Public Trust Board

Thursday 26 November 2026, 10:00 - 13:00

Charnwood Room, Trust Headquarters, Nantgarw

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

1.1. Welcome and Apologies

Sara Moseley, Chair

1.2. In Attendance

Sara Moseley, Chair

1.3. Declarations of Interest

Sara Moseley, Chair

1.4. Minutes of the Public Trust Board meeting held on 24th September 2026

Sara Moseley, Chair

1.4.0 Public Trust Board minutes 24-09-2026 (v4SM).pdf (13 pages)

1.5. Public Action Log

Sara Moseley, Chair

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

1.6. Matters Arising

Sara Moseley, Chair

10:15 - 10:30
15 min

2. PATIENT / DONOR / STAFF STORY

2.1. Patient Story: Arts in Health Music Therapy pilot

Sally Thelwell, Arts and Health Coordinator

*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 November 2026 Trust Board (v2SM).pdf (6 pages)

3.2. Chief Executive's Update

Carl James, Chief Executive Officer

3.2.0 CEO Update November 2026 Trust Board (v2CJ).pdf (6 pages)

10:40 - 11:30
50 min

4. QUALITY, SAFETY & PERFORMANCE

4.1. Performance Management Framework (September 2026)

Victoria Oxley, Interim Director of Strategy, Planning and Performance

- 4.1.0 Trust Board 25.11.26 - PMF September 2026 Version 001.pdf (39 pages)
- 4.1.0a Month 6 2026-27 Finance Report Cover Paper - TB 26112026.pdf (9 pages)
- 4.1.0b Appendix 1 - M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPT 2026 - TB 261126.pdf (43 pages)

4.2. Integrated Operational and Strategic Risk Report

Non Gwilym, Interim Director of Corporate Governance

- 4.2.0 TRUST BOARD RISK PAPER NOVEMBER 2026.pdf (7 pages)
- 4.2.0a TRR November 2026 .pdf (3 pages)
- 4.2.0b 01 - CAPACITY.pdf (8 pages)
- 4.2.0c 02 - QUALITY.pdf (13 pages)
- 4.2.0d 03 - RDI.pdf (5 pages)
- 4.2.0e 04 - FINANCE.pdf (9 pages)
- 4.2.0f 05 - SUSTAINABILITY.pdf (4 pages)
- 4.2.0g 06 - POD.pdf (5 pages)
- 4.2.0h 07 - DIGITAL FINAL.pdf (6 pages)
- 4.2.0i 08 - GOVERNANCE.pdf (4 pages)

11:30 - 11:40
10 min

BREAK

11:40 - 11:50
10 min

5. ORGANISATIONAL DEVELOPMENT

5.1. Strategic Partnerships Update

Lauren Fear, Director of Place, Portfolio and Partnerships

- 5.1.0 Strategic Partnerships Update - Trust Board - Nov 26 -final.pdf (6 pages)

11:50 - 11:55
5 min

6. ITEMS ESCALATED TO BOARD VIA COMMITTEES

6.1. Performance & Finance Committee Escalation

John Union, Independent Member and Chair of the Performance & Finance Committee

- 6.1.0 Escalation Report_Public PF_12th November 2026.pdf (1 pages)

11:55 - 12:10
15 min

7. ITEMS FOR APPROVAL

7.1. Charitable Funds Committee (CFC) Terms of Reference

Non Gwilym, Interim Director of Corporate Governance

- 7.1.0 board paper cfc.pdf (5 pages)
- 7.1.0a Charitable Funds Committee ToR for Board.pdf (12 pages)
- 7.1.0b Appendix 1 to Board Committees.pdf (6 pages)

7.2. Amendments to Standing Orders

Non Gwilym, Interim Director of Corporate Governance

- 7.2.0 Standing Orders Board Paper Nov 26.pdf (5 pages)
- 7.2.0a GC02 v42 SOs Excluding Schedules_NOV 2026.pdf (45 pages)

- 7.2.0b GC02a v42 SOs Schedule 1_NOV 2026.pdf (24 pages)
- 7.2.0c GC02b v42 SOs Schedule 2_NOV 2026.pdf (77 pages)
- 7.2.0d GC02c v42 SOs Schedule 3_NOV 2026.pdf (52 pages)
- 7.2.0e GC02d v42 SO Schedule 4_NOV 2026.pdf (19 pages)
- 7.2.0f GC02e v41 Schedule 5 Standing Orders SSPC_MAR 2026.pdf (111 pages)

7.3. Policies for approval

Sarah Green, Executive Director of OD and Workforce and Anne Carey, Chief Operating Officer

- Equalities Policies Review – Sarah Green
- Domestic Abuse Workplace Policy and Procedure
- PP06 Business Continuity Policy Emergency Planning Policy

