen (HLA) matched red blood cells.
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSFUSION MODERNISATION PROGRAMME Automated Blood Processing Project To enhance blood processing efficiency and reliability by evaluating and implementing automated solutions based on service requirements.	n/a	n/a	Trial on non DEHP on automated manufacturing solution.	Strategic decision point to automate manufacturing processes.	Procurement timelines to be defined if appropriate.	To be confirmed following strategic decision point in Q4.	To be confirmed following strategic decision point in Q4.	To be confirmed following strategic decision point in Q4.	To be confirmed following strategic decision point in Q4.	Service development / improvement. Maximise use of automation. Efficiencies.	Clinical demand for red cells met. Clinical demand for platelets met. Red blood cell stock stability.	Modernised manufacturing workflows that improve efficiency. Reduced variation. Enhanced resilience across Transfusion

														laboratories.
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSFUSION MODERNISATION PROGRAMME Implementation of X-Ray Technologies Project To modernise irradiation technology by transitioning from Gamma to X Ray irradiation, in alignment with the UK-wide national initiative.	Validate chosen solution.	Complete validation & go live.	Decommission of existing irradiator.	Continue decommission and removal of irradiator (subject to Home Office timelines). Close project.	n/a	n/a	n/a	n/a	n/a	Service development / improvement. Efficiencies.	Turnaround times. Safety and quality metrics.	Improved turnaround times. Strengthened safety and reliability of component preparation
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSFUSION MODERNISATION PROGRAMME Red Cell Immunohaematology (RCI) Review Project Review of Red Cell Immunohematology Service - Education, Training & Workforce model.	Develop workforce plan.	OCP consultation (if required) and implementation of outcomes.	Complete the transition to new workforce model.	Complete the transition to new workforce model. Close project.	n/a	n/a	n/a	n/a	n/a	Increase in staff wellbeing by creating an environment that meets best practice. Increase in retention and recruitment of staff. Increased opportunities for staff development aligned to workforce and succession planning. Increased workforce resilience and flexibility.	People & OD (POD) metrics.	Resilient and robust service delivery through workforce development. Increased staff retention and recruitment.
Outstanding For Quality, Safety and Experience	Quality, safety and value: doing it right, first time	TRANSFUSION MODERNISATION PROGRAMME Wholesale Product Management System Project To implement a robust wholesale product management digital system that streamlines product data handling, improves operational efficiency, and supports accurate inventory and pricing management for commercial products.	Progress with procurement of Oracle module.	Oracle module configuration. User Acceptance Testing (UAT).	Validation and implementation of Oracle module.	Project closure.	n/a	n/a	n/a	n/a	n/a	Service development / improvement. Continued service provision and business continuity.		Streamlined product data. Improved operational efficiency. Accurate inventory and pricing for blood derived medicines and other wholesale products.
Outstanding For Quality, Safety and Experience	Build a sustainable donor base that meets clinical need	BLOOD DONATION MODERNISATION PROGRAMME	Launch Donor & Advocate Forum (Donor Voices).	Embed the Donor & Advocate Forum.	Scale the impact of the Donor & Advocate Forum	Scale the impact of the Donor & Advocate Forum	n/a	n/a	n/a	n/a	n/a	Strengthened donor insight through structured co-design.	Forum participation rate.	Establish forum. Increased meaningful

	and represents the diverse communities we serve	Donor & Advocate Forum (Donor Voices) Project Creating a co-design forum that enables donors and advocates, including underrepresented groups, to actively shape future donation services, strengthening engagement and ensuring services reflect donor needs and experience.										Improved inclusivity by increasing participation from under-represented groups. Enhanced donor experience.	Proportion of participants from under-represented groups. % of forum-generated recommendations progressed and implemented. Donor experience feedback.	Engagement with currently under-represented groups who are not yet participating in our services. Demonstrate measurable improvement in donor satisfaction for targeted services.
Outstanding For Quality, Safety and Experience	Build a sustainable donor base that meets clinical need and represents the diverse communities we serve	BLOOD DONATION MODERNISATION PROGRAMME Mobile Donor Application Project Introduce a mobile donor application, fully integrated with the BECS system, to enhance donor self-service, simplify account management, and strengthen WBS's overall donor engagement capability.	n/a	n/a	n/a	n/a	Project planning.	Procurement process.	Procurement process.	Implementation.	Go-live. Benefits realisation and project closure.	Increase retention of O- & O+ blood groups by 5%. 40% using the WBS app to make bookings.	Retention metrics. Utilisation of app. Donor experience metrics.	Provision of intuitive digital platform to book manage and track donations.
Outstanding For Quality, Safety and Experience	Develop great people and a great place to work	BLOOD DONATION MODERNISATION PROGRAMME Workforce Review Project (Clinically Led Donation Model) Collaborate with blood donation staff to review the current workforce model for blood donation teams and design a new, clinically led model under the leadership of registered nurses.	Implement blood donation team driver consultation outcome. RN/Supervisor/Deputy Supervisor OCP pre-consultation engagement.	Undertake RN/Supervisor/Deputy Supervisor OCP consultation.	Implement RN/Supervisor/Deputy Supervisor consultation outcome.	Implement RN/Supervisor/Deputy Supervisor consultation outcome.	Project closure.	n/a	n/a	n/a	n/a	Improved donor & staff satisfaction. Reduced SABRE reports by 10% within 12 months. Reduction in number of harm events by 20% within 12 months. 20% reduction in number of donor complaints. 10% increase in number of donor compliments.	Donor experience metrics. Quality & safety metrics.	A clinically driven, workforce modelled approach to blood donation activity. Capacity and skills aligned to clinical need.

Outstanding For Quality, Safety and Experience	Achieving excellence in research, development and innovation to improve outcomes for our donors and patients.	BLOOD DONATION MODERNISATION PROGRAMME Live Connectivity on Blood Donation Clinic Project Introduce live connectivity to systems and equipment on blood donation clinics, including the Blood Establishment Computer System (BECS).	Preparation for live incident reporting with at-source investigation (Datix).	Implementation of live incident reporting with at-source investigation (Datix).	Planning and scoping for live connectivity between clinics and BECS.	Planning and scoping for live connectivity between clinics and BECS.	Planning and scoping for live connectivity between clinics and BECS.	Test and validate live connectivity between clinics and BECS. Test and validate live connectivity between weighing and mixing equipment and BECS.	Go-live for live connectivity between clinics and BECS. Go-live for live connectivity between weighing and mixing equipment and BECS.	Benefits realisation and project closure.	n/a	Increased accuracy of donation data on clinics. Reduction in paper copies on clinic. Increased efficiencies at clinic. Reduced manual data collection and risk of data inputting errors. Increase in accountability.	Quality & safety metrics.	Enabled real time access to systems and data on mobile and static blood donation clinics.
A sustainable organisation that plays its part in creating a better future for people across the globe	Sustainable services that deliver the greatest value to our communities	BLOOD DONATION MODERNISATION PROGRAMME Fleet Implementation Strategy Project	Phase 2 – Procure Mobile Donation Clinic x 1 / Equipment Vehicles x 4)	n/a	n/a	Delivery of Phase 2 vehicles.	Phase 3 – Procure Mobile Donation Clinic x 1 / Small Delivery Vehicle x 3 / Large Delivery Vehicle x 4 / Minibus x 4	n/a	n/a	Delivery of Phase 3 vehicles.	Completion of fleet procurement project. Project closure.	Decrease in clinic and donor appointment cancellations. Reduced vehicle maintenance costs. Measurable carbon-reduction targets.	Sustainability metrics. Clinic cancellation metrics.	Reduced carbon impact. Modern fleet. Improved access to blood donation services.
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 A sustainable organisation that plays a	Quality, safety and value: doing it right first time Achieving excellence in research, development and innovation to improve outcomes for our donors and patients Sustainable services that deliver the greatest value to our communities Develop great people and a great place to work	TALBOT GREEN INFRASTRUCTURE (TGI) PROGRAMME To provide a facility at Talbot Green site that delivers safe, quality services, that meets standards for legislation, regulation and of accreditation bodies, can meet carbon neutral targets and is able to meet the future service requirements.	Approval process for Outline Business Case and Business Justification Case for advanced works (Energy Centre & purchase of Welsh Wound Innovation Centre).	Construction of Energy Centre begins August 2026 (if BJC approved).	Construction of Energy Centre continues (if BJC approved).	Construction of Energy Centre continues (if BJC approved). Develop Full Business Case (TBC) Submission of Full Business Case to Welsh Government (TBC).	Construction of Energy Centre completed April 2027 (if BJC approved). Approval process of Full Business Case (TBC).	Approval process of Full Business Case (TBC).	Construction begins (TBC).	Construction continues (TBC).	Construction continues (TBC).	Compliance with mandated legislative & regulatory standards. Reduction in energy consumption & carbon emissions. Ability to implement new services to meet demands of NHS service requirements. Increase in staff morale & well-being. Increase in donor satisfaction.		Infrastructure that is fit for the future, supports service growth and provides the environmental and operational standards required for the next 50 years.

part in creating a better future for people across the globe														
Outstanding for quality, safety and experience An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Quality, safety and value: doing it right, first time	DIGITAL MODERNISATION PROGRAMME Blood Establishment Computer System Project To procure and implement a new Blood Establishment Computer System (BECS) that ensures sustainable, secure, and efficient information management for blood manufacturing and tracking, supporting service continuity and compliance.	Scope minimum viable product. Configuration of infrastructure.	Configuration of BECS modules in line with current specification. Testing and validation cycles. Scoping of data migration.	Configuration of BECS modules in line with current specification. Commence data migration.	Data migration. User Acceptance Testing (UAT).	Final phase of configuration User Acceptance Testing (UAT) cycle. System Validation.	Go live readiness.	BECS go live. Post go live validation.	Achieve stable operations.	Additional BECS modules including Hospital Ordering; donor relationship management	Real-time access to donation, stock, and demand data for better decision-making. Reduced risk of supply-demand mismatch and costly imports. Improved capacity planning and resource utilisation. Richer data for reporting and vein-to-vein monitoring in collaboration with health boards.	Quality & safety metrics. Turnaround times. Clinical demand met. Donor experience	Upgraded core operational system. Improved digital workflows. Strengthened data integrity. End-to-end visibility across the donation, testing, manufacturing and distribution process.
Outstanding for quality, safety and experience An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Quality, safety and value: doing it right, first time	DIGITAL MODERNISATION PROGRAMME Welsh Histocompatibility and Immunogenetics Service (WHAIS) Laboratory Information Management System Project To implement a new Laboratory Information Management System (LIMS) within the Transplantation Services Laboratory to enhance data accuracy, workflow efficiency, and compliance with national standards.	Achieve stable operation post go live. Completion of post go live validation.	Commence Phase 2 WHAIS requirements delivery. Successful integration of demographic modules (Digital Health & Care Wales).	Complete Phase 2 WHAIS requirements delivery.	n/a	n/a	n/a	n/a	n/a	n/a	Improved testing efficiency. Enhanced traceability. Improved integration with wider laboratory and clinical systems. Improved patient experience.	Turnaround times. Safety & quality metrics. Patient experience	Modern digital capability to support histocompatibility and immunogenetics services.
Outstanding for quality, safety and experience	Quality, safety and value: doing it right, first time	DIGITAL MODERNISATION PROGRAMME Welsh Laboratory Information Management System (WLIMS) Project – National Project Maintain active engagement in the national programme to support the development and enhancement of WLIMS modules for Blood Transfusion, followed by the	Secure internal go-live readiness.	Go Live currently September 2026 - TBC (Dependent on National programme)			Digital connectivity scoping for IBI.				Digital connectivity implementation for IBI.	Improved efficiency and accuracy through faster testing and real-time data. Enhanced service capacity. Improved patient experience.	Quality & safety metrics.	Improved interoperability across NHS Wales. Enhanced accuracy and timeliness of diagnostic reporting.

		implementation of the system within the Red Cell Immunohaematology (RCI) and Automated Testing Laboratories.												
An internationall y renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Quality, safety and value: doing it right first time	PLASMA FOR MEDICINES PROGRAMME Recovered Plasma Implementation Project	Develop processes to support the supply of plasma to Octapharma. Octapharma submission to MHRA to request that WBS be added to UK Plasma Master File (PMF). WBS to commence collection & testing of recovered plasma for fractionation. Octapharma audit of WBS.	Commence collection and testing of recovered plasma for Fractionation. MHRA approval for WBS recovered plasma in UK PMF & first immunoglobulin and Albumin products for clinical use received at WBS. New component codes to be added for medicines received back.	The first Immunoglobulin and Albumin products for clinical use received at WBS from Octapharma. Annual Epidata & PMF submission.	n/a	Cryo depleted plasma planning.	Cryo depleted plasma implementation	Annual Epidata & PMF submission .	Project closure, transition to BAU.	n/a	Plasma available for fractionation in Wales. Production of essential plasma derived medicines for NHS Wales. Alignment with national plasma programme for recovered plasma.	Plasma specific metrics	strengthened resilience of the UK plasma supply chain. Reduced reliance on international imports. Enhanced contribution to national self sufficiency efforts.
Outstanding for Quality, Safety and Experience	Quality, safety and value: doing it right, first time	BLOOD HEALTH PLAN PROGRAMME Anaemia Management Project Optimisation of screening and management of anaemia across priority population groups in Wales.	Perform baseline review of Health Boards against the post-operative anaemia pathway.	Report baseline review of Health Boards against the post-operative anaemia pathway. Develop an action plan to support implementation of the post-operative pathway.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps. Scope long term opportunity for compliance monitoring.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps. Develop long term opportunity for compliance monitoring.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps. Implement long term opportunity for compliance monitoring.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps. Continue implementing long term opportunity for compliance monitoring.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps. Continue implementing long term opportunity for compliance monitoring.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps.	Following finalisation of the action plan in Q2, this plan will be updated to reflect the agreed next steps.	Reduction in avoidable transfusion. Prudent Blood Supply Chain. Reducing patient safety risk related to Blood Transfusion. Support Infected Blood Inquiry recommendations. Ensuring standardisation of care.	% preoperative anaemia prevalence . % major surgery event with anaemia screening. % patients ID with anaemia screened for iron assessment.	Improved anaemia diagnosis and management. Better surgical outcomes.
Outstanding For Quality, Safety and Experience	Drive the prudent use of blood across Wales	BLOOD HEALTH PLAN PROGRAMME Interoperative Cell Salvage (ICS) Project Ensure equitable and effective use of ICS as a core patient blood management initiative.	Finalise ICS review to establish effectiveness of current ICS utilisation across Wales and identify opportunities to enhance a standardised approach.	Implement recommendations of review.	Implement recommendations of review.	Implement recommendations of review.	Review and evaluate the effectiveness of the implementation plan, ensuring delivery against	Review and evaluate the effectiveness of the implementation plan, ensuring delivery against agreed milestones, identification of barriers, and timely	Review and evaluate the effectiveness of the implementation plan, ensuring delivery against agreed	Review and evaluate the effectiveness of the implementation plan, ensuring delivery against agreed milestones, identification	n/a	Reduction in avoidable transfusion. Prudent Blood Supply Chain. Reducing patient safety risk related to Blood Transfusion.	Total numbers of ICS. % infusion rate.	Equitable and effective use of ICS as a core patient blood management initiative.

							agreed milestones, identification of barriers, and timely adjustments to optimise impact.	adjustments to optimise impact.	milestones, identification of barriers, and timely adjustments to optimise impact.	of barriers, and timely adjustments to optimise impact.		Support Infected Blood Inquiry recommendations. Ensuring standardisation of care.		
Outstanding For Quality, Safety and Experience	Drive the prudent use of blood across Wales	BLOOD HEALTH PLAN PROGRAMME Genetic Haemochromatosis (GH) Pathway Project Enable individuals diagnosed with Genetic Haemochromatosis (GH) to access blood collection services for therapeutic and maintenance phase treatment through a nationally standardised pathway.	Develop GH Dashboard for Health Boards. Publicise data collected from Health Boards including sustainability metrics. Stakeholder Event to launch the GH referral pathway and begin roll out. Recruit medical students to review survey data.	Continue to develop GH dashboard for Health Boards. Apply for Clinical Fellow to support project (HEIW funding - not guaranteed).	Launch GH Dashboard for Health Boards. Further plans to be finalised subject to project funding.							Improved service choice and access for individuals diagnosed with GH. Optimised use of resources. National consistency. New donor pool for WBS (who can donate more frequently supporting blood supply resilience).	Number of new referrals. Outpatient clinic chair time saved. Staff time saved. Additional units of blood generated. CO2 emissions avoided. Cost savings. Patient experience metrics.	Expanded GH pathways. Increase in referrals to WBS. Community based management of eligible donors. Reduction of pressure on secondary care. Improved patient experience.

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Timely Care	Safe and Effective Transition of Services to the nVCC Site –Priority 1	Agree transition principles and approach. Workstreams with delivery plans and milestones in place for operational preparedness; move plan and execution; workforce; accommodation Develop transition plan for 'back office' functionality Finalisation of digital roadmap for nVCC readiness - including implementation plans	Develop transition programme for equipment, interface and operational commissioning - including dual running options Develop communication plan - operational Clarity on MIM governance - operational and clinical lens Accommodation design and delivery plan in place	Detailed planning and implementation of the equipment phasing and commissioning of radiation equipment Engage with workforce to support operational readiness and transition Finalise dual running plans and secure additional funds and workforce to support transition phase Finalisation of communication plans with external stakeholders	Transition to nVCC - - equipment and environmental testing and cleaning from service perspective - commissioning commences for first linac -training of staff to support operational readiness -procurement of goods and services to support operational readiness - workforce familiarisation and training Full implementation of agreed digital roadmap New aseptic unit impact assessment complete Communicate with patients regarding nVCC and VCS services Commence de-commissioning plan as part of transition plan	nVCC Go Live April 2027	Dual Running Concludes	Snagging commences for nVCC All services in place Benefits realisation commences	Baseline review for utilisation in Q2 and development of plan to maximize utilisation by Q4 -consider options to offer any additional capacity released to Wales or 'sell' to England	Transition of all services to nVCC site and initiation of first clinical service delivery by April 2027. Decommissioning of current site. Effective implementation of MIM - effective transfer of soft FM with clear signed off operational SLA A fully digitalised medical record.	Equitable, timely access to state-of-the-art treatment and support facilities for patients with cancer in south-east Wales. Modern, safe and compliant facilities. Well-designed therapeutic environment. Increased patient safety. Improved environment for patients, staff and visitors. Improved patient experience. Delivery of care closer to patients' homes - promoting patient choice, reducing disruption and the need to travel.	Patient and Staff Feedback Patient safety metrics Staff retention and recruitment Activity and performance metrics	NVCC benefit criteria
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Timely Care, by Design	Consistent and reliable service delivery across ALL standards by 2028 – Priority 2	Implementation of performance management framework at VCS Implementation of waiting list management at VCS Development of operational and clinical dashboards Development of patient administration	HIR: exploration of integration of HIR within HBs, led by COO Implementation of patient administration change process Implementation of patient flow SOP and OPEL framework at VCS Implementation of delayed	Full implementation of operational cancer meetings between VCS and HBs Implementation of shared care approach to SCP breach reporting	Target achieved	Pathway consolidation, performance improvement				Implementation of systematic operational and clinical quality performance management across VCS - I Urgent/emergency Care - Remote Clinical Assessment Service in place - implementation of acute frailty model at front door	Timely access to care No delays through the cancer pathway - planned and emergency Better patient outcomes Better patient experience when communicating with VCS Standardisation and rationalisation of patient referral and	Timely access to care - 75% of patients on an SCP receive first definitive treatment in 62 days Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-	75% of patients progressing along SCP begin FDT within 62-days. 100% compliance with relevant Welsh Language Standards.

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
			case for change to support implementation of performance management including OCP where applicable Hospital Initiated Referral (HIR): implementation across VCS Development of patient flow SOP including escalation and OPEL framework for VCS	pathways of care dashboard							- implementation of hospital flow framework planned care Implementation of PIFU Monitoring of DNA/DNA rates for all OP clinic Quality standards - SACT quality clinical standards radiotherapy COSC standards implementation quality management system across VCS Telephony system in place which will support delivery of key standards including Welsh Language, delivering a more efficient service with patients Hospital Initiated Referral in place Delivery of revised models for patient communication in a range of contexts including electronic referrals, booking processes and telephony. Implementation of a centralised VCS booking	booking processes. More timely scheduling of first VCS Outpatient appointment for patients with cancer. Improved patient experience.	day pathway i.e. patients received on or before day 38 of their pathway SACT clinical quality metrics Radiotherapy COSC metrics Planned care - PIFU and DNA/CNA rates in OP UEC - SDEC metrics & patient flow metrics Population health and diversity metrics 100% SOPs on QMS by Q4 2026-2027 Compliance with SCP time to treatment target. Time to first outpatient appointment (10-day target). Compliance with Welsh Language Standards.	

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
											management facility.			
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Effective Care	Widening access to treatments available in comparable specialist cancer centres – Priority 3	Undertake gap analysis through benchmarking exercise of VCS clinical services against that of specialist cancer centres Membership to FSH	IO: Development of costed business case outlining service delivery model for lung and skin Lung cancer: development of costed business case for radical RT Neurological: development of costed business for expansion of SRS	Complete equity audit of access to specialist treatments by geography, deprivation, ethnicity & tumour site Research - develop research-ready pathways aligned with nVCC commissioning Complete PET/CT business case	Introduction of commissioned new neo-adjuvant immunotherapy treatment for treatment of skin cancer patients. Embed research as a core component of specialist treatment pathways	Implement capability to treat a larger cohort of neurological cancer patients with Stereotactic Radiosurgery (SRS). Implement new radiotherapy techniques for treatment of breast cancers (Axillar and partial breast radiotherapy). Improved access to radical radiotherapy treatment for lung cancer patients.				Patients able to access high quality, evidenced base treatment locally with no delay through the adoption of new technologies, treatments, drugs, services identified through new horizon scanning infrastructure Implementation with appropriate funding of partial breast radiotherapy, axillary RT as an alternative to axillary node dissection, Internal mammary node irradiation and simultaneous integrated boost. implementation of prostate SBRT for low/ intermediate risk prostate cancer as per PACE B trial. Finalisation of PET CT Business	Improved patient outcomes Reduction in reported toxicities for breast cancer patients treated with new radiotherapy techniques. Access to new treatments locally	Improved compliance with post-NICE FAD publication 60-day target to make newly approved medicines available for clinical use. Improved PROMS scores (particularly outcomes and toxicity scores). Patients acuity and level of care on the ward Compliance with SCP time to treatment target. Time to first outpatient appointment (10-day target). Compliance with Welsh Language Standards..	NICE compliance within set timeframes Improved PROMS scores for clinical outcomes and reduced toxicity scores for breast cancer patients treated with new radiotherapy techniques.

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
											Case - 2027-2028			
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Timely Care	Implement Integrated Radiotherapy Solution (IRS) – Priority 4	True Beam validation Brachytherapy Implementation	Upgrades and optimisation of existing Linac fleet	IRS linac 1-5 orders and installation at nvCC	IRS linac 1-5 machine commissioning at nvCC	IRS Go Live	Transition of Linac machines from VCS to nvCC	IRS Project closure and benefits realisation		All elements of the IRS programme fully implemented by April 2027 and the opening of nvCC. Introduction of new external beam radiotherapy treatment techniques (e.g. axillary radiotherapy for the treatment of eligible breast cancer patients) resulting in improved clinical outcomes. Phased implementation of Linac upgrade and replacement programme VCC Transition of LINACs to nvCC All elements of the IRS programme fully implemented by April 2027 and the opening of nvCC.	Improved patients and carer experience as a result of improved machine resilience Access to improved analytics and reduction in manual data collection reduced clinical time required for patient scheduling as a result of increased automation better patient outcomes due to the improved functionality and compliance with good practice Improved well being of workforce due to state of the art machines Increase R&D opportunities as a result of newer equipment and collaboration with a single vendor	Compliance with SCP time to treatment target. Time to radiotherapy (VCS-specific): Emergency - treatment to commence within 2-days. Scheduled - treatment to commence within 21-days. Urgent Symptom Control - treatment to commence within 7-days. No. appointments cancelled due to machine failure Time released from workforce undertaking manual data collection and analysis PROMS No. of new trials opened	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 80% by March 2026 75% of patients progressing along SCP begin FDT within 62-days. VCS-specific improvement trajectory for 2027 TBC. Benefits realised in line with Full Business Case
An internationally renowned provider of	Timely Care	Deliver Improved Systemic Anti-Cancer Therapy	SACT demand and capacity model completed -	Development of costed business case outlining SACT clinical	Go Live ePMA Phased Implementati	SACT clinical standards - year on year improvement in delivery of SACT standards	Transition into nvCC Capacity & flow - full	Consolidat e systems and processes	Evaluate impact of expanded capacity	Full evaluation of two-year SACT	Implementation of a new prescribing and medicines	Improved patient safety by reducing of medication errors.	Total number of medication errors.	Annual reduction in total number

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
exceptional clinical services that always meet, and routinely exceed, expectations		(SACT) Pathways and Processes – Priority 5	chairs, pharmacy and workforce SACT PTL - roll out of SACT PTL across the administration team Baseline assessment of workforce - skills and capabilities - hub and spoke	delivery model - addressing any gaps identified from demand and capacity model and clear on hub and spoke requirements Development of SACT chair utilisation tool	on of funded hub and spoke model		operationalisa tion of expanded SACT capacity full rollout of redesigned SACT pathways across all tumour groups. Implement remote toxicity monitoring at scale. Begin predictive analytics development for toxicity risk and SACT demand forecasting. Integrate SACT data with regional cancer information systems.	post move into nVCC	and digital tools on delays and cancellati ons. Achieve measurabl e reduction s in toxicity-re lated emergenc y admission s. Pilot predictive analytics in live SACT pathways. Embed remote monitorin g into routine SACT practice.	transformatio n impact. Publish Year 2 SACT Outcomes & Digital Transformatio n Report. Deliver sustainability plan and next-cycle IMTP recommendat ions. Embed continuous improvement cycles across all SACT services.	administration system which will replace existing paper-based systems. Q1: Undertake review of digital patient toxicity management and develop improvement plan/ lessons learned Delivery of SACT clinical quality indicators. Introduction of next generation immunotherapi es as standard of care increasing treatment options and improving clinical outcomes. Expansion of Virtually Assessed Patient (VAP) Clinic Capacity. Introduction of new medicines patient self-administration pathways providing patient choice, reducing requirement for patients to attend a clinical setting to undergo treatment and releasing treatment capacity.	Medication records will be stored electronically with 24/7 access. The system will deliver a range of other administration efficiencies reducing the time taken to prescribe, check, supply and administer medicines. More timely access for patients to modern, advanced, high quality SACT. Rationalised treatment pathways. Improved patient safety by reducing possibility of medication errors. Improved capability to monitor expenditure on HCDs in a timely fashion.	Compliance with SCP time to treatment target. Time to SACT: P1 (Emergency) - treatment to commence within 28-hours. P2 (Urgent) - treatment to commence within 14-days. P3 (Routine) - treatment to commence within 21-days. Total number of medication errors. Clinical audit of treatment efficacy. Actual drug utilisation costing. Reduction in £ high cost drugs Compliance with VCS SACT protocols. Compliance with 90-day implementati on target for newly approved medicines	of medication errors. 12-moth improvement trending the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 80% by March 2027 75% of patients progressing along SCP begin FDT within 62-days. Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway XX% of patients to commence treatment within P1, P2 and P3 targets.

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			2026-2027				2027-2028							2028-2029	
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.	
													Routine screening for Blood Borne Viruses (BBV) for all patients beginning SACT treatment. Implementation of Chemo Care Upgrade and System Re-Procurement Implementation of a new prescribing and medicines administration system (EPMA) which will replace existing paper-based systems. Implement BlueTeq at VCS		(post-NICE Final Appraisal Document (FAD)). Annual reduction in total number of medication errors. 100% compliance with 90-day implementation target for newly approved medicines. 100% compliance with VCS SACT protocols.
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Timely Care	Deliver a modern, patient centred, outpatient service that is accessible, efficient and digitally enabled – Priority 6	Complete baseline review of outpatient capacity, demand, workforce, and pathway variation. Develop OP Performance dashboard and baseline key OP performance metrics Finalise digital roadmap (scheduling optimisation, remote monitoring, PROMs).	Develop business case for Year 2 capacity expansion (rooms, hours, workforce) and clear on hub and spoke model Expand virtual and telephone follow-up pathways where clinically appropriate. Begin centralised oversight of scheduling and slot release.	Phased Implementation of funded expansion of the OP hub and spoke model Introduce remote monitoring and digital PROMs for selected tumour groups Pilot digital check-in and digital patient information tools. Full implementati	Referral Management •Publish post implementation review of new referral processing programme •Explore opportunities for complete digital enablement (private, out of area) Scheduling & Clinic Management •Roll out redesigned clinic templates for remaining tumour groups •Begin role out of PIFU and SOS in priority areas •Publish end of year outpatient progress report identifying key deliveries and next steps Data Quality •Publish end of year data quality progress report Workforce	Launch expanded outpatient capacity (extended hours, additional rooms, or satellite clinics).	Transition into nVCC Evaluate impact of expanded capacity and digital tools on flow and delays. - Achieve measurable reduction in cancellations, rebooking, and avoidable acute admissions - Pilot predictive			Q1: Full evaluation of two-year outpatient transformation impact. Development of optimum patient treatment pathways Development of digital front door Implementation of digital self check in system at VCS Centralisation of patient booking	More timely patient communication Improved patient experience More timely access to OP services More visibility of patient pathway to facility More timely access to treatment	Reduction in Patient Waiting times on the day. Reduction in number of patients waiting over 62 days for FDT across the SCP pathway Reduction in patients waiting 10 days or more for 1st outpatient appointment. 75% reduction in face-to-face attendances. Improvement in patient Satisfaction scores.	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion building toward a national target of 75% by March 2027 75% of patients progressing along SCP begin FDT within 62-days.	

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
					on of digital medical records	•Begin workforce redesign in preparation for nVCC transition		analytics for demand forecasting and clinic optimisation. - Embed remote monitoring into routine outpatient practice.			Standardisation of workforce plan for all disciplines within outpatient service delivery in line with new delivery models for nVCC Hybrid Mail in place		Reduction in NRI's Reduction in incidents recorded via Datix Reduction in patients waiting for first outpatient appointment Increase in number of virtual appointments in line with national guidance Delivery of effective outpatients through See on Symptom (SOS) and patient initiative follow up (PIFU) by default. DNA/CAN rates in place for every outpatient clinic, with overbooking implemented and monitored where combined rate is over 5%,	Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway DNA/CAN combined rate no greater than 5% improvement trend in percentage of patients attending virtual appointments
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Safe Care	Deliver a resilient, patient-centred oncology acute care service that delivers safe, timely and equitable care while expanding capacity, modernising pathways and strengthening	Establishment of acute care steering group with agreed workstreams to review: AOS; SDEC; AU; IO; Acute ward, Enhanced care service - in line	Development of costed business case outlining acute clinical delivery model - scope and options for enhanced care, SDEC/ambulatory and IP care and virtual ward	Implementation of patient flow models of best practice - 6 goals Phased implementation of funded acute model	Full Implementation of robust Regional AOS model in association with HB funded model Evaluate impact of ambulatory pathways on admission avoidance, reduction of length of stay	Implement findings of ambulatory pathway review, in collaboration with UHB's / Commissioners				Q2: Review service model to assess any further changes to optimise care Provides the right care, first time by giving patients direct access to	Delivers safe alternatives to hospital admission - treatments that otherwise would require a hospital bed (IV, steroids, fluids, biologics etc) Rapid specialist response during	% patients receiving ambulatory care Number of patients treated Waiting time for treatments IP bed days	Annual reduction in number of inpatient admissions related to cancer / oncology treatment toxicities.

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
		multidisciplinary collaboration – Priority 7	with Ministerial Priorities Co-create regional mechanism for developing service models that meets new and novel treatment advancements.	interface that integrates with wider digital ecosystem Implement standardised AOS Performance dashboard enabling regional benchmarking	business case - including remote digital Expansion of IOS toxicity service						oncology specialists via a same-day ambulatory service 7/7 Improved access to expert acute oncology services for patients with cancer in south-east Wales. Sustainable model for the management of immunotherapy toxicities. Cardiac base-line testing for patients receiving immunotherapy treatments. Design and Implementation of enhanced care capability offer at VCS.	clinical deterioration Reduced pressure on acute hospitals by managing cancer-related emergencies within oncology	ALOS Number of avoidable admissions IO 30 day readmission rate <grade 4 toxicity <bed reduction <ALOS <admissions Total number of unwell patients transferred to acute secondary care settings. Compliance with NICE guidance on management of sepsis, neutropenic sepsis, Malignancy of Unknown Origin (MUO) and Malignant Spinal Cord Compression (MSCC).	Annual reduction in number of unwell patients transferred to acute secondary care settings. 100% compliance with NICE guidance at audit. SDEC data quality framework
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Effective Care	Implementation of National service specific for Wales: Palliative and end of life care – Priority 8	PEoLC: implementation of national KPI framework and national dashboard (subject to formal issue) PEoLC: undertake service review and gap analysis against national specification and All Wales	PEoLC: piloting palliative specific All Wales Civica feedback questionnaires to inform service delivery PEoLC: develop costed business case to support sustainable service delivery model and formal	Phased implementation of funded business case to expand hours of cover and links to community offer	Full Implementation of service specification as per funded business case Section 5 DNACPR Competency Framework for Nurses and AHPs – rolled out and 85% achieved	Roll out of the Verification of Expected Death All Wales policy and education programme				Q1: Assess potential to further extend PROMs in End of Life and Palliative Care services. Improved access to expert palliative care and end of life services for patients with cancer in south-	Improved patient experience Welsh Government Standards of care will be met Improved understanding of service demand through implementation of PROMS and e-forms Future care planning and support for	PROMS CIVICA All Wales referral standards All Wales 7-day service standards No. patients referred and transferred to	

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
			Palliative Competency Framework	extended working days/weekend							east Wales through implementation of the quality standards for palliative care Implementation of 7-day palliative care services	patients living longer with complex needs	hospice No. patient contacts No. same day unscheduled admissions and discharges Quality statement for palliative and end of life care 6 Goals	
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Safe Care	Pharmacy Modernisation - Priority 9	nVCC Preparedness - Increase use of outsource products to 30% by end of June 2026 Complete baseline review of oncology pharmacy workload, capacity, and workflow. Dispensary work rationalisation complete - Map end-to-end SACT prescribing, screening, dispensing, and release processes. Digital - EPMA system functionality testing BLUETEQ project initiated	EPMA - pilot early adopter implementation Workforce review - pharmacy demand and capacity assessment linked to SACT & OP models of care BLUETEQ configuration of system and process design	EPMA system go-live Finalisation of pharmacy workforce plan BLUETEQ pilot roll-out in identified areas	Commissioning of pharmacy robot - nVCC Evaluate effectiveness of EPMA roll out				Publish Year 2 outcomes and digital transformation reports. Deliver sustainability plan and next-cycle IMTP recommendations. Embed continuous improvement across all oncology pharmacy services.	Q1: Undertake review of digital patient toxicity management and develop improvement plan/ lessons learned Deploy and tailor TRAMS locally to enable effective delivery and monitoring of pharmacy provision for VCS patients enabling effective patient flow and pathway tracking Delivery of 30% in-house production within the aseptic unit from June 2026 Increased number of patients receiving	Standardised approach to data collection. Improved capture of patient specific data and to monitor treatment efficacy and tolerability. Improved capability to monitor expenditure on HCDs in a timely fashion.	Clinical audit of treatment efficacy. Actual drug utilisation costing. Compliance with VCS SACT protocols. Compliance with 90-day implementation on target for newly approved medicines (post-NICE Final Appraisal Document (FAD)).	30% aseptic in-house manufacturing by June 2026 100% compliance with 90-day implementation on target for newly approved drugs 100% compliance with VCS SACT protocols.

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performanc e indicator (how the improveme nt will be routinely measured)	G Target Performanc e for 2026- 2027 (what we expect the plan to deliver
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Expected Outcome: Set out what will be delivered e.g. establishment of a new service; delivery of a new treatment/test; a new building or equipment.			
											medication at home Local implementation of BlueTeq, a web-based software system for the management of High-Cost Drugs (HCDs). The sysyem will support a standardised approach to data collection.			
An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Effective Care	Accreditation of OECI – Priority 10	Recruitment to OECI internal accreditation team Establish OECI accreditation steering group	Finalise programme, governance, reporting & risk framework Begin evidence collection architecture (policies, SOPs., KPIs)	Comprehensiv e gap analysis against all OECI standards Identify priority areas for improvement Engage clinical, research and patient groups	Self assessment development					Q1: Finalisation of OECI portfolio Q2: Undertaken a successful OECI inspection and be accepted as a accredited member Accreditation of OECI quality standards by 2028 - complete quality system for cancer diagnosis, care, education and research by using OECI standards and indicators and peer review	Improved patient experience		

Appendix 2c: Trust Delivery Plan – RESEARCH and DEVELOPMENT

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1-5)	B Outcome required e.g., Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative							E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performance indicator (how the improvement will be routinely measured) 2026-2027	G Target Performance for 2026-2027 (what we expect the plan to deliver 2027-2028)	
			2026-2027				2027-2028				2028-2029		
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
3		Improve equitable patient access to cancer research	Ensure that appropriate patients across tumour groups and pathways are routinely considered for research participation. Q1 - Establish a clear Trust-wide understanding of current patient access to research and where variation exists. Q2 - Agree priority areas where access to research opportunities should improve. Q3 – Ensure the embedding of consideration of research opportunities within routine clinical pathways. Q4 - Demonstrate clearer and more consistent visibility of research access across tumour groups and services.				Access considerations are embedded into routine portfolio planning and study commitment decisions, including coordination with outreach and satellite services where appropriate.				Access to research is consistently planned as part of service delivery, with patterns explainable at tumour-group and Trust level. More patients are routinely considered for appropriate research opportunities as part of their care. Reduced risk of patients missing research opportunities due to pathway design, geography, or service variation. Greater consistency and transparency in how research access is offered across tumour groups and services.	Proportion of eligible patients offered research participation. Recruitment and access patterns by tumour group, pathway, and study type (commercial / non-commercial). Board-level narrative explaining variation in access and actions agreed through governance.	Patient access to cancer research is visible, routinely reviewed, and explainable at tumour-group and Trust level. Differences in access across tumour groups and pathways are understood and discussed through established governance. No unexplained or unacknowledged variation in access to research across Velindre Cancer Services.
		Operate a controlled and shared system for cancer research delivery	Introduce a clear and consistent approach to selecting, approving and delivering research studies across Velindre Cancer Services and the Research Service. Q1 - Agree an enhanced shared approach for overseeing the cancer research portfolio and delivery risks. Q2 - Introduce consistent oversight of study selection and delivery across clinical services and research teams. Q3 - Demonstrate improved coordination in how studies are prioritised and supported. Q4 - Confirm that the shared delivery approach is operating consistently across services.				The shared system is embedded and operating consistently across directorates, tumour groups, and support services.				The delivery system is stable and predictable, supporting growth without increasing risk at the same rate. Patients are offered research studies that are well prepared and deliverable, supporting a reliable and positive research experience. Research studies run with greater consistency and predictability, reducing disruption once they are open. Patients experience a more consistent approach to research across tumour groups and services. Research participation is planned, coordinated, and well supported, building confidence for patients and carers.	Evidence that portfolio, commitment, and delivery controls are applied consistently to cancer studies. Reduction in unexplained variation in study set-up and delivery across tumour groups and services. Number and nature of delivery escalations, and how they are resolved. Qualitative feedback from clinical teams, Research Service staff, and sponsors on delivery predictability.	A shared delivery system is in place and actively used across Velindre Cancer Services and the Research Service. Decisions to open, prioritise, or escalate cancer studies are consistent, documented, and explainable. Clear decision-making and escalation routes are understood by clinical and research delivery teams.
		Improve reliability and consistency of study set-up and delivery	Strengthen coordination across clinical teams and support services so research studies are prepared and delivered reliably. Q1 - Establish clearer visibility of the factors that influence study start-up timelines. Q2 – Ensure earlier coordination between research teams and key support services to reflect UK timeline targets. Q3 - Demonstrate improved understanding of delays and clearer routes for resolving issues. Q4 - Show greater consistency in how studies are prepared and started across tumour groups.				Set-up and delivery timelines are more consistent across tumour groups, supported by alignment between services and clearer escalation routes.				Study set-up and delivery are dependable and explainable, with reduced variability and fewer late-stage issues. Patients are invited to take part in studies that are ready to start and well-coordinated across services. Fewer delays between consent and treatment or intervention. Reduced risk of late changes, cancellations, or rescheduling once studies are underway.	Study set-up timelines, with variation and outliers reviewed through routine governance. Number and nature of set-up escalations and late-stage changes. Qualitative feedback from clinical teams, Research Service staff, and sponsors on set-up	Study set-up is managed as a coordinated, whole-system process across clinical services, research delivery teams, and support services. Key dependencies are identified and discussed earlier in the set-up process. Variability in set-up timelines is visible,

						Greater confidence that research activity fits smoothly alongside routine care.	experience and predictability.	understood, and actively discussed through established governance.
		Strengthening integration between research and clinical services	Ensure research activity is planned and delivered as part of routine clinical service delivery. Q1 - Strengthen visibility of research activity within clinical directorates and tumour groups. Q2 - Align research planning more closely with clinical service priorities. Q3 - Demonstrate shared ownership of research delivery between clinical and research teams. Q4 - Confirm that research planning is embedded within routine clinical governance discussions.	Joint ownership of research delivery is embedded across clinical services and tumour groups.	Research is fully integrated into routine clinical pathways and service planning.	Research participation is better coordinated with clinical care, reducing disruption to treatment and appointments. Patients experience research as a planned and integrated part of their care pathway rather than an add-on. Improved continuity and clarity for patients as clinical and research teams work more closely together. Greater confidence that research activity is aligned with clinical priorities and service capacity.	Evidence of regular research discussion and review through Clinical Directorates and Site-Specific Team (tumour group) forums. Visibility of research commitments and delivery impact within routine clinical and research governance reporting. Qualitative feedback from clinical teams and patients on the coordination of research and care.	Research planning and review are routinely aligned with Clinical Directorates and Site-Specific Teams. Clinical teams have clear visibility of research commitments and their impact on service delivery. Decisions to open new studies consistently consider both research opportunity and clinical service pressures.
		Strengthen early phase, radiotherapy, and translational research capability	Support delivery of complex and innovative research studies in areas of strategic importance. Q1 - Clarify Trust priorities for complex and innovative cancer research. Q2 - Align research capability with service readiness and available expertise. Q3 - Strengthen coordination with partners involved in delivering complex research. Q4 - Demonstrate clearer and more reliable arrangements for supporting complex research studies.	Delivery models for complex research are operating reliably, including through the Cardiff Cancer Research Partnership and relevant outreach settings.	Capability is aligned to future service configuration, including the new Velindre Cancer Centre.	Patients have access to more complex and innovative research studies that are appropriate to their care and delivered safely. Improved reliability of early phase, radiotherapy, and translational studies, reducing disruption or delays once studies are opened. Greater confidence that complex research is supported by the right expertise, facilities, and coordination across services. Enhanced patient experience where advanced research is integrated into care in a planned and well-supported way.	Delivery performance of early phase, radiotherapy, and translational studies, including consistency of set-up and delivery. Evidence that complex study decisions reflect agreed capability, service readiness, and coordination across sites. Qualitative feedback from clinical teams, Research Service staff, and sponsors on the reliability and support of complex research delivery.	Trust priorities for early phase, radiotherapy, and translational research are clearly agreed and understood. Decisions on complex studies consistently reflect delivery capability and service readiness. Coordination across sites and services is strengthened for complex research, with clearer routes for support and escalation.
		Support sustainable growth in commercial cancer research	Increase the proportion of commercially sponsored trials within the cancer research portfolio to strengthen patient access and research sustainability. Q1 - Confirm the baseline of commercial research activity and agree principles for sustainable growth. Q2 - Introduce a more deliberate approach to selecting and supporting commercially sponsored studies. Q3 - Demonstrate progress towards a more appropriate split in the portfolio of commercial and non-commercial research. Q4 - Confirm that commercial research growth is aligned with delivery capacity and clinical priorities.	Controlled growth in commercial research is embedded within portfolio and delivery governance, supporting workforce and infrastructure resilience.	Commercial research operates as a sustained contributor to long-term capability and system resilience.	Patients have access to a wider range of innovative and early-access cancer treatments delivered through well-supported studies. Commercial research activity contributes to the stability and resilience of research services that support patient care.	Commercial research activity reviewed as part of routine portfolio oversight alongside non-commercial studies. Evidence that VPAG objectives and reinvestment principles are applied to commercial research income.	Commercial research is consistently reviewed and governed as part of the overall cancer research portfolio. Decisions on commercial growth are clearly linked to delivery capacity, service readiness, and VPAG objectives.

						Reduced risk of disruption to clinical services as commercial studies are planned and delivered within agreed capacity. Greater confidence that commercial research activity is purposeful, sustainable, and aligned to patient and service benefit.	Delivery performance of commercial studies, including impact on clinical services and research capacity. Sponsor feedback and repeat engagement reflecting delivery credibility.	The impact of commercial studies on clinical services and research delivery is visible and considered in decision-making.
		Build a stable and capable cancer research workforce	Ensure the workforce supporting cancer research is appropriately structured, supported and aligned with future portfolio ambition. Q1 - Clarify research roles, responsibilities and workforce expectations across services. Q2 - Improve understanding of workforce capacity and pressures supporting research delivery. Q3 - Introduce actions to strengthen research workforce resilience and capability. Q4 - Demonstrate improved alignment between workforce capacity and research portfolio demands.	Research delivery is supported through clearly defined roles and planned capacity across services.	Workforce capacity and capability are matched to portfolio ambition and VCS / Research service configuration.	Patients experience greater continuity and reliability in research delivery, with fewer changes caused by staffing pressures. Research activity is supported by appropriately trained and prepared staff, improving confidence in the quality and safety of care. A more consistent and supportive research experience across tumour groups and services.	Visibility of research workforce roles, responsibilities, and capacity within routine governance and portfolio reporting. Compliance with required training and regulatory expectations (e.g., GCP currency). Evidence of alignment between portfolio demands and workforce capacity across clinical services and the Research Service. Number and nature of workforce-related escalations and pressure points discussed through governance.	Research roles and responsibilities across clinical services and the Research Service are clearly defined and understood. Training and regulatory requirements are maintained and monitored. Workforce pressures and capacity risks are visible and discussed through established governance. Research delivery is supported through planned capacity arrangements.
		Strengthening partnerships and system leadership in cancer research	Strengthen Velindre's role as a trusted partner in cancer research across Wales and internationally. Q1 – Ensure that existing partnerships supporting cancer research delivery are clearer and better aligned to delivery priorities. Q2 - Strengthen collaboration with key partners across academia, industry and NHS organisations. Q3 - Demonstrate learning from partners to improve local research delivery. Q4 - Confirm Velindre's role as a credible and reliable research partner within the wider research system.	Velindre's role as a credible research partner is reinforced through consistent delivery and collaboration.	Velindre is recognised as a system leader in cancer research delivery, contributing to Wales-wide capability.	Patients benefit from access to a broader range of high-quality research opportunities enabled through strong partnerships. Research studies are better coordinated across organisations, reducing delays and duplication. Improved consistency and reliability of research delivery as partners work to shared expectations.	Evidence that partnerships with academia, industry, and NHS partners are actively supporting study delivery and portfolio objectives. Clarity of roles and contributions within regional and national research structures. Qualitative feedback from partners on collaboration effectiveness and delivery credibility. Evidence that learning from partners and benchmarking is informing local improvement.	Existing partnerships are actively contributing to cancer research delivery and are aligned to Trust priorities. Roles and expectations within collaborative arrangements are clear and understood. Learning from partners and system peers is visible and applied to improve local research delivery. Velindre is recognised by partners as a reliable and credible research collaborator.

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			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
Goal 3	Effective care with a great experience	Alignment of Innovation Strategy	Increase staff engagement by hosting an information stand at VCC		Monitor and CO ₂ report reduction achieved through implemented sustainability innovations.	Projects aligned with Trust innovation priorities	Ensure strategic alignment of innovation projects through regular portfolio analysis and reporting				Ensure strategic alignment of innovation projects through regular portfolio analysis and reporting	Enhance Patient Outcomes and Improve patient and donor Experience. Improve Operational Efficiency. Strengthen Collaboration. Cultivate an Innovation Culture.	Percentage of innovation projects aligned with Long Term Plan. Number of innovations improving patient /donor safety and outcomes. Cost savings from operational efficiency innovations. Carbon footprint reduction for sustainability-driven projects. Patient outcomes/experience measures (VBHC). Number of awareness campaigns held. Staff sign up for innovation activities/distribution list.	Key Targets: ≥ 50 staff interactions during event. ≥ 20 feedback responses or ideas collected. ≥ 50% sign-ups for innovation activities or mailing lists. ≥ 80% positive feedback from participants. 100% projects aligned with Trust innovation priorities.
Goal 3	Safe Care	Strengthen and Sustain Innovation Infrastructure	Develop ISO56001 Awareness module for Trust staff. Recruit and retain Innovation Champions.	Roll out Bright Ideas across VCS.	Initiate collaboration with WBS to roll out Bright Ideas.	Develop and deliver Innovation Toolkit training sessions Trust-wide. Mandate Innovation training for all Trust staff. Achieve recertification ISO 56001.	Continue roll out of ISO56001 training and awareness.	Deliver Innovation Toolkit training sessions Trust-wide.		Recruit and retain Innovation Champions (target: 10 per year, 80% retention).	Continue roll out of ISO56001 training and awareness. Recruit and retain Innovation Champions (target: 10 per year, 80% retention). Embed innovation training as a core requirement for all Trust staff.	Faster implementation of innovations/changes. Accelerates Innovation Adoption. Evidence-based scaling. Continuous improvement.	ISO56001 module developed with phased implementation according to competency requirements. Achieve ISO 56001 recertification. Number of staff attending innovation training sessions. Number of Innovation Champions retained /recruited. Innovation Bright Ideas platform rolled	Key targets: Recruit 10 innovation champions. Achieve Recertification of ISO56001. 50% of employees complete innovation competency training within 12 months. Bright Ideas rolled out across VCS. Develop and deliver Innovation Toolkit training.

											90% of employees complete innovation competency training within 12 months.		out across departments. High visibility executive support and sponsorship.	
Goal 3	Effective care with a great experience	Promote Innovation driven culture	Capture innovation projects for submission to the National Innovation Awards. (Q1–Q4)		Trust Job descriptions to include innovation. Innovation objectives to be included in appraisal process. Capture and submit eligible innovation projects for national recognition (Annual MediWales Innovation Awards).				Capture and submit eligible innovation projects for national recognition (Annual MediWales Innovation Awards).			Accelerates Innovation Adoption. Enhances staff engagement and morale. Promotes open collaboration. Creates a Sustainable Innovation Culture.	Recognition awards given for innovation contributions. Job description/appraisal guidance to include innovation. Frequency of internal communications on innovation progress.	Key targets: Four innovation projects submitted to MediWales Innovation Awards. Internal comms on innovation progress published monthly. Integrate innovation responsibilities and objectives into job descriptions and appraisal framework.
Goal 3	Timely care	Secure sustainable funding streams	Two funding applications submitted Q1 – Q4							Four funding applications submitted Q1 – Q4		Longevity programmes. Continuity of innovation infrastructure. Enhanced portfolio.	Number of funding applications submitted. Number of funding applications awarded captured against national average.	Key targets: Two funding applications submitted.
Goal 3	Effective care with a great experience	Collaboration with external stakeholders	Horizon scanning for potential collaborations/ partnerships / funding opportunities. Attendance at key networking events.	Expand reach and readership of the Innovation newsletter to maximize awareness, sharing case studies and patient impact stories.		Engagement with Cardiff Health Partners (CHP) for collaborative opportunities.				NHS Wales Innovation Symposium in CCfLRI Five collaborative projects.	Eight collaborative projects.	Development of strategic / inclusive partnerships. Funding opportunities pursued. Innovations developed.	Number of collaborative projects implemented. Four newsletters distributed per year. Engage in key industry networking events to foster strategic partnerships and enhance innovation visibility.	Key targets: Four newsletters published. Establish a structured horizon scanning process to identify at least five potential collaborations, partnerships, or funding opportunities. Participation in at least four key industry networking events.

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			2026-2027				2027-2028							2028 - 2029
			Q1	Q2	Q3	Q4	Q1	Q 2	Q 3	Q 4				
Outstanding for quality, safety & experience	Safe, timely, effective, efficient, person-centred	Priority 1 - Improve patient & donor communications A. Ensure letters on the VCS Document Management System (DMS) are consistently approved and sent within 30 working days. B. Improve patient and donor communications	A. Commence regular audit of the DMS to ensure all clinic letters are authorised and sent within 30 working days. Establish a baseline. B. Thematic analysis of concerns feedback to understand the root cause.	A. Target of 80%. B. Improvement will be demonstrated through a progressively reduce concerns relating to appointment communications.	A. Target of 90% with reduced variation between specialities.	B. Target of 100% to sustain and embed business as usual.	A. Measured and monitored via outpatient improv. programme, KPIs and reported via governance structures.					Improved quality, safety, and reliability of communication with patients, donors and other clinicians. Clearer information about treatment, disease management and appointments. Improved utilisation of appointments.	Regular audits to ensure that a copy of all clinic letters are sent to patients who have not opted out of receiving a copy. Regular audits of the Document Management System to ensure all clinic letters are authorized and sent within 30 working days of the appointment. Achieve a 25% reduction in the number of concerns where treatment communication regarding patient treatment/outcomes is identified as a theme. Achieve a 25% reduction in the number of concerns/feedback where appointment communication is identified as a theme.	Achievement of all deliverables.
Outstanding for quality, safety & experience	Safe, timely, effective, equitable, person-centred	Priority 2 - Strengthen quality and safety infrastructure A. Ensure all levels of patient/donor safety investigations are robust and undertaken by trained investigators at the	A. Increase the number of trained investigators to improve quality and timeliness of investigations. B. Establish hot and cold debriefs and reliable feedback	A. Undertake samples audits of patient / donor investigations at each level. B. Establish hot and cold debriefs and reliable feedback mechanisms with an SOP. C. Recruit OECI accreditation lead.	B. Review investigation timeliness to monitor compliance with agreed timescales. C. 90% of staff involved in incident to receive feedback and debrief opportunity within 14 days of incident closure. D. Undertake scoping and field work, in	A. Collect staff feedback to strengthen debrief process and after incident support. B. VCS to apply for OECI accreditation. C. Capture and report via internal quality governance staff voices which will also be captured and reported in					Services that emphasize quality and patient & donor safety, resulting in enhanced patient experience. Improved opportunity to identify themes and learning.	Undertake sample audits of all patient / donor safety investigations at each level. Achieving at least two new accreditations during as well as maintaining existing accreditations.	Achievement of all deliverables. Successful implementation of pilot.	

		appropriate levels. B. Ensure feedback and support is provided to all staff involved in the incident. C. Develop a Trust wide accreditation plan – with clear trajectory to having nationally / internally recognized accreditation across all core services. D. Continue to strengthen the quality and safety culture across the organisation, including psychological safety – Implement Trust wide cultural and behaviour programme. E. Implementation of QUAIL an artificial intelligence system that supports the management, analysis and actioning of patient feedback and safety incidents.	mechanisms with an SOP. C. Develop job descriptions and role profiles OEI accreditation team in the cancer service. D. VCS - Development of 15 step assurance framework to include magnet methodology to actively capture staff feedback on psychological safety via regular audits. Agree methodology and sign-off approach to 15 step assurance programme across VCS. E. Engage the stakeholders and commence the pilot.	D. Capture and report via AMaT 15 step programme. E. Conduct analysis reviewing theme and trend opportunities and develop structured reports for insight.	preparation for OEI accreditation. Capture and report via AMaT 15 step programme. E. Share insights with wider organisation.	yearly staff experiences survey results. E.Establish regular insight reporting and evaluate pilot.								Review staff survey 2025-2026 results regarding psychological safety. Improved thematic detailing in reports.	
Outstanding for quality, safety & experience	Safe, timely, effective, efficient, equitable, person-centred	Priority 3 - Improve patient & donor safety A. Reduce harm related to urgent clinical information being circulated via email. B. Fully implement 'Call for Concern' in Velindre Cancer Service. C. Ensure that 100% of bloods taken within Velindre Cancer Service are reviewed within 48 hours. D. WBS – Anaemia management project. Optimisation of screening and management of anaemia across priority population groups in Wales. E. WBS - HLA-Selected Red Cells for Solid Organ Transplant Recipients -Feasibility Assessment Project.	A. Replace unsafe email communication of urgent clinical information with reliable communication process. Outpatient transformation programme map high risk email process. B. To develop and implementation plan and monitor by the Trust regulatory tracker. To commence pilot aligned to national workstream.	A. Outpatient transformation programme map high risk email process. B. Implement method of documenting 'patient self-reported wellness/concern' at least twice per day in all acute hospital in-patient areas. Implement a patient and family-initiated escalation system including phone numbers to activate senior review in in-patient areas. C. Define clinical ownership and SOP. D. Report baseline review of HBS	A. Transition to urgent results communicated via approved pathway. B. Demonstrate that 'patient self-reported wellness/concern' is reliably documented at least twice per day in all acute hospital in-patient areas. C. Implementation and tracking of process plus escalation where required. D. Progress action plan for Post operative anaemia pathway implementation. Scope long term opportunity for	A. Transition to urgent results communicated via approved pathway. B. Demonstrate that 'patient self-reported wellness/concern' is additionally reliably documented at least once per day in all non-acute in-patient settings. Demonstrate reliable use of the patient and family-initiated escalation system including phone numbers to activate senior review in all in-patient settings. C. Sustain 100% compliance and a	B. Monitor and evaluate implementation .					Improved patient & donor safety.	Measured by number of patient incidents linked to urgent clinical information via email is zero. Conduct monthly audits to measure compliance against key performance indicators for sepsis identification and treatment. Introduce and evaluate 'Call for Concern' at VCS. Reduce to zero the number of incidents reported where omission or delay in reviewing bloods is identified as a contributory factor.	Achievement of all deliverables.	

		To assess the feasibility of providing HLA-selected red cells for solid-organ transplant recipients in Wales, including evaluating donor panel size and suitability, cost-effectiveness, clinical demand and operational impact.	C. Define clinical ownership and SOP. E. Begin feasibility assessment. Initial modelling of donor panel size required and costing.	against the Post-operative anaemia Pathway and action plan for implementation. Actions related to support anaemia in women's health and Public health TBC. E. Further modelling. Review outcome data from NHSBT pilots, Assess risks and regulatory issues.	compliance monitoring against the post operative anaemia pathway. Actions related to support anaemia in women's health and Public health TBC. E. Develop Options appraisal and decision on whether to proceed with business case development.	change of culture and clinical practice. Measure by zero incidents where delayed blood results that there is a clear accountable clinical for every blood test requested with evidence for review within 48 hours. D. Continue with monitoring. E. Develop Options appraisal and decision on whether to proceed with business case development.								Reduction in harm incidents related to referral processes.	
Outstanding for Quality, safety & experience	Safe, timely, effective, efficient, person-centred	Priority 4 – Implement a Trust Quality Dashboard	Review progress against the agreed roadmap.	Technical development, select and build the platform ensuring interoperability, usability, and secure access.	Piloting and iteration, test and pilot each phase of the dashboard with a small group of users, gather feedback and refine measures and visuals before wider rollout.	Embedding systems, make dashboard use part of routine governance and clinical practice, supported by training and leadership.	Sustainability and continuous improvement, create feedback loops, update measures and scale across services to keep the dashboard relevant and impactful.					Accurate access to real time data to identify themes, risk and trends.	To compare previous reporting. Monitor and report predicted efficiencies with dashboard users.	Fully functioning quality dashboard.	
Outstanding for Quality, safety & experience	Safe, timely, effective, efficient, person-centred	Priority 5 – Fully embed the national people's experience framework (includes priority 4 from 2025-2026).	Review the trust People's Experience self-assessment and identify priority areas.	Demonstrate evidence of increased capacity and capability to gather people's feedback including utilizing digital stories.	Evidence of analysis and triangulation of lived experience data in reports.	100% RAG rating. Green – Sufficient relevant evidence in the trust people's experience local self-assessments.	To continue to be measured and monitored through the trust quality governance structure. To ensure people's experience drives improvement.					Evidence of using experience to drive improvements. Improved patient/donor outcomes.	Delivery of learning plan milestone. Agree patient experience metrics to include in the quality dashboard.	Achievement of all deliverables.	
Outstanding for Quality, safety & experience	Safe, timely, effective, efficient, person-centred	Priority 6 – Implement the Listening to People Regulations	Awaiting statutory guidance and refine and amending processes. Review developed implementation plan.	Agree and monitor compliance with new stage LTP process. Target 75% compliance.	Commence people's experience surveys to assess the impact of the changed concerns process.	Review the implementation and delivery and highlight risks and benefits.						Increased empathy and rapport. Ensure people feel listened to and understood. Validates their experience. Supports clearer articulation of desired outcomes.	Compliance with concerns resolution staged targets to be agreed, expected 75%. 100% compliance with redress cases within 120 days as set out in the regulations.	Successful implementation of the new regulations.	

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performance indicator (how the improvement will be routinely measured) 2026-2027	G Target Performance for 2026-2027 (what we expect the plan to deliver 2027-2028)
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Skilled and Developed Workforce Roll out new Performance Appraisal and Development Review process with aim of 85% participation by Q4 ~Year 1. Working with medical colleagues to ensure a robust and effective process for job planning that is built into our workforce plans Review digital capabilities	New PADR process in place Job Planning process in place				Maintain ing process and monitori ng outcom es Liaising with Digital to deliver the plan				Skilled and Developed Workforce	PADR 85% Job Planning 90%	85% 90%	
		Healthy and Engaged Workforce Specific goals for 2026-2027 will be: Culture work being scoped Implement a Wellbeing Framework which: Maintain (as a minimum) the current sickness absence rate at 5.1% Develop the Employee Voice process for Speaking Up Safely	business case for wellbeing service Speaking up safely infrastructure in place Sickness plans in place and monitoring ongoing		E learning sexual safety		Wellbei ng support in place via a robust wellbein g service				Healthy and Engaged Workforce	Sickness not greater than 5.1%	Sickness not greater than 5.1%	

		Introduce support for Sexual Safety at Work in partnership with NHS Wales colleagues Develop a Staying Well at Work Package with the aim of preventing sickness absence and improving perceived organizational wellness Explore funding opportunities to create an embedded Health and Wellbeing Service with space and staff for each site											
		Planned and Sustained Embed ED&I initiatives into the recruitment plans and strategies Ongoing engagement with schools and colleges regarding apprenticeship programmes and alternative routes into employment Launch new Recruitment Campaign for Velindre Via our internal Steering group ongoing monitoring of agency spend and its reduction Workforce plans developed with the service	Recruitment campaign in place Agency spend monitored Widening Access plan in place Workforce plans being developed	Monitoring via EMB and Divisional Groups Plans monitored via EMB (Supply and Shape paper)							Right People, Right Place, Right time	Turnover (between 7-9%) Staff Survey Results Equality monitoring Welsh Language Monitoring Time to Hire (less than 72 days) Agency spend (reduction of 30%)	
		Caring Ensure a reduction in sickness absence in 2026-2027 in comparison to 2025-2026, through maximizing adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales	See Enabling Actions and Expectations										

		Occupational Health minimum service levels.M53												
		Respectful Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular. Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025	See Enabling Action and Expectations											
		Accountable Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025-2026 from 2024-2025 outturn, and ensuring no off-contract expenditure. Ensure a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to zero by 30th September 2026.Q3	See Enabling Actions and Expectations											

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performance indicator (how the improvement will be routinely measured) 2026-2027	G Target Performance for 2026-2027 (what we expect the plan to deliver 2027-2028)
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
All goals	nVCC Digital	Digitally enable the new Velindre Cancer Centre and support the transition of the VCS service model into nVCC	Planning in readiness for Implementation	Planning & Mobilisation activities	Beneficial Access to commence infrastructure commissioning	Commissioning of services	nVCC opens optimization of digital services in nVCC	Achieve stable operations Commence nVCC planning & Delivery Day +1 services	Delivery of additional Digital Services	Delivery of additional Digital Services	Day + 1 optimization			
1&2	WHAIS	Digital Transformation of the Welsh and Histocompatibility Immunogenetics Service	Achieve stable operations post go live Completion of post go live validation	Commence phase 2 WHAIS requirements delivery Successful integration of demographic models (DHCW)	Complete phase 2 WHAIS requirements delivery									
1&2	Radiology Informatics System Programme (RISP)	Establish a new Radiology/PACS system on the National RISP platform.	RISP Go Live	Achieve Stable operations Completion of legacy data migration	Transition to BAU									
1&2	Welsh Laboratory Information System (WLIMS 2.0)	Precursor for digital connectivity for the Infected Blood Inquiry digital solutions		Blood Transfusion Module go-live in WBS and HBs TBC	Blood Transfusion Module go-live in WBS and HBs TBC		Digital Connectivity scoping for IBI				Digital Connectivity implementation for IBI			
1&2	Blood Establishment Computer System (BECS)	Establish a new BECS for the Welsh Blood Service by Oct '27.	Scope Minimum Viable Product Configuration of infrastructure	Configuration of BECS modules in line with current specification Testing & Validation cycles Scoping of data migration	Configuration of BECS modules in line with current specification Commence Data Migration	Data Migration UAT	Final Phase of configuration UAT cycle Validation	Go Live Readiness	BECS Go Live Post go live validation	Achieve stable operations	Additional BECS modules including Hospital ordering; Donor relationship management			

		The ACT Well-being of Future Generations Act	Further embed into refreshed Trust Strategy					
		Sustainability • Travel Plan • Climate Adaption • Sustainable funding model for change • Energy	Refresh the Trust Travel Plan (2028) Continue delivery on climate adaption risks, working with the Climate adaptation leads across NHS Wales.	Model for funding streams and management of savings, building on Site Improvement Plan approach	Remove gas from all sites and invest in renewable energy for all sites			

A Destination 2033: Strategic Goal (which Goal(s) will be taken forward 1 -5)	B Outcome required e.g. Timely Care; Safe Care; Effective Care with a great experience	C Strategic Objective that will drive the achievement of the outcome	D Deliverables: the key deliverable(s) in each year (by Quarter (Q1; Q2; Q3; Q4) for each year Note: 2026-2027 and 2027-2028 must be firm with 2028-2029 being indicative									E Expected Benefit (set out the benefit(s) for the patient / donor)	F Key performance indicator (how the improvement will be routinely measured) 2026-2027	G Target Performance for 2026-2027 (what we expect the plan to deliver 2027-2028)
			2026-2027				2027-2028				2028-2029			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Cardiff Health Partners - Health innovation, anchored in Cardiff, connected for global impact. - The model reduces barriers through shared governance, streamlined research delivery, and federated data access. - It is health improvement and economic growth and regeneration, delivered together. - Significant progress on a long-term strategic partnership for cancer therapies.				include development of an investment strategy.								
		South East Regional Joint Committee The Trust is an active participant in the newly established South East Regional Joint Committee. The Regional Joint Committee's purpose is to enhance collaboration, reduce inequalities, and promote sustainable healthcare services across the region, marking a step toward integrated regional health governance.		Agree workplan and delivery of the Trust's role in contributing to the wider regional health system.										
		South East Wales Regional Cancer Programme The Programme's overarching aim is to improve cancer prevention, early detection, treatment, and palliative care, delivering services that are high quality, equitable, and centred on patient needs for the population of South East Wales. The Programme Board provides strategic oversight, guiding the design, implementation, and evaluation of the programme to ensure these objectives are achieved. All projects and change initiatives within the programme are aligned to the individual cancer strategies of partner organisations, while also prioritising areas where regional collaboration delivers added value and strengthens outcomes across South East Wales.	Tracking implementation of cancer-related MAG actions. Consistent delivery of cancer-related MAG actions across SEW (i.e. Capsule sponge, symptomatic FIT, Unscheduled bleeding on HRT/Post-menopausal bleeding pathway, breast pain only pathway (BPOP), Tele-derm)		Regional Oncology workforce plan. To establish a regional oncology workforce baseline with an associated Workplan Plan to address any gaps identified	Support consistent approach to MDTs across SEW by supporting implementation and spread of NHS P&I's MDT Charter and associated 'Bridging Document' to be published Dec '2025-Jan '2026 to achieve consistent approach and standards across all MDTs which are auditable and support								

						identification of resource gaps.								
						Shared Patient Treatment List (PTL) established. Individual cancer patients tracked in real time across their pathway with all the relevant demographic, referral, clinical and operational data visible to those responsible for patient care. Hospital Initiated Referral (HIR) from HBs into VCS will also provide an in-built validation to the PTL								
		Cardiff & Vale UHB Executive Partnership Cardiff & Vale University Health Board and Velindre University NHS Trust share a long standing partnership that has been central to delivering high quality cancer services for the population of South East Wales. In 2025-2026, this relationship was further strengthened through the establishment of a formal partnership programme designed to support a unified strategic response to an increasingly complex and rapidly evolving oncology landscape. The partnership aims to ensure both organisations can meet the challenges and opportunities created by rapid innovation in oncology, including the emergence of Advanced												

[illegible]

		• Providing a coordinated provider planner input into the Advanced Therapies Wales Therapeutic Apheresis Project. • Scoping sessions have been held between Velindre and CAVUHB colleagues confirmed a shared commitment to strengthening the prevention agenda. Both organisations recognise the opportunity to maximise research, development and innovation (RD&I) potential and to embed prevention more systematically across services. • As part of the ongoing partnership between Cardiff & Vale UHB and Velindre University NHS Trust, strategic cancer prevention has been identified as a key area where collaborative working can deliver greater impact than independent efforts.		Embed processes within partnership structures Reviewing primary care cluster profiles to identify areas with the greatest potential impact. Q2 year one- Reviewing the MECC training offer across both organisations Developing a draft high-level plan to guide early collaborative activity										
		Sustainability Driven Partnerships Impact will continue to be evidenced in sustainable outcomes by end of year one through the following partnerships: • All Wales Walking Aid Recycling scheme • Climate Adaptation Leads across NHS Wales collaborate through regular meetings and shared platforms to align actions, reduce duplication, and share best practice Genetic Hemochromatosis pathway	Ongoing											
		Hefyd Partnerships Impact will continue to be evidenced in patient, staff and community outcomes by end of year one through the following partnerships: • Arts in Health Programme • Nature-Based Social Prescribing • Sustainable Jamborees	Ongoing											

Priority area(s) to deliver 26/27:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Community by Design • Mental Health Access • Women's Health • Quality and Safety

Priority area(s) to deliver 26/27:				
Key focus should be on delivering		Timely Access for Care		
Ref:	(Indicate if new priority or continued from 25/26)			
2025-2026	12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route), building toward a national target of 80% by 31 March 2026.			
Updated Priority 2026-2027 VUNHST Plan and VCS Delivery Plan & Outcome Measures	1. Health boards to achieve the suspected cancer pathway target of 75% through implementing the nationally agreed pathways, while reducing the backlog of patients waiting more than 62 days by end of March 2027. 2. Performance will be measured in two ways, firstly based on all patients received and secondly based on shared accountability across the 62-day pathway i.e. patients received on or before day 38 of their pathway			
2026-2027 Out of Scope	2. <i>Velindre University NHS Trust contributing to the wider system requirement</i> Number of patients waiting more than 8 weeks for a specified diagnostic – target zero			
2026-2027 Out of Scope	3. Ensure no patient spend spends 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge.			
2026-2027 Out of Scope	4. Ensure no ambulance patient handover waits over 45 minutes			
Resume of planning Milestones 25/26:				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				
Progress synopsis				
Outcomes of delivering Ministerial Priorities:				
Ref:				

Planned milestones for Priority area to deliver 2026/27				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref: 2.	Participate in the establishment of diagnostics pathways for the Community Diagnostic Hubs	Provide workforce and demand and capacity data to support development of regional reporting models and workforce plans		
1.	Details in Section 2 of VUNHST IMTP and Outcome Measure in VCS Plan			
Overarching outcome measures/ metrics:				
1. VCS Component of FDT for patients referred to us on or before day 38 by March 2027				
The performance will improve incrementally over the time period based on pathway improvement work rolled out across the Tumour Sites.				
Baseline position 25/26				
Quarter 1		Quarter 2	Quarter 3	Quarter 4 – 39%
Performance Trajectories 26/27				
Quarter 1		Quarter 2	Quarter 3	Quarter 4 – 75%
Risks	Risks of Non-Delivery		Mitigations	
	Target Not achieved		Portfolio and Programme approach in place Escalation and Management through Trust Governance Structure	
	Risks to Delivery		Mitigations	
	Digital Team Capacity to support VCS and WBS plans		Managed through WBS / VCS Futures Programme and Portfolio at Trust level	
Critical Enablers	Finance			
	LTA agreements are in place			
	Workforce			
	Workforce change plans realised to provide optimised efficiency and effectiveness			
	See VCS / WBS and Our People in Trust Plan			
	Digital			
	See Digital Plan			
	Other (Specify)			
Quality Safety and Prevention Population Health	& Opportunities identified			
	& As per Division and Departmental Plans			

Priority area(s) to deliver 26/27:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Community by Design • Mental Health Access • Women's Health • Quality and Safety

Priority area(s) to deliver 26/27:

Key focus should be on delivering	Population Health and Protection

Ref:	(Indicate if new priority or continued from 25/26)
New Priority 2026-2027	1. At least 90% of individuals identified via the Audit Plus Frailty Tool (or its replacement) to receive proactive care in line with their agreed care plans.
Out of scope	2. Velindre Trust Contributing to the wider system requirements Reduce inequity in the uptake in the most and least deprived areas in preventing ill-health especially in relation to vaccination, screening and diabetes prevention and care.
Out of scope	3. Increase the proportion of children in Wales who are a healthy weight by halting the rise, and contributing to a year-on-year decrease in the levels of overweight and of obesity as measured and reported through the National Child Measurement Programme, focusing on those most disadvantaged.
Out of scope	4. Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes.

Resume of planning Milestones 25/26:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				
Progress synopsis				

Outcomes of delivering Ministerial Priorities:

Ref:	

Planned milestones for Priority area to deliver 2026/27

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:		VCS undertaking an audit of access equity by specialist treatments by geography, deprivation ethnic ity and tumour site		
	Details in Section 2 VUNHST IMTP – Outcome Measure WBS & VCS Plan			

Overarching outcome measures/ metrics:			
Baseline position 25/26			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
Performance Trajectories 26/27			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
Risks	Risks of Non-Delivery		Mitigations
	Risks to Delivery		Mitigations
Critical Enablers	Finance		
	Workforce		
	Digital		
	Other (Specify)		
Quality Safety and Prevention Population Health	&	Opportunities identified	
	&		

Priority area(s) to deliver 26/27:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Community by Design • Mental Health Access • Women’s Health • Quality and Safety

Priority area(s) to deliver 26/27:				
Key focus should be on delivering		Community by Design		
Ref:	(Indicate if new priority or continued from 25/26)			
New Priority 2026-27 Out of Scope	1. <i>Velindre Trust Contributing to the wider system requirements</i> Deliver a 12-month reduction trend in both the number of people who are delayed in hospital and the total days delayed for these patients, as measured by the Delayed Pathways of Care dashboard.			
2026-2027 Out of Scope	2. <i>Velindre Trust Contributing to the wider system requirements</i> Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible. Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027.			
Resume of planning Milestones 25/26:				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				
Progress synopsis				
Outcomes of delivering Ministerial Priorities:				
Ref:				
Planned milestones for Priority area to deliver 2026/27				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4

Ref:	Implement Palliative Care and End of Life framework and national specification Q1-Q4	Develop a business case to support extended working hours		Develop a 7-day sustainable fully funded palliative care service by March 2027 Q1-Q4
1. & 2.	Details in Section 2 of VUNHST IMTP - Outcome Measures in VCS Plan			
Overarching outcome measures/ metrics:				
Baseline position 25/26				
Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Performance Trajectories 26/27				
Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Risks	Risks of Non-Delivery		Mitigations	
	Risks to Delivery		Mitigations	
Critical Enablers	Finance			
	Workforce			
	Digital			
	Other (Specify)			
Quality & Safety and Prevention Population Health	Opportunities identified			

Priority area(s) to deliver 26/27:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Community by Design • Mental Health Access • Women’s Health • Quality and Safety

Priority area(s) to deliver 26/27:				
Key focus should be on delivering		Mental Health		
Ref:	(Indicate if new priority or continued from 25/26)			
New Priority 2026-27 Out of Scope	1.Implement and evaluate Open Access Mental Health Support by March 2027.			
2026-2027 Out of Scope	2. Improve safety in Secondary Care Mental Health services (measured through agreed mental health safety matrix and PROM ReQuol) by March 2027.			
2026-2027 Out of scope	3. Improve Physical Health of People with long term MH problems by carrying out mortality reviews and implementing improvement plans from the learning by March 2027.			
Resume of planning Milestones 25/26:				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				
Progress synopsis				
Outcomes of delivering Ministerial Priorities:				
Ref:				
Planned milestones for Priority area to deliver 2026/27				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				

	Velindre University NHS Trust contributing to the wider system requirements. Details in Section 2 of VUNHST IMTP - Outcome Measures in VCS Plan		
Overarching outcome measures/ metrics:			
Baseline position 25/26			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
Performance Trajectories 26/27			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
Risks	Risks of Non-Delivery		Mitigations
	Risks to Delivery		Mitigations
Critical Enablers	Finance		
	Workforce		

Priority area(s) to deliver 26/27:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Community by Design • Mental Health Access • Women’s Health • Quality and Safety

Priority area(s) to deliver 26/27:				
Key focus should be on delivering		Quality & Safety		
Ref:	(Indicate if new priority or continued from 25/26)			
New Priority 2026-27	1. Days of safe care delivered since the last never event, monitored using SPC T Chart			
2026-2027 Out of Scope	2. Downward trend in 12-month rolling average crude mortality while maintaining a flat 7-day readmission rate.			
New Priority 2026-2027	3.Percentage proportion of complaints dealt with via early resolution - target 40% by March 2027			
New Priority 2026-27	4. The clinical coding service must ensure that at least 95% of inpatient and day-case episodes are fully coded within one reporting month of discharge, in line with Welsh Government delivery measures. In addition, 90% of all identified coding errors must be corrected within 35 days of identification, ensuring timely and accurate data quality improvements across all health boards. There must be a focus on quality of coding with an emphasis on specificity, and comorbidity capture demonstrated by an increase in depth index by 10% year-on-year.			
Resume of planning Milestones 25/26:				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ref:				
Progress synopsis				

Outcomes of delivering Ministerial Priorities:				
Ref:				
Planned milestones for Priority area to deliver 2026/27				
Ref:	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1.	Develop SPC data capture for utilisation should a ‘never event’ occur			Maintain Trust delivered ‘proportionate investigation training’ to ensure staff awareness or never events, and risk of under reporting Q - Q4
3.	Planning for the implementation of the new Listening to People Process to be enacted in April.			Continue with monthly monitoring of delivery against quality indicators and this measure Q1-Q4
4.	Maintain existing processes to ensure performance is sustained and improved Q1-Q4		Explore the utilisation of AIDHCW and Welsh to maintain performance whilst improving efficiency	Collaborate with Government colleagues to resolve current challenges with the applicability and validity of this newly proposed measure Q1-Q4
	Details in Section 2 VUNHST IMTP – Outcome measure WBS & VCS Plan			
Overarching outcome measures/ metrics:				
Baseline position 25/26				
Quarter 1	Quarter 2	Quarter 3		Quarter 4

Performance Trajectories 26/27			
Quarter 1	Quarter 2	Quarter 3	Quarter 4
Risks	Risks of Non-Delivery	Mitigations	
	Risks to Delivery	Mitigations	
Critical Enablers	Finance		
	Workforce		
	Digital		
	Other (Specify)		
Quality Safety and Prevention & Population Health	& Opportunities identified		

Quality-driven decision-making Equality Impact Assessment

Overview

The Trust is currently in the process of refreshing and updating its three year Integrated Medium Term Plan (IMTP) for 2026-2027 to 2028-2029.

As part of this process there is a requirement to undertake an Equality Impact assessment (EQIA), in relation to any new service developments not previously agreed and / or approved, to assess the impact on people who possess one or more of the nine specific protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The requirement to undertake an Equality Impact Assessment (EQIA) forms an integral part of our approach to ensure that our services address the needs of vulnerable groups focusing as it does, on the way our current services, and any development programmes, are designed and delivered in a way that no patient, donor or member of staff is unintentionally disadvantaged.

EIA is a valuable step in our planning process for all key IMTP developments. Undertaking an EQIA requires you to gather data, consult with stakeholders and formulate options and mitigate risks in your plans. It is not the finishing off of the plan but the exploratory process in drafting the plan.

The Equality Act places an 'equality duty' on public bodies; it came into force on 5 April 2011. The equality duty intends to ensure that public bodies are proactive in eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations. They must consider equality issues in everything they do with regard to the protected characteristics and produce a Strategic Equality Plan (see later)

This means that Health Bodies have a duty to consider the diverse needs of the individuals they serve, minimising disadvantage and ensuring the inclusion of under-represented groups.

What is equality and diversity?

- Equality means ensuring everyone in your setting has equal opportunities, regardless of their abilities, their background or their lifestyle.
- Diversity means appreciating the differences between people and treating people's values, beliefs, cultures and lifestyles with respect.

Anti-discriminatory practice is fundamental to the ethical basis of care provision and critical to the protection of people's dignity. There are five main acts relating to equality and diversity:

- **The Human Rights Act 1998** – this legislation outlines the basic human rights and principles of equality.
- **The Mental Capacity Act 2005** – notably the Deprivation of Liberty Safeguards (DoLS) which aim to help people who lack the capacity to maintain their independence, dignity and the right to freedom.

- **Social Services and Wellbeing (Wales) Act 2014** – The Act provides a legal framework for improving the wellbeing of people who need care and support, and carers who need support.
- **Well-being of Future Generations (Wales) Act 2015**- This legislation is about improving the social, economic, environmental and cultural well-being of Wales.
- **The Equality Act 2010** – this legislation provides protection against discrimination for people who possess one or more of the nine specific protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Our Strategic Equality Plan 2025-2028

Our IMTP sets out the detail of the Trust commitment in our Strategic Equality Plan. The actions, projects and programmes of work included in the IMTP are subject to existing EQIA, and a high-level summary of the key changes are detailed below.

1. Fairness and Respect

This will be a core component of our organisational culture and leadership programmes, sponsored by our Board. This will work on a number of priorities including ensuring compassionate leadership, that we live our values and tackling poor behaviour. A milestone plan has been shaped, and we will co create the action plans with our Trade unions. As part of this programme of work, we will look for opportunities to increase workforce diversity and inclusion and eliminate Pay Gaps. We would like the workforce to better reflect the diverse nature of the communities that we serve, and to ensure that there is no systemic pay disparity between people of different genders, races or disability.

Key Milestones:

- Develop a positive organisational culture, across all training and communication mechanisms.
- Implement the Trust's Widening Access Plan.
- Implement the second phase of the Wales Anti-racist Action Plan.
- Implement the LGBTQ+ Action Plan.

4. Engagement

As well as continuous engagement with staff regarding the culture and leadership programme, we will engage with the community to ensure that we are providing services that our patients and donors want and need. It is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways. This is led by our clinical service connecting with patients and donors as reflected in their delivery plans.

Key Milestones:

- Increase the number of donors across specified target groups in line with the Welsh Blood Service 5 Year Strategy.
- Use Equality Impact Assessment process to prepare cancer services for the move into new Velindre Cancer Centre.

5. Accessibility

Communicate with people in ways that meet their requirements. We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.

Milestones:

- Any legislative changes in British Sign Language are translated into service plans.
- Implement the Welsh language clinical consultation plans 2026-2027
- Any regulatory changes regarding accessibility are translated into service plans.

IMTP Lead:

Kathy Ikin

Deputy Director of Transformation, Performance & Planning (Interim)

IMTP Equality Impact Assessment VUNHST 2026-29

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age Younger people Middle age people Older people Other...	✓	✓		Positive IMTP actions support earlier diagnosis, improved access to cancer pathways, and expanded palliative and supportive care. Community based services : SACT outreach, blood donation sites, extension of Satellite Radiotherapy, telehealth, virtual assessment, PIFU) reduce the need for travel—benefiting older adults and those with frailty. Prevention, screening, anaemia management, and public health initiatives improve outcomes across all age groups. Increasing patient and donor engagement will ensure co design of blood and cancer services to meet the needs of all protected characteristics. Negative Digital first approaches (digital front door, online booking, PROMs) may disadvantage older adults with lower digital confidence. Service transitions (e.g., move to nVCC) may temporarily disrupt continuity for frail older people. Increasing patient and donor engagement will ensure co design of	Provide digital-skills support for patients, donors and carers during consultations, support services and volunteers. Ensure age-friendly communication materials (large print, clear language). Include age monitoring in impact data for pathway redesign.

			blood and cancer services to meet the needs of all protected characteristics. Details The IMTP prioritises earlier treatment, same-day emergency cancer care, better pathway flow and improved palliative care, all of which impact older people most directly due to higher cancer incidence. Digital tools will require targeted support for users with low digital literacy.	
Disability <i>Physical</i> <i>Learning needs</i> <i>Neurodiversity</i> <i>Sensory Loss</i> <i>Mental Health issue</i> <i>Other...</i>	✓	✓	Positive Improved access arrangements through virtual assessment, reduced travel, and more consistent service pathways. nVCC design includes modern accessibility standards, better wayfinding, quieter environments, and digital check-in options. Workforce wellbeing and mental health initiatives contribute positively to staff with disabilities. Increasing patient and donor engagement will ensure co design of blood and cancer services to meet the needs of all protected characteristics. Negative Digital transformation may disadvantage some disabled people without support (e.g., screen reader compatibility, cognitive overload).	Ensure compliance with Web Content Accessibility Guidelines (WCAG). Involve disabled people in testing digital services. Provide offline and telephone routes for all critical pathways. Clear signage and quiet spaces at nVCC.

				Temporary disruption during transitions (construction, service moves) may impact physical access or predictability for neurodivergent patients. Details Some services remain complex for those with sensory, cognitive or physical impairments. Digital or automated processes need robust accessibility standards applied early. The Trust has access to online interpreters for BSL users, including patients and carers. • Velindre Cancer Service has a Video Relay Service (VRS – Convo) available 24/7. This service allows patients or carers to: - o Contact the service if they have concerns following treatment - o Check whether interpreters have been booked for appointments - o Receive support and interpretation into BSL where written or spoken English is difficult to understand	

Gender re-assignment <i>Would this affect those in/post-transition differently?</i>	✓	✓		Positive IMTP commitments to equality, anti-discrimination, anti-racist action plans, and inclusive workforce practices create a safer environment for trans patients and trans staff. Increasing patient and donor engagement will ensure co design of blood and cancer services to meet the needs of all protected characteristics. Negative A lack of explicit references to transgender population health needs may create risk of inconsistent experiences. Details Clinical pathways (cancer, blood, emergency, palliative) must be gender affirming and sensitive to needs such as body dysphoria, name/pronoun use, and safeguarding.	Ensure staff training includes transgender awareness and inclusive communication. Ensure digital systems record preferred names and gender independently of legal sex where clinically appropriate.
Marriage or civil partnership <i>Are people affected differently?</i> <i>Are married people or civil partners treated differently?</i>	✓			Positive No differential access based on marital status. Improved patient communication helps carers/partners be involved earlier. Negative No foreseeable negative impacts. Details	Ensure appointment systems allow flexible inclusion of family/carers contacts.

				Carer-involvement pathways need to be inclusive, recognising diverse family structures.	
Pregnancy or Maternity <i>Whilst pregnant</i> <i>On maternity leave</i> <i>Returning to work</i> <i>Other...</i>	✓	✓		Positive IMTP improvements in women's health pathways, screening, diagnostics and personalised care benefit pregnant people. Flexible outpatient, virtual and community-based care improves access for pregnant patients and new parents. Welsh Blood Service improvements ensure safe donation pathways, including haemoglobin and anaemia monitoring. Negative Service transition periods (e.g., nVCC move) may temporarily affect access. Digital-led models might not meet needs of those requiring face-to-face care during pregnancy. Details Some SACT, radiotherapy, and diagnostic pathways require specific safeguards for pregnant patients.	Ensure maternity-specific clinical alerts in digital systems. Maintain face-to-face options for vulnerable patients. Provide clear patient information on treatment restrictions in pregnancy.
Race <i>Colour</i> <i>Nationality</i> <i>Ethnic group</i> <i>National origins</i> <i>Other...</i>	✓	✓		Positive Strong commitments to reducing health inequalities, widening access to blood and stem-cell donation from ethnically diverse groups, and anti-racist Wales action plan implementation.	Continue targeted recruitment and community engagement with ethnic minority groups. Equality-proof AI and predictive analytics tools before deployment. Ensure interpreters are readily available (face-to-face and telephone).

				Better data and digital monitoring will support tracking of inequity. Outreach and community-based models improve access for areas with higher ethnic diversity. Negative Digital transformation may disproportionately disadvantage groups with lower digital access. Risk of unintentional bias in algorithms or clinical decision tools if not evaluated for equality impacts. Details The IMTP explicitly includes anti-racism, improved access, diverse donor recruitment and widening workforce diversity.	
Religion <i>Affects one religious group more?</i> <i>Clashes with religious holidays?</i> <i>What about groups with no religion?</i>	✓	✓		Positive Patient-centred care pathways allow for personalisation that can accommodate religious needs (e.g., blood product consent, end-of-life preferences). Welsh Blood Service donor panels expanding diversity improve culturally-sensitive provision. Negative Nothing within the IMTP restricts access based on religion. Some appointment times may coincide with significant religious periods unless mitigated.	Provide flexible booking and culturally-sensitive communication. Ensure chaplaincy and spiritual-support access in nVCC plans.

Sex/Gender <i>Does it only apply to men / women?</i> <i>Could this affect one group more than the other?</i>	✓	✓		Positive Women's Health improvements underpin national policy. Equity-focused cancer diagnostics and treatment pathways reduce variation. Workforce equity and anti-harassment plans particularly support women in the workforce. Negative Some digital or remote pathways may disproportionately affect women (e.g., caring responsibilities limiting availability for virtual calls).	Monitor service use by gender to identify emerging inequalities. Ensure appointment pathways consider caring responsibilities.
Sexual Orientation <i>Would this affect any group from LGBTQ+ communities differently?</i>	✓			Positive Commitment to LGBTQ+ Action Plan and inclusive service design. Psychological and palliative services structured around whole-person care will benefit LGBTQ+ people. Increasing patient and donor engagement will ensure co design of blood and cancer services to meet the needs of all protected characteristics.	Include LGBTQ+ representation in patient involvement structures. Staff training on inclusive language and confidentiality.
Socio Economic Duty <i>Low income / no income groups?</i> <i>Rural locations affected differently?</i>	✓	✓		Positive Community-by-design model improves local access and reduces travel costs. Digital services reduce time off work for appointments.	Provide digital-access support (loaned devices, on-site kiosks, telephone alternatives). Monitor postcode-based access inequalities. Include transport-cost mitigation in service redesign

<i>Those with caring responsibilities?</i>				Strong focus on prevention, early diagnosis and care closer to home. Widening access workforce programmes support fair employment. Marmot-aligned actions (transport, sustainability, green spaces) support deprived communities. Negative Digital exclusion may affect those on low incomes or without devices/data. Transition to new sites may temporarily increase travel for some areas.	
Welsh Language <i>Will everything be available bilingually?</i> <i>How many staff might need to know Welsh?</i>	✓	✓		Positive Strong commitment to bilingual services and Welsh Language Standards. New telephony, donor screening, and clinical consultation plan improve bilingual access. Workforce Welsh-language training expanded. Negative Digital content and new systems must be bilingual from launch — risk of delay if not resourced.	All digital systems (PROMs, booking, EPMA, BECS, WLIMS, digital front door) must be bilingual. Continue mystery shopper process and early bilingual testing. Recruit/retain Welsh-speaking clinical staff.

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	VUNHST IMTP 2026-2029
Reference of proposal:	Detailed annual plan and high level 3-year business plan
Details of Board / Committee the paper is being presented to and when:	VUNHST Board 26 th March 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 <i>Click each icon for its definition</i>	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	3	3	The combined IMTP programmes improve safety through strengthened clinical governance, digital prescribing (EPMA), improved transfusion and plasma safety, modernised radiotherapy and SACT systems, earlier recognition of deterioration, better toxicity management, improved

				traceability, modern digital systems, and enhanced urgent oncology response. Safety risks across the organisation are reduced through modern equipment, standardised pathways, improved data accuracy, and enhanced quality assurance.
	+1	3	3	Timely care improves across pathways through digital Patient Tracking Lists, redesigned outpatient and SACT flow, expanded urgent oncology capacity, modernised radiotherapy workflows, better pathway coordination, improved donor and laboratory turnaround times, and reduced bottlenecks linked to manual processes. Improved scheduling, digital automation and increased capacity all support faster assessment, treatment and decision making.
	+1	3	3	Effectiveness increases through evidence based pathways, improved MDT working, new digital radiotherapy/SACT platforms, modernised medicines processes, better alignment to national and European cancer standards (OECI), and improved research/data capability. Standardisation across multiple programmes reduces unwarranted variation and strengthens clinical outcomes
	+1	3	3	Efficiency gains come from digital automation, reduced duplication, modernised workflow design, improved stock control, robotics in aseptic areas, improved mobile session planning for WBS, and alignment of pathways across regions. Modern systems (WLIMS, BECS, RISP, IRS, EPMA) reduce manual workarounds and avoid waste and delays.
	+1	2	2	Equity improves through expanded outreach treatment options, donor diversity programmes, consistent pathway standards across tumour sites, consistent access to modern radiotherapy and SACT across regions, and improved digital accessibility. Some digital-exclusion risks remain but are mitigated by targeted support.
	+1	3	3	Person centred care is strengthened through clearer communication, expanded supportive and palliative care services, digital tools and patient engagement, improved treatment experience, predictable pathways, reduced delays, and improved access to psychological and holistic support.

Overall impact	Overall Impact: Positive – High level <i>The organisation wide review demonstrates that IMTP programmes collectively improve safety, timeliness, experience, effectiveness, efficiency and equity.</i> <i>The quality impact is strongly positive and supports the safe and sustainable modernisation of cancer services, blood services and digital systems</i>

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 <i>Click each icon for its definition</i>	Amount of activity required High (3), Medium (2) or Low (1)	Key points and actions to achieve the changes required
	3	Substantial strategic and clinical leadership required across all programmes to manage digital transformation, nVCC readiness, clinical pathway redesign, national WBS programmes and cross system governance.
	3	Significant workforce training, digital capability development, new roles, extended hours models (e.g., AO, PEOLC), and specialist staffing for SACT, radiotherapy, digital systems and WBS.
	2	Cultural change needed to support digital first working, continuous improvement, MDT collaboration, equity focus, person centred care and psychologically safe environments.
	3	Upgrades to RISP, IRS, WLIMS, BECS, EPMA, analytics, cyber security, digital front door, patient engagement and high data quality expectations across all services.
	2	Ongoing audits, PROMS/PREMS, OEI aligned standards, continuous learning from incidents, and research enabled digital infrastructure.
	3	Collaboration across Health Boards, national digital bodies, regional cancer services, transplant networks, transfusion laboratories, and primary/community care.

Overall amount of activity required	Overall Activity Required: High <i>Delivering the IMTP portfolio requires largescale workforce, digital, cultural and operational transformation and coordination across multiple regional and national partners.</i>

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)

Level of risk to Quality of implementing this proposal	Low	Low/medium	Medium	Medium/high	High
Level of risk to Quality of NOT implementing this proposal	Low	Low/medium	Medium	Medium/high	High

Describe the main risks to Quality of implementing this proposal?
Describe the main risks to Quality of NOT implementing this proposal?

RISK OF IMPLEMENTING — MEDIUM/HIGH

Main risks:

- *Digital transition instability (EPMA, IRS, RISP, WLIMS, BECS).*
- *Workforce pressure during major service redesigns.*
- *Variation in readiness across teams and sites.*
- *Temporary service disruption during changeover periods.*
- *Interdependency risk between programmes.*
- *Data quality and digital literacy challenges.*

RISK OF NOT IMPLEMENTING — HIGH

Main risks:

- *Continued safety risk from outdated systems and workflows.*
- *Reduced clinical effectiveness and widening variation in care.*
- *Inability to meet national cancer and WBS quality standards.*
- *Increased delays across all pathways (RTT, SACT, AO, OPD).*
- *Reduced resilience in transfusion, transplantation and plasma supply.*
- *Digital and cybersecurity vulnerabilities.*
- *Loss of equity improvements and patient experience gains*

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
<i>Kathy Ikin Deputy Director Transformation, Planning & Performance 6th March 2026</i>	<i>Carl James Chief Executive Officer (Interim) 17th March 2026</i>	<i>N/A</i>

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
Nicola Williams, Executive Director Nursing, AHP & Health Science 17/3/26	Dr Jacinta Abraham, Executive Medical Director 18/03/26	N/A

Benchmarking

WBS Benchmarking

The WBS participates annually in the European Blood Alliance (EBA) benchmarking programme, which allows us to compare our performance across approximately 25 European blood services.

Each year, EBA issues a standardised dataset and analytical presentation, from which WBS extracts benchmark indicators covering donor behaviour, operational productivity, component utilisation, workforce metrics, testing performance, losses and wastage, and supply/demand trends.

This intelligence helps us understand underlying trends and supports continuous improvement across the service.

Each year's dataset is reviewed to identify WBS's position across the comparative range, with particular attention given to areas where we appear in the upper or lower quartiles, ensuring that both strengths and pressure points are clearly understood.

This benchmarking activity forms part of our broader effort to strengthen service intelligence and align with international best practice.

EBA outputs feed directly into WBS Futures, identifying area for improvement and leading to prioritisation within our IMTP Delivery Plan. These actions complement national work under the Blood Health Plan for Wales to deepen understanding of variation, performance, and system demand.

VCS Performance Benchmarking

Performance Framework and Waiting List Management

Velindre Cancer Services is developing a performance framework and structured waiting list management processes. This includes:

- Patient Tracking Lists
- Electronic Hospital Initiated Referral system
- Standard operating procedures for waiting list management

These tools increase visibility of patient pathways and enable reporting against targets such as the Suspected Cancer Pathway.

Cancer Service Specific Metrics - Use of English Model Health System to Benchmark Specialist Cancer Services

- The Model Health System (MHS) is NHS England's data driven improvement and benchmarking platform, includes Model Health System view for provider-level benchmarking
- Provides peer comparative insights across quality of care, productivity/efficiency, responsiveness, workforce, finances, and organisational culture, enabling identification of unwarranted variation and opportunities for improvement
 - o dedicated compartments for theatre productivity, diagnostics, urgent & emergency care, patient safety/quality, workforce, medicines optimisation, and more
 - o Clinical specialties & programmes: Deep integration with GIRFT (Getting It Right First Time)
- Breadth and depth of comparators: For specialist cancer providers MHS and NHS England datasets (including NCCI) provide the most complete UK benchmarks for productivity, workforce, pathway performance and cost—supporting rapid opportunity identification for 2026- 2027 planning.

- Improvement Opportunities:
 - o Identify gaps in productivity, quality, and cost
 - o Target unwarranted variation in clinical pathways
 - o Align improvement plans with national best practice
 - o Support IMTP/QSP performance packs with robust external comparators

Approach to Specialist Cancer Benchmarking using MHS

- **Define a peer set:** Prioritise English specialist cancer trusts (Christie, Clatterbridge, Royal Marsden) for pathway-level benchmarking across SACT, radiotherapy, outpatient flow, theatres, and workforce productivity.
- **Focus on GIRFT specialty views:** Use GIRFT dashboards in MHS to target **variation drivers** (e.g., day-case conversion, theatre turnaround, length of stay, readmissions) and cross-reference with HVLC pathways relevant to oncology and perioperative services.
- **Triangulate with finance/costing:** Align MHS productivity findings with **NCCI/PLICS** outputs and ESR workforce profiles to size **cashable vs. non-cashable** opportunities (e.g., agency reduction, procurement price convergence, throughput gains).

VCS Proposed Benchmarking Metrics

Metric / Area	Velindre Cancer Centre	The Christie NHS Foundation Trust	The Clatterbridge Cancer Centre	The Royal Marsden NHS Foundation Trust
LINACs (Radiotherapy Machines)	Data available internally	Data via MHS	Data via MHS	Data via MHS
Annual Radiotherapy Fractions	Data available internally	Data via MHS	Data via MHS	Data via MHS
Av. Fractions per Linac	Data available internally	Data via MHS	Data via MHS	Data via MHS
Systemic Anti-Cancer Therapy (SACT)	Data available internally	Data available via MHS	Data available via MHS	Data available via MHS
Outpatient Attendances	Data available internally	Data available via MHS	Data available via MHS	Data available via MHS
Workforce (WTE, Trust-wide)	Data available internally	Data available via ESR/MHS	Data available via ESR/MHS	Data available via ESR/MHS
Activity Growth (2019/20–2025/26)	Data available internally	Data available via MHS	Data available via MHS	Data available via MHS
Radiotherapy Delivery Growth	Data available internally	Data available via MHS	Data available via MHS	Data available via MHS
SACT Delivery Growth	Data available internally	Data available via MHS	Data available via MHS	Data available via MHS
Mortality & Quality Metrics	In development	Available via MHS/GIRFT	Available via MHS/GIRFT	Available via MHS/GIRFT

Oncology Patient Reported Experience & Outcomes (PREMs/PROMs)	Developing – Limited data	Available via MHS	Available via MHS	Available via MHS

Additional Metric / Area	Velindre	Christie	Clatterbridge	Royal Marsden
Total Operating Expenditure (£m)	Data available internally	Data via MHS	Data via MHS	Data via MHS
Cost per Radiotherapy Fraction (£)	Data available internally	Data via MHS	Data via MHS	Data via MHS
Patient Safety Incidents (per 1,000)	In development	Via MHS/GIRFT	Via MHS/GIRFT	Via MHS/GIRFT
30-day Mortality (SACT/Radiotherapy)	In development	Via MHS/GIRFT	Via MHS/GIRFT	Via MHS/GIRFT
Day Case Rate (Oncology)	Data available internally	Data via MHS	Data via MHS	Data via MHS
Average Length of Stay (days)	Data available internally	Data via MHS	Data via MHS	Data via MHS
Pathway-Specific Metrics (e.g., SACT)	Data available internally	Data via MHS	Data via MHS	Data via MHS

Cancer Waiting Times Benchmarking

The Cancer Standards metrics for England and Wales are not directionally comparable i.e. when data for Wales has been mapped to NHS England definitions, this is NOT equivalent. This is due to differences in definitions, numerators, denominators, clock rules, and inclusion/exclusion criteria are not the same. These differences need to be clearly understood to enable meaningful benchmarking.

1. Clock rules differ

- NHS England Cancer Standards, radiotherapy, and SACT clocks have **nationally mandated start/stop rules** embedded in MHS.
 - Faster Diagnosis Standard (28 days)
 - Decision-to-treat Treatment (31 days)
 - Cancer Treatment Standard (62 days)
- NHS Wales PMF measures are based on guidance:
 - 62 day clock starts at Point of Suspicion (PoS) rather than point of referral
 - Treat suspensions, pauses, or clinical deferrals differently
 - Apply different rules for pathway breaks or transfers

2. Population coverage differs

- MHS specialist trust figures typically include **all England-defined consultant-led pathways**.
- Velindre PMF figures are based on Welsh National guidance, which:
 - Exclude certain pathway types

- o Use service-specific filters (e.g. cancer-only cohorts)

Again, until formally reconciled, this affects comparability.

A key part of the Benchmarking & Productivity Programme will be to undertake definition alignment and assurance work to ensure that any identified improvement opportunity is not due to definition differences.

Velindre data will be benchmarked against Peer data for The Christie, the Clatterbridge, and the Royal Marsden based on the latest Model Health System and NHS England league tables for specialist cancer trusts. Where exact peer data is not available, values are estimated from published league tables and Model Health System dashboards for the relevant period.

Key areas of focus will be

- Radiotherapy
- SACT
- Peer performance
- How benchmarking can translate into an improvement plan
- Dashboards for each level of the organisation

Performance & Efficiency

Improving our efficiency and productivity is focused in our workforce supply management and non-pay expenditure. Our workforce controls relate to sickness absence management, effective job planning and agency staff management.

Job Planning

The Job Plan compliance level in January 2026 was 88% with a target of 90% by the end of 2026-2027. The impact of our actions to improve job plan compliance will have the following impact.

A 2% increase applied to the Trust's consultant workforce (64.22WTE) and applying an assumption that each non-compliant job plan equates to 0.5DCC 'surplus' sessions per week. This amounts to c0.05WTE. This is capacity equivalent to approximately 0.06WTE, delivering C.105 additional net productive hours per annum. This would produce approximately 26 additional DCC sessions (clinical activity) per annum.

If this methodology is applied with a more optimistic, (but still reasonable assumption of 1 DCC session per week, this increase to approximately 52 additional consultant clinical sessions per annum.

Benefits will be:

- Better alignment of consultant time to demand
- Improved visibility of DCC vs SPA balance
- Stronger grip on clinic templates to support more affect patient scheduling, MDT capacity and support the SACT and RT times for treatment
- Support targeted action on SACT/RT service pressure areas and high impact tumour groups

Sickness Absence Reduction

The Trust achieved a sickness absence reduction from 5.7% to 5.1% in 2025-2026. The Trust recognises that during periods of major change, sickness absence is often adversely affected. We will strengthen access to our support services during the transition to nVCC to mitigate the impact on staff absence. The Trust acknowledges the scale of change of transition to nVCC and therefore have reflected an ambition to ensure staff sickness does not deteriorate from the 2025-2026 position

of 5.1%. The reduction achieved in 2025-2026 applied across the Trust workforce (1,703FTW), this equates to approximately 6.8 WTE of additional capacity.

Using a net available hours assumption of 1,650 hours per WTE per annum, this delivers c11,200 additional productive hours per year during this financial year.

From a 'value' perspective this will produce a material non cashable productivity gain which can contribute to reduced pressure on agency and bank staff usage, overtime and resilience gaps in workforce.

Medicines Management

In March 2026, the Medicines Management Group of the Trust will be producing a formal response and action plan on the Nationally agreed Medicines Value and Sustainability priorities for NHS Wales 2026-2027. The Recommendations 1(b), and 3-6 are not applicable to the Trust. Our summary plan on recommendations 1 (a), 2 (a) and 2(b) are:

1. (a) Maximise biosimilar use, including preferential use of best value biologic where appropriate. In the 'Drugs from Basket' options, Bevaizumab used in treatment for colon and gynaecology cancer patients, is relevant. The Trust implemented this switch in November 2025.
2. (a). Maximise on-contract generic medicine use in secondary care –Trust 'Drugs from Basket' which are applicable to the Trust are, apixaban, and abiraterone. We have identified an error with the data recording for abiraterone, which is dispensed in the Medicines at Home Setting. Once the data errors have been adjusted this should reflect a 100% utilisation measure for the Trust.
2. (b). The Trust purchases axitinib according to the All Wales Drug Contract. It is a dual award contract which is purchased on generic naming. It is switched to a branded product if out of stock. This switch is of generic name and brand name is the data error recording for abiraterone, and the same data error applies to axitinib.

Income Assumptions

Income Assumptions and Extent of Alignment with Commissioner and WG Plans:

The following are the income growth assumptions the Trust has made to meet the unavoidable inflationary, demand and growth pressures forecast during 2026-27:

- Commissioners will uplift LTA values by 1.11% which amounts to £1.141m core uplift in 2026-27. For planning purposes, the Trust is assuming a 1.0% uplift to LTA values for 2027/28 and 2028/29. The Trust expectation is the uplift is 1.11% and will be passed on by the commissioners as clearly set out in the Health Board Allocation Letter
- The Trust will receive a further loss of LTA income from Hywel Dda UHB based on the historic activity shares baseline funding allocation which is on top of the £0.825m loss incurred during 2025-26. In addition, there is a risk on the baseline cash allocations of c£0.290m.
- Commissioners will pass through as additional income to the LTA the 2025/26 Agenda for Change (AfC) Medical and VSM staff costs as per the WG Pay award matrix.
- The 2026-27 Pay Inflation of 3.3% expected to be funded directly by WG over the 3 years of the IMTP (any shortfall such as staff increments and use of bank staff will need be met by discretionary uplift, additional savings or absorbed by Divisions).
- **In line with WG guidance any planning assumption for the 2026-27 pay award is excluded from the IMTP financial plan, but the assumption is WG will continue to fund on the basis above.**
- Funding for the Real Living Wage (the impact of the policy on Social Care) will be dealt with as a non-recurrent allocation, addressed in year.
- Funding for the increase in Employer's National Insurance Contributions that came into effect on 1st April 2025 is provided to the Trust at the same rate of 2025/26 and will be passed through on a recurrent basis from the Trust Commissioners via the LTA agreement on the agreed historic share basis.
- The cost increase in employer's pension contributions from 14.3% to 23.7% will continue to be paid by WG. **(As per WG guidance this is again excluded from the plan.)**
- Allocations for accelerated depreciation, AME depreciation for donated assets, relevant IFRS 16, and DEL and AME impairments will be issued as direct funding from WG. This will also apply to any increases in depreciation related to approved schemes with confirmed strategic support.
- Activity demand modelling forecasts £1.135m additional LTA marginal cost income above the 2024-25 projected outturn.
- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs VCS uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to a £7.7m increase in 2026-27.

- The Trust will receive pass through income from LHBs through their SLAs to cover the cost of wholesale blood derived products WBS supplies to them. The forecast annual cost growth for 2026-27 has been calculated based on an estimated 12% volume growth and general price inflation totalling £3.5m.
- In 2022-23 the Trust secured funding from WG from the Value Based Healthcare (VBHC) fund. Funding during 2026-27 will be passed through on a recurrent basis from the Trust Commissioners via the LTA agreement on the agreed historic share basis.
- The SDEC funding for 2026-27 will be passed through on a recurrent basis from the Trust Commissioners via the LTA agreement on the agreed historic share basis.
- WG and / or JCC will fund the WBS business cases resubmitted in 2026-27 however this remains a significant risk to the Trust.
- WBS has been managing a number of financial risks within the service that support supply chain sufficiency, demand and patient safety. In addition, since the publication of the Infected Blood Inquiry in May 2024, the service will be required to improve patient safety for transfusion wherever possible.

The Trust submitted six WBS business cases during 2025/26 relating to key service areas for consideration that help either maintain or improve the safety of the supply chain for the transfused patients in Wales. These cases included:

1. Plasma for Medicines: Implementation of the Welsh Government Policy for the collection, processing and supply of plasma for the manufacture of Immunoglobulin and Albumin products.
2. Red Cell Immuno-haematology Laboratory: £0.251m for additional capacity 24/7 for the Red Cell Immunohaematology laboratory
3. Haemoglobin S screening: £0.052m for implementation of Haemoglobin S (HbS) testing to comply with national guidance
4. Blood Component Development: £0.703m for investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns
5. Buccal Swab Pathway: £0.259m for introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel
6. Blood Donation Team Resilience: £0.266m for additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.

JCC has not approved additional funding for any of the business cases for WBS. This places a significant increased financial risk on the Trust as these cases are necessary to maintain and improve quality and safety, so the Trust in 2025/26 was forced to make the investment at financial risk. The cases have been resubmitted to JCC for consideration as part of the 2026-27 IMTP process.

- WG will support the significant investment required in WBS and wider NHS Wales to deliver the actions required to meet the recommendations from the Infected Blood Inquiry (IBI) Report, ensuring quality and safety within the Welsh Blood System. The investment required in WBS to respond to recommendation 8 are set out in the Business Cases that have been submitted to JCC and shared with WG seeking funding consideration.

The current approved VCS Service Growth investment is provided in the table below:

VCS Service Growth Investment	2026/27		Incremental Income		
	LHB (£000)	TOTAL (£000)	IMTP Total 2026/27 £000	IMTP Total 2027/28 £000	IMTP Total 2028/29 £000
Acute Oncology Services	989	989	296	0	0
Integrated Radiotherapy Solution	1,162	1,162	(50)	18	42
Radiotherapy Satellite Centre	1,487	1,487	139	30	30
nVCC Revenue Budget Recurrent		0	0	39,368	0
nVCC Revenue Budget Non-Recurrent		0	0	2,412	(2,412)
SACT (MIFs)	100	100	100	100	100
Total Approved Service Improvement & Growth	3,738	3,738	485	41,928	(2,240)

- The current financial plan assumes no additional internal investments in major programmes and projects beyond resources agreed within approved business cases. Any additional funding requirements will either need to be met through a reallocation of existing resources, additional savings above the £2.000m target or additional commissioner funding following consideration of a business case.

Pay Related Cost Assumptions:

- Expectation that Pay inflation funding received will cover the cost growth based on actual staff in post. (Any shortfall such as the cost of increments and the use of bank staff will need be met by additional savings or absorbed by service Divisions).
- The Trust financial plan assumes a £1.5m divisional vacancy factor target through natural staff turnover, which will need to be achieved on an ongoing basis in order to balance the overall financial position.
- In line with the guidance the 2026-27 pay inflation and employer's pension contributions from 14.3% to 23.7% have been excluded from the financial plan.

Non-Pay Related Cost Assumptions:

- The national / general cost pressures have currently been estimated at £1.571m for 2026-27 which includes the anticipated increase in WRP costs (£0.948m) on a non-recurrent basis. General Non-Pay inflation is forecast to be 2.5% c(£0.120m).
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 1.11% have been assumed for 2026-27 on the basis of a 1.11% core funding uplift to LTA values is passed through to the Trust.

National / General Cost Pressures:

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
ESR (Funded via WG 25/26 & 26/27)	Trust	Rec	0
BMA Pay Negotiations (TBC)	Trust	Rec	300
Total National Cost Pressures			1,571

Local Core Service Growth and Cost Pressures:

- The Trust has undertaken a review of its local core service growth and cost pressures, which has resulted in a number being mitigated, removed or costs reduced.
- The cost pressures in the table below are included in the financial plan as needed to meet demand, quality & safety statutory requirements and essential Trust wide infrastructure so unavoidable for 2026-27:

Local Cost Pressures	Division	Recurrent/ Non- Recurrent	2026/27 £K
RISP	VCS	Rec / Non Rec	183
Marginal Income underachievement	VCS	Rec	500
C&V Pathology SLA	VCS	Rec	157
VCS Pay Increments (50%)	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 (50%)	WBS	Rec	87
RD&I Pay Increments (50%)	RD&I	Rec	48
VCS Estate running costs	Corporate /VCS	Non Rec	300
Corporate Pay Increments (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

- The current financial plan assumes that national and local cost & growth pressures that have been identified as unavoidable for 2026-27 will be funded in part by the 1.11% LTA core uplift and in part from savings delivery.
- Other local pressures of c£1.000m are expected to be mitigated or managed at Divisional level.

Other Assumptions:

- Prioritised service developments over the course of the year will be submitted to commissioners as business cases for funding consideration however there is clear expectation that no funding will be provided.
- No additional investment in major programme / project resources beyond those agreed in capital business cases.
- Divisions will mitigate or manage other local cost pressures not recognised in the financial plan.
- Other new cost pressures that may materialise over the period are either avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be required to fund them.

Investment in organisational staff capacity and capability to deliver major change Programmes is required to progress regional work to deliver improved cancer services,

establish clinical leadership and to meet statutory duties around quality & safety and duty of candor.

Without funding support for major change capacity and capability the Trust is considering what decisions are required with regards to reallocation of existing resources or delivery of additional savings and efficiencies, but this is proving difficult given competing priorities and will only enable a small element of the staff capacity and capability to be implemented with consequential impact on delivery of major change.

Planned Savings

The following table summarises the level of savings the Trust is planning to deliver in 2026-27.

Savings Plan	2026/27 £m
CIP Planned Savings	1.4
Income Generation	1.2
Total Savings / Income Generation	2.6
CIP % (of Core LTA values)	2.5%

The Trust has currently Identified schemes against full savings target of 2.647m, (£1.458m RAG Green, £1.189m RAG Amber.

	Recurrent	Non Recurrent	TOTAL
Saving RAG Rating	£k	£k	£k
Green RAG Rated Schemes	746	712	1,458
Amber RAG Rated Schemes	517	673	1,189
Red RAG Rated Schemes	0	0	0
Total	1,263	1,308	2,647

Savings Plan by Division	Target £K	Identified (Green) £k	Savings Target Gap £k
Welsh Blood Service	880	880	0
Velindre Cancer Centre	1,302	500	(802)
Corporate Services	178	78	(100)
RD&I	287	0	(287)

Total	2,647	1,458	(1,189)

- Work is ongoing within the Divisions to urgently finalise the savings plans and address those schemes that are RAG rated amber. Each Senior Management member has been assigned a target to achieve, ensuring ownership and clear routes for escalation.

Contracting Model & National Funds Flow Framework:

LTA Contract Rebasing for Velindre Cancer Services:

- The Trust was unable to complete the proposed LTA Contract Rebasing exercise during 2025/26.

In 2018-19, Commissioners agreed to re-base LTAs from 2004-05 activity and prices to a more current baseline, originally proposing 2019-20 with financial neutrality managed through Welsh Government allocation adjustments. This was not implemented due to COVID. In 2023-24, Commissioners agreed to revisit re-basing using 2023-24 as the baseline year. All Health Boards agreed to this year, but all except Hywel Dda UHB agreed to neutralise the financial impact through allocation adjustments.

Due to the lack of collective agreement, the Trust issued 2024-25 LTAs on historic shares. All Health Boards accepted this approach except Hywel Dda, which unilaterally re-based its LTA to 2023-24 outturn, reducing Trust income by £0.843m (£0.360m activity and £0.483m NICE/HCDs). To avoid arbitration, the Trust agreed a compromise: a non-recurrent £0.483m reduction in NICE/HCD income only, with no change to the activity baseline.

During 2024-25, Commissioners again failed to reach collective agreement on the LTA re-basing principles. For 2025-26, the Trust agreed an increased non-recurrent £0.825m reduction in Hywel Dda's NICE/HCD funding (100% of the difference between historic shares and resources consumed) to avoid an arbitration process. This was again in the hope that commissioners would reach a collective agreement on LTA re-basing principles, which has not happened, although the DDoF have established a working group to review LTA principles across NHS Wales, which may provide resolution for the 2027-28 financial year.

For 2026-27, Hywel Dda has stated it will apply a recurrent £0.825m NICE/HCD reduction and will move to an actual recharge from the historic share basis on activity. This approach is not agreed by the Trust Board and is inconsistent with previously agreed Commissioner principles. The Trust has therefore reflected this £0.825m income reduction non-recurrently in its financial plan, alongside non-recurrent savings.

There are still ongoing discussion regarding the historic ring fenced allocations (including Capital Charges, pay lifts, infl uplifts etc) totalling £0.290m. However, there is agreement from Hywel Dda UHB that on the Trust providing evidence to support these funding arrangements that Hywel Dda UHB will settle the full cash allocations.

Hywel Dda has suggested that its patients have materially moved away from Velindre. The Trust does not agree. Only a small cohort (c4%) of specialist SABR radiotherapy activity transferred following Velindre Trust training of Swansea oncologists in this specialist treatment. Forecast activity for 2025-26 is c1,055 treatments compared with 1,202 in 2019-20, a 12% reduction that does not represent a material shift and already delivers marginal cost savings through the LTA to Hywel Dda UHB.

Furthermore, discussions with Swansea UHB indicate that additional radiotherapy capacity is likely to be commissioned from other providers in 2026-27 to support cancer waiting times target delivery, which Velindre has been in initial discussions with Swansea around providing. This would lead to additional Hywel Dda activity flowing to Velindre.

To ensure the full cost of Velindre specialist cancer services is funded, all Commissioners must agree to move from historic shares based on 2004-05 activity and NICE consumption to a current activity and consumption baseline. Hywel Dda has unilaterally made this decision without Velindre other commissioners' agreement to pick up the funding reduction, essentially meaning the Trust fixed costs are no longer fully funded. Velindre view is Commissioners must collectively agree how to manage the resulting financial gains or losses between themselves; applying different principles is not acceptable as it potentially leads to the Trust fixed costs not being funded as has happened with Hywel Dda's approach.

Despite support from all other Commissioners that LTA principles should be applied consistently, the Velindre Director of Finance has again reluctantly agreed LTA principles on a non-recurrent basis with the Hywel Dda UHB Director of Finance.

Financial Risks and Opportunities:

There are several financial risks that could impact on the successful delivery of the plan. The Trust recognises these and is taking appropriate actions as set out below, to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed, and any identified risks are included within the Board Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Cost £m	Description
Commissioners not supporting Service Investment / Growth in VCS	TBC	Several service growth investments were presented to the Trust Commissioners as part of last year's IMTP process, however, there has since been a firm stance that no commitment will be made this year. The Trust re-submitted the service growth investments to our Commissioners on the 22 nd October in line with the IMTP governance timeline process for 2026/27 with the Trust Commissioners confirming that no funding will be allocated this year to support these investments.
Radiotherapy Activity Income UnderAchievement	(0.300)	A risk has emerged, and crystallised in part, whereby the forecast activity income is not expected to match the level of investment in the Workforce. £0.500m crystallised in 2025/26 which will be funded via the VCS anticipated marginal income during 2026-27 with a further £0.300m being held as a risk with hope that activity will increase next year.
Management of operational Pressures	(0.500)	Cost pressures that may emerge over the course of the year that cant be mitigated or are beyond divisional control. As in last year current status is the Trust will expect to manage these cost pressures non-recurrently during 2026-27 however remains a risk due to the financial challenges facing the Trust.
Hywel Dda UHB LTA baseline Cash allocations	(0.290)	The Trust has faced further challenges from HD in terms of the WG direct funding allocations such as Capital Charges, Pay Award, Energy funding, prior Service Investment, and the National Discretionary are provided to the Trust via the LTAs as per the Trust funding model. The current gap in agreed position is £0.290m.
Total Risks	(1.090)	
Key Financial Opportunities	Cost £m	Description
Vacancy Savings	0.200	Further vacancy turnover savings above the vacancy factor held in divisions
Bank interest overachievement	0.200	Potential for further overachievement of bank interest above budget set to support cost pressures and savings target.
Total Opportunities	0.400	
Net Financial Risk	(0.690)	

Value & Sustainability

- The Trust is committed to delivering the minimum 2% savings in the next financial year. Further, we will continue to integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline.
- The Trust will continue with the Finance and Investment Enhanced Monitoring arrangements as enhanced measures.
 1. Savings delivery
 2. Cost control
 3. Choices and Options which could contribute towards wider system financial pressures
 4. Impacts of spending decisions considering quality, safety, experience and value

This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust.

It will provide an additional level of assurance before reporting to external monitoring bodies including:

- o Monthly Value and Sustainability Board
 - o WG / NHS Exec Quarterly Reviews – JET & IQPD
- The Trust is continuing to review its productivity & efficiency using measures to compare to its peer organisations in England – The Clatterbridge Cancer Centre, The Christie, Royal Marsden, and Leeds Cancer Care to identify areas of improvement.
- The Trust is committed to reducing its reliance on the use of agency staff and the premium costs associated. A significant reduction was seen over the course of 2024-25 with further progress made in 2025-26. Minimal, exceptional spend is forecast for 2026-27 only where service needs can only be met via this.
- Divisions will continue to review non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.
- The Trust will continue to explore ways to deliver value through the organisation and relieve financial pressures across the Welsh NHS system.

Capital Plans for the Trust

The focus of the Capital Investment Programme is to maintain a high-quality environment in which to collect, transport, process and supply blood, treat cancer patients and provide modern treatment equipment.

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. These include:

All Wales Approved and Unapproved Capital Schemes	2026-27	2027-28	2028-29	2029-30	Further Years	Total All Wales Schemes
£m	£m	£m	£m	£m	£m	£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

Trust Discretionary Capital Funding:

Per the allocation letter the Trust discretionary allocation of £2.240m for 2025-26 is an increase of £0.240m (12%) from the £2.000m allocated during 2025-26.

Depreciation Funding:

The Trust will require additional WG funding to support the accelerated depreciation in relation to the existing cancer centre building and equipment.

The total cost for the accelerated depreciation is expected to be £35.441m with £21.414m having been funded during the two years 2024-26. This will leave a required funding balance of £13.997m over the three years of the IMTP 2026-27 to 2028-29. These costs are set out in the table below and were approved as part of the nVCC FBC:

Depreciation Forecast	2026-27	2027-28	2028-29	Further Years	Total All Wales Schemes
	£m	£m	£m	£m	£m
Baseline Specific Depreciation	4.958	4.671	4.541	0.000	14.170
Strategic/All Wales Depreciation	4.924	9.706	9.155	0.000	23.785
Accelerated Depreciation nVCC	10.877	3.120	0.000	0.000	13.997
Baseline Depreciation Funding	-6.208	-6.208	-6.208	0.000	-18.624
Total	14.551	11.288	7.488	0.000	33.328

27 February 2026

Jacqueline Totterdell

Director General of Health and Social Services
and Chief Executive of NHS Wales

Dear Jacqueline,

Re: IMTP Financial Plan and Long-Term Agreements (LTAs) for 2026-27

I am writing to update you on the position regarding Velindre University NHS Trust's LTAs with Commissioners, as required by the Health Board Allocation Letter, and to outline the key assumptions and risks within our draft IMTP.

All Commissioners have confirmed they will pass on the 1.11% uplift through LTAs which the Trust is using to support inescapable demand and unavoidable core cost inflationary pressures. No additional funding beyond this uplift has been agreed by Commissioners for either VCS or WBS, despite increasing demand leading to cancer waiting time pressures as well as quality & safety pressures. The Joint Commissioning Committee (JCC) has not approved funding for WBS business cases that would improve assurance of blood supply in Wales and enable implementation of quality and safety recommendations arising from the Infective Blood Inquiry.

The Trust has agreed LTA funding principles with all Commissioners for VCS and WBS. However, to reach agreement with Hywel Dda UHB, the Trust has again had to accept a non-recurrent loss on LTA income because of Hywel Dda UHB unilaterally re-basing its LTA. The history and detail of this position are set out in Annex 1. This matter has been discussed with Hywel Jones, Director of Finance, HSSG Welsh Government, and his team, and we are continuing to work with Hywel Dda to identify a sustainable resolution.

Aside from this, the Trust has not yet received confirmation of continued Welsh Government funding for HTW in 2026-27 and has assumed £1.517m within its financial plan. Shared Services, a statutory responsibility of the Trust, will submit a separate IMTP following endorsement in March 2026.

The draft IMTP financial plan is balanced across 2026-27 to 2028-29. To achieve balance in 2026-27, the Trust must fund £4.9m of inescapable demand and unavoidable core cost inflationary pressures through a minimum 2.5% savings target £2.6m, full utilisation of the 1.11% uplift funding £1.15m, and activity growth marginal income of £1.15m. We have a range of actions in place to manage and mitigate the identified risks associated with the financial plan.

The draft IMTP will be considered by the Trust Strategic Development Committee on 17 March and approved by the Trust Board on 26 March.

In summary, we have LTA agreements in place with all commissioners but as set out above we have had to agree a non-recurrent reduction in funding with Hywel Dda.

I hope this provides the context for our planned submission of a financially balanced IMTP; confirms LTA principles are agreed, however highlights the ongoing LTA discussions with Hywel Dda UHB, and confirms we have mitigating actions to manage the associated financial risks. Whilst the outcome of the Hywel Dda LTA principles discussion is important, I have sufficient confidence that we can achieve financial balance.

Yours sincerely,

Carl James

Chief Executive (interim)

c.c. Hywel Jones, Director of Finance, HSSG Welsh Government

Annex 1

Hywel Dda UHB LTA

In 2018-19, Commissioners agreed to re-base LTAs from 2004-05 activity and prices to a more current baseline, originally proposing 2019-20 with financial neutrality managed through Welsh Government allocation adjustments. This was not implemented due to COVID. In 2023-24, Commissioners agreed to revisit re-basing using 2023-24 as the baseline year. All Health Boards agreed to this year, but all except Hywel Dda UHB agreed to neutralise the financial impact through allocation adjustments.

Due to the lack of collective agreement, the Trust issued 2024-25 LTAs on historic shares. All Health Boards accepted this approach except Hywel Dda, which unilaterally re-based its LTA to 2023-24 outturn, reducing Trust income by £0.843m (£0.360m activity and £0.483m NICE/HCDs). To avoid arbitration, the Trust agreed a compromise: a non-recurrent £0.483m reduction in NICE/HCD income only, with no change to the activity baseline.

During 2024-25, Commissioners again failed to reach collective agreement on the LTA re-basing principles. For 2025-26, the Trust agreed an increased non-recurrent £0.825m reduction in Hywel Dda's NICE/HCD funding (100% of the difference between historic shares and resources consumed) to avoid an arbitration process. This was again in the hope that commissioners would reach a collective agreement on LTA re-basing principles, which has not happened, although the DDoF have established a working group to review LTA principles across NHS Wales, which may provide resolution for the 2027-28 financial year.

For 2026-27, Hywel Dda has stated it will apply a recurrent £0.825m NICE/HCD reduction and will move to an actual recharge from the historic share basis on activity. This approach is not agreed by the Trust Board and is inconsistent with previously agreed Commissioner principles. The Trust has therefore reflected this £0.825m income reduction non-recurrently in its financial plan, alongside non-recurrent savings.

There are still ongoing discussion regarding the historic ring fenced allocations (including Capital Charges, pay lifts, infl uplifts etc) totalling £0.290m. However, there is agreement from

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

Hywel Dda has suggested that its patients have materially moved away from Velindre. The Trust does not agree. Only a small cohort (c4%) of specialist SABR radiotherapy activity transferred following Velindre Trust training of Swansea oncologists in this specialist treatment. Forecast activity for 2025-26 is c1,055 treatments compared with 1,202 in 2019-20, a 12% reduction that does not represent a material shift and already delivers marginal cost savings through the LTA to Hywel Dda UHB.

Furthermore, discussions with Swansea UHB indicate that additional radiotherapy capacity is likely to be commissioned from other providers in 2026-27 to support cancer waiting times target delivery, which Velindre has been in initial discussions with Swansea around providing. This would lead to additional Hywel Dda activity flowing to Velindre.

To ensure the full cost of Velindre specialist cancer services is funded, all Commissioners must agree to move from historic shares based on 2004-05 activity and NICE consumption to a current activity and consumption baseline. Hywel Dda has unilaterally made this decision without Velindre other commissioners' agreement to pick up the funding reduction, essentially meaning the Trust fixed costs are no longer fully funded. Velindre view is Commissioners must collectively agree how to manage the resulting financial gains or losses between themselves; applying different principles is not acceptable as it potentially leads to the Trust fixed costs not being funded as has happened with Hywel Dda's approach.

Despite support from all other Commissioners that LTA principles should be applied consistently, the Velindre Director of Finance has again reluctantly agreed LTA principles on a non-recurrent basis with the Hywel Dda UHB Director of Finance.

Quality-driven decision-making

Quality Impact Assessment

Title of proposal this Quality Impact Assessment (QIA) is supporting:	<i>VUNHST IMTP 2026-2029</i>
Reference of proposal:	<i>Detailed annual plan and high level 3-year business plan</i>
Details of Board / Committee the paper is being presented to and when:	<i>VUNHST Board 26th March 2026</i>

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 <i>Click each icon for its definition</i>	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	3	3	The combined IMTP programmes improve safety through strengthened clinical governance, digital prescribing (EPMA), improved transfusion and plasma safety, modernised radiotherapy and SACT systems, earlier recognition of deterioration, better toxicity management, improved traceability, modern digital systems, and enhanced urgent oncology response. Safety risks across the organisation are reduced through modern equipment, standardised pathways, improved data accuracy, and enhanced quality assurance.

	+1	3	3	Timely care improves across pathways through digital Patient Tracking Lists, redesigned outpatient and SACT flow, expanded urgent oncology capacity, modernised radiotherapy workflows, better pathway coordination, improved donor and laboratory turnaround times, and reduced bottlenecks linked to manual processes. Improved scheduling, digital automation and increased capacity all support faster assessment, treatment and decision making.
	+1	3	3	Effectiveness increases through evidence based pathways, improved MDT working, new digital radiotherapy/SACT platforms, modernised medicines processes, better alignment to national and European cancer standards (OECI), and improved research/data capability. Standardisation across multiple programmes reduces unwarranted variation and strengthens clinical outcomes
	+1	3	3	Efficiency gains come from digital automation, reduced duplication, modernised workflow design, improved stock control, robotics in aseptic areas, improved mobile session planning for WBS, and alignment of pathways across regions. Modern systems (WLIMS, BECS, RISP, IRS, EPMA) reduce manual workarounds and avoid waste and delays.
	+1	2	2	Equity improves through expanded outreach treatment options, donor diversity programmes, consistent pathway standards across tumour sites, consistent access to modern radiotherapy and SACT across regions, and improved digital accessibility. Some digital-exclusion risks remain but are mitigated by targeted support.
	+1	3	3	Person centred care is strengthened through clearer communication, expanded supportive and palliative care services, digital tools and patient engagement, improved treatment experience, predictable pathways, reduced delays, and improved access to psychological and holistic support.

Overall impact	Overall Impact: Positive – High level <i>The organisation wide review demonstrates that IMTP programmes collectively improve safety, timeliness, experience, effectiveness, efficiency and equity.</i> <i>The quality impact is strongly positive and supports the safe and sustainable modernisation of cancer services, blood services and digital systems</i>

1b: Briefly outline the amount of activity required to ensure successful implementation of the proposal or strategic decision (in line with enabling Quality Standards)

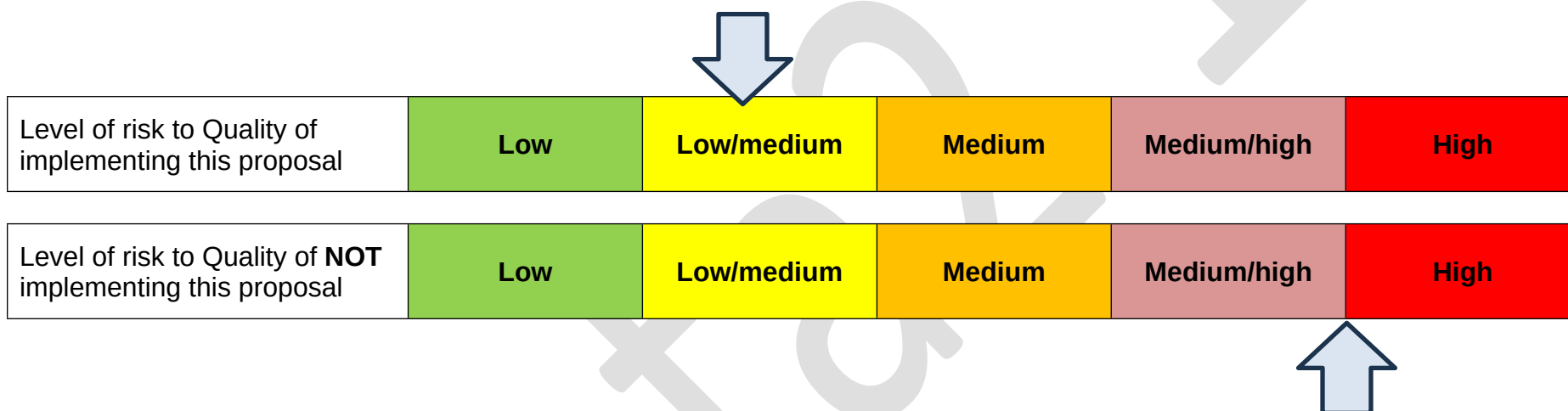
Quality Standard <i>Click each icon for its definition</i>	Amount of activity required High (3), Medium (2) or Low (1)	Key points and actions to achieve the changes required
	3	Substantial strategic and clinical leadership required across all programmes to manage digital transformation, nVCC readiness, clinical pathway redesign, national WBS programmes and cross system governance.
	3	Significant workforce training, digital capability development, new roles, extended hours models (e.g., AO, PEOLC), and specialist staffing for SACT, radiotherapy, digital systems and WBS.
	2	Cultural change needed to support digital first working, continuous improvement, MDT collaboration, equity focus, person centred care and psychologically safe environments.
	3	Upgrades to RISP, IRS, WLIMS, BECS, EPMA, analytics, cyber security, digital front door, patient engagement and high data quality expectations across all services.
	2	Ongoing audits, PROMS/PREMS, OECI aligned standards, continuous learning from incidents, and research enabled digital infrastructure.

	3	Collaboration across Health Boards, national digital bodies, regional cancer services, transplant networks, transfusion laboratories, and primary/community care.
Overall amount of activity required	Overall Activity Required: High <i>Delivering the IMTP portfolio requires largescale workforce, digital, cultural and operational transformation and coordination across multiple regional and national partners.</i>	

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)



Level of risk to Quality of implementing this proposal	Low	Low/medium	Medium	Medium/high	High
Level of risk to Quality of NOT implementing this proposal	Low	Low/medium	Medium	Medium/high	High

Describe the main risks to Quality of implementing this proposal?
Describe the main risks to Quality of NOT implementing this proposal?

RISK OF IMPLEMENTING — MEDIUM/HIGH

Main risks:

- *Digital transition instability (EPMA, IRS, RISP, WLIMS, BECS).*
- *Workforce pressure during major service redesigns.*
- *Variation in readiness across teams and sites.*
- *Temporary service disruption during changeover periods.*
- *Interdependency risk between programmes.*
- *Data quality and digital literacy challenges.*

RISK OF NOT IMPLEMENTING — HIGH

Main risks:

- *Continued safety risk from outdated systems and workflows.*
- *Reduced clinical effectiveness and widening variation in care.*
- *Inability to meet national cancer and WBS quality standards.*
- *Increased delays across all pathways (RTT, SACT, AO, OPD).*
- *Reduced resilience in transfusion, transplantation and plasma supply.*
- *Digital and cybersecurity vulnerabilities.*
- *Loss of equity improvements and patient experience gains*

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
Kathy Ikin Deputy Director Transformation, Planning & Performance 6 th March 2026	<Name, role and date>	<Name, role and date>

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
Nicola Williams, Executive Director Nursing, AHP & Health Science 17/3/26	Dr Jacinta Abraham, Executive Medical Director ,18/03/26	N/A



Technoleg Iechyd Cymru
Health Technology Wales

2026-2030 STRATEGIC PLAN



Mae'r ddogfen hon hefyd ar gael yn Gymraeg
This document is available in Welsh

HTW Strategic Plan 2026-2030

Developed by Health Technology Wales (HTW) in consultation with key stakeholders

The HTW Strategic Plan 2026-2030 sets out our organisation’s immediate and medium-term strategic goals and objectives.

This Strategic Plan was developed iteratively, using a mixed methods approach, inviting contributions from key HTW stakeholders including: Welsh Government; key opinion leaders within the Welsh health and social care system; and members of key HTW decision-making groups including the Executive Group, Appraisal Panel, Assessment Group, Patient and Public Involvement Group and Stakeholder Forum. A development session was also held with the HTW team. Finally, the Strategic Plan was posted for public consultation on the HTW website with communications activities to encourage feedback.

The HTW Strategic Plan should be regarded as a living document. It will be continually refined to reflect changing priorities and demands on HTW resources and changes to the health and social care policy agenda for Wales.

Contents

- P3 Strategic context
- P4 About HTW
- P5 Mission, vision and values
- P6 Strategic goals and objectives

Our partners:



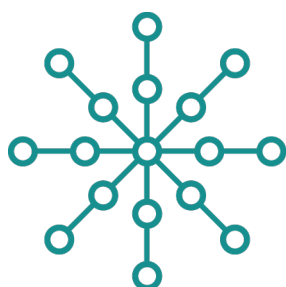
1. Strategic context

Health Technology Wales (HTW) was established and operates in the context of an ambitious and evolving health and social care policy agenda for Wales, which sets out a clear plan to:

- Ensure the principles of prudent care are firmly embedded in all health and social care services ([PHC 2013 – Bevan Commission](#)).
- Deliver a whole system approach as outlined in A Healthier Wales, focused on preventative, person-centred, sustainable, equitable, high quality and safe services for the people of Wales. ([AHW 2019](#))
- Prioritise the focus on: Utilising digital and data developments; optimising the workforce; strengthening research, development and innovation; ensuring co-production and partnership working; and integrating services in communities across Wales. ([AHW 2024-25](#))
- Improve performance by: Reducing waiting times, care pathways delays and improving women's health; strengthening services through improved leadership and culture, regional working, openness, accountability and collaboration; and future proofing services by focusing on prevention, shifting care into the community and realising the potential of digital and innovation. ([WG statement 2025/26](#))
- Improve the well-being of people and carers who need support and transfigure social services in Wales. ([SSWBA 2014](#))
- Enhance the future social, economic, environmental and cultural well-being of citizens. ([WFGA 2015](#))
- Embed a socio-economic duty, requiring public bodies to have due regard to the need to reduce the inequalities of outcome that result from socio-economic disadvantage. ([WA45 2017](#))
- Transform services to provide care of the highest quality that is seamless, proactive and delivered as close to people's home as possible. ([PRHSCW 2018](#))
- Re-design a whole system approach emphasising prevention, encouraging self-management, supported by integrated health and social care services that utilise the benefits new technologies offer. ([AHW 2019](#))



HTW will contribute significantly to delivering this plan for health and social care in Wales by appraising the scientific evidence to inform technology adoption and disinvestment decisions. This will encourage best use of the scarce resources available to invest in health and social care technologies and maximise the health gain they offer for the people of Wales.



2. About HTW

HTW is a national health technology assessment (HTA) body working to improve the quality of health and social care in Wales. Established in 2017, our remit is to “provide a strategic, streamlined and nationally coordinated approach for the identification, appraisal and adoption of medical technologies into practice across Wales.” (MHSS 2015). HTW’s remit covers assessment of any care technology that isn’t a medicine such as medical devices, diagnostic tests, implants, surgical procedures, assistive technologies, social interventions, digital innovations and changes in care pathways.

HTA is a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its lifecycle. The purpose is to inform decision-making in order to promote an equitable, efficient, and high-quality health system.

[International Network of Agencies for Health Technology Assessment \(INAHTA\) 2020](#)

HTW adapts its HTA methods when appraising technologies used in social care settings in line with international good practice in social intervention assessment.

[International Network for Social Intervention Assessment \(INSIA \)Position Paper 2025](#)

HTW was established to address recommendation 3 of the 2014 Inquiry into Access to Medical Technologies in Wales, which recommended establishment of “...an all-Wales medical technologies appraisal mechanism...” (HSCC 2014).

HTW’s unique contribution is its clear focus on evidence. We research and appraise the best available evidence to assess the value of technologies for Wales. Based on this evidence, we publish evidence summaries on health and social care technologies and authoritative national guidance for NHS Wales to support decisions on technology adoption. We support those innovations that are proven to offer value and suggest disinvestment in those that do not.

HTW values our independence. We have no ties to industry or other organisations that could result in conflict of interest. We are funded by Welsh Government and hosted within NHS Wales, but are independent of both. We are transparent in our goals and methods and have an unerring focus on improving outcomes for the people of Wales.

An [independent expert review](#) of HTW’s progress in its first five years in operation concluded that “HTW is a distinct, trusted and valued part of the innovation landscape in Wales and its strategic plan provides an excellent foundation for future development...” The review made improvement suggestions, which have helped to inform the 2026-2030 strategic objectives.



3. Vision, mission and values

3.1 Vision

A healthier Wales through the responsible adoption of innovative health and social care technologies. We envision a future where every person in Wales benefits from timely, evidence-based innovations that improve outcomes, reduce inequalities and support sustainable services.

3.2 Mission

To identify, evaluate, and promote the adoption of health and social care technologies that offer the greatest value for the people of Wales. We work collaboratively across sectors to provide independent, high-quality evidence that informs policy and practice, ensuring that innovation leads to real world impact.

3.3 Values

The core values underpinning our work include:

People First

We put the needs and experiences of patients, service users, and the public at the heart of everything we do.

Evidence-Driven

We are committed to rigorous, transparent and independent evidence appraisal to support informed decision-making.

Collaboration

We work in partnership across health, social care, academia, industry and the third sector to maximise impact.

Innovation with purpose

We champion technologies that are not only novel but also impactful, equitable, and sustainable.

Equality, Diversity and Inclusion

We strive to reduce health inequalities and ensure that diverse voices are heard and valued.

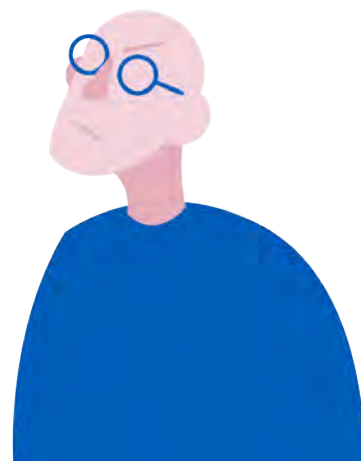
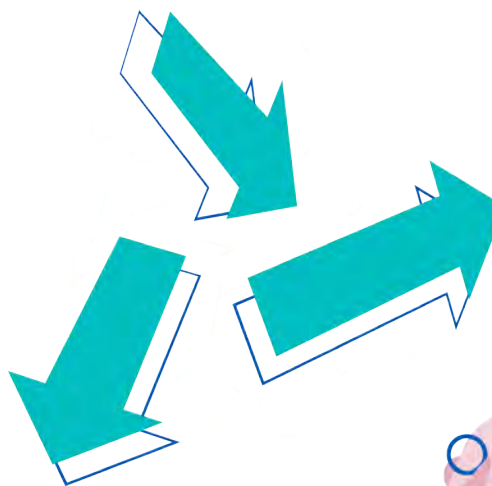
4. Strategic goals and objectives

Our four strategic goals for 2026-2030 are outlined below, alongside our top five priority objectives.



4.1 Top five priority objectives

- Produce and disseminate high quality, inclusive health and social care evidence appraisals and national guidance for NHS Wales.
- Ensure alignment with Ministerial, policy and health and social care system priorities.
- Support time-critical health and social care policy decision making via Welsh and UK initiatives, programmes and groups.
- Undertake an annual adoption audit of HTW and select NICE guidance.
- Collaborate with Welsh health and social care ecosystem partners and UK HTA partners (e.g. National Institute for Health and Care Excellence (NICE), Scottish Health Technologies Group (SHTG) and Medicines and Healthcare products Regulatory Agency (MHRA) to support relevant Welsh Government innovation and MedTech policy.



4.2 Strategic goal: Identification

Identify the technologies that are expected to have major impact on health and social care services and offer the most benefit for the people of Wales.

Objectives

- Ensure alignment with Ministerial, policy and health and social care system priorities.
- Work in partnership with key stakeholders to continually improve approaches to horizon scanning, topic identification and prioritisation.
- Ensure a technology life-cycle approach, identifying technology investment and disinvestment topics.
- Offer the Scientific Advice Service (SAS) to support the Welsh life science sector and innovation landscape.
- Explore opportunities to encourage the submission of topics from patient organisations.
- Continue working with the All Wales Clinical Effectiveness Group (AWCEG) to produce evidence summaries to support compilation of a single national list of Interventions Not Normally Understaken (i.e INNUS).
- Explicitly encourage key stakeholders to refer disinvestment topics for consideration.



4.3 Strategic goal: Appraisal

Deliver high quality, inclusive HTW evidence outputs, promoting a co-ordinated national approach to evidence-informed decision making on care technologies across Wales.

Objectives

- Produce and disseminate high quality inclusive health and social care evidence appraisals and national guidance for NHS Wales.
- Support time-critical health and social care policy decision-making via Welsh and UK initiatives, programmes and groups.
- Continually improve and develop HTW appraisal methods with a particular focus on appraising health technologies that use artificial intelligence (AI) alongside use of AI in our appraisal methods.
- Strengthen HTW's commitment to ensuring that equality, diversity and inclusion are considered in the appraisal of all topics.
- Continuously evolve HTW's process for patient and public involvement within the appraisal process.

4.4 Strategic goal: Adoption & Impact

Improve the quality of health and social care in Wales, by encouraging and monitoring the adoption of HTW national NHS guidance recommendations expected to have a major impact in Wales.

Objectives

- Undertake an annual adoption audit of HTW's national guidance for NHS Wales and select NICE guidance.
- Continually improve the HTW adoption audit to ensure effective audit of HTW guidance.
- Assess the impact of HTW evidence reviews and national NHS guidance and associated learnings for care organisations.
- Work with the National Institute for Health and Care Research (NIHR) to identify and highlight research gaps and support research of national importance.
- Build patient and public voices into our impact work.
- Promote greater understanding and use of HTW's HTA outputs with key Welsh, UK and international stakeholders.

4.5 Strategic goal: Engagement

Promote greater understanding and use of HTW's HTA outputs with key Welsh, UK and international stakeholders.

Objectives

- Collaborate with Welsh health and care system partners to support relevant Welsh Government innovation and MedTech policy.
- Continue to ensure the patient and public voice is central within all of our work.
- Build understanding of HTA and promote awareness of HTW outputs in health and social care systems.
- Engage with other HTA bodies both nationally and internationally to share best practice and prevent duplication.



Detailed implementation proposals outlining key activities proposed to deliver the HTW Strategic Plan - including key performance indicators and a prioritised timeline - are available on request

Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our [website](https://healthtechnology.wales).



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Health Technology Wales

healthtechnology.wales

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