- 7.3.0a Trust Board Equalities Policy Pack 13.11.26.pdf (4 pages)
- 7.3.0b Appendix 1 Equality and Diversity Policy 15.9.26.pdf (15 pages)
- 7.3.0c Appendix 2 Supporting Transgender Staff Policy 15.9.26.pdf (25 pages)
- 7.3.0d Appendix 3 WF40 - Supporting Staff Who are Carers Policy 15.9.26.pdf (13 pages)
- 7.3.0e Domestic Abuse Policy Report Board cover paper_Nov 2026.pdf (4 pages)
- 7.3.0f Domestic Abuse Workplace Policy Nov 26_Final version.pdf (18 pages)
- 7.3.0g Trust Board Cover Paper - EPRR Policy v4.pdf (6 pages)
- 7.3.0h FINAL PP06 Business Continuity Emergency Planning Policy_v4.0.pdf (8 pages)

12:10 - 12:20
10 min

8. ITEMS FOR NOTING AND ASSURANCE

8.1. Trust Seal Report

Non Gwilym, Interim Director of Corporate Governance

- 8.1.0 Trust Seal Report -18.09.2026-18.11.26.pdf (3 pages)

8.2. Trust-wide policy approvals update

Non Gwilym, Interim Director of Corporate Governance

- 8.2.0 TRUST WIDE POLICIES APPROVED UPDATE NOV 2026.pdf (4 pages)
- 8.2.0a APPENDIX 2 PP03 Environmental & Climate Resilience Policy DRAFT V3 Aug26.pdf (11 pages)
- 8.2.0b APPENDIX 3 PP08 Trust Waste Management Policy_v3 August 2026.pdf (13 pages)
- 8.2.0c APPENDIX 4(i) PP17 Electric Vehicle Charging Procedure DRAFT V2.0.pdf (15 pages)
- 8.2.0d APPENDIX 4(ii) PP17 EQIA EV Charging Procedure.pdf (11 pages)

8.3. NHS Wales Shared Services Partnership Committee Assurance Report (15/09/2026)

Provided by Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services

- 8.3.0 Shared Services Partnership Committee (SSPC) Assurance Report 15 Sept 2026 VTB CP Nov 2026.pdf (3 pages)
- 8.3.0a Appendix 1 Shared Services Partnership Committee (SSPC) Assurance Report 15 September 2026.pdf (6 pages)

8.4. NHS Wales Shared Services Partnership Audit Committee Highlight Report (13/10/2026)

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

- 8.4.0 Highlight Report from the NWSSP Audit Committee Meeting Held on 13 October 2026.pdf (8 pages)

8.5. Joint Commissioning Committee Highlight Reports (21/07/2026 & 22/09/2026)

Provided by JCC Secretariat

- 8.5.0a JC Highlight Report - 21 July 2026.pdf (5 pages)
- 8.5.0b JC Highlight Report - 22 Sept 2026 Final.pdf (6 pages)

8.6. Links to public Committee minutes on Trust website

For information only

- **Public People, Culture and Engagement Committee – 08/09/2026**

https://velindre.nhs.wales/about-us/board-and-committee-structure/committees/people-culture-and-engagement-committee/unconfirmed-minutes/2026/public-minutes-people-culture-and-engagement-committee-8-september-2026/

- **Public Charitable Funds Committee - 01/10/2026**

  https://velindre.nhs.wales/about-us/charitable-funds/charitable-funds-draft-unconfirmed-minutes1/unconfirmed-draft-minutes-public-charitable-funds-committee-1-october-2026/?ts=1795089957112

- **Public nVCC Project Scrutiny Committee – 08/10/2026**

  https://velindre.nhs.wales/about-us/board-and-committee-structure/committees/nvcc-scrutiny-committee/unconfirmed-minutes/minutes-public-nvcc-project-scrutiny-committee-08-10-2026-pdf/?ts=1795087059369

12:20 - 12:30
10 min

9. ANY OTHER BUSINESS

Sara Moseley, Chair

12:30 - 12:30
0 min

10. DATE OF NEXT MEETING

Sara Moseley, Chair

The next meeting will be held on 28th January 2027 at 10:00

12:30 - 12:30
0 min

11. CLOSE

Sara Moseley, Chair

The Board is asked to adopt the following resolution:

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

12:30 - 12:30
0 min

12. ITEMS FOR DISCUSSION IN PART B

- Minutes and actions of previous meeting
- VCS Business Cases
- nVCC Exclusive Access Requirements
- nVCC Progress on Outstanding Issues
- NWSSP Hosting Framework
- Integrated Operational and Strategic Report
- Legal Matters Update
- Shared Services items for approval

MINUTES PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
24th September 2026 – 10:00am-1:00pm
Welsh Blood Service Headquarters, Talbot Green / via Microsoft Teams

PRESENT	
Sara Moseley	Chair
Carl James	Chief Executive Officer
Gareth Jones	Independent Member
Vicky Morris	Independent Member
Hilary Jones	Independent Member
John Union	Independent Member
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director / Deputy Chief Executive
ATTENDEES	
Anne Carey	Chief Operating Officer
Victoria Oxley	Director of Strategy, Planning and Performance (interim)
Lauren Fear	Director of Place, Portfolio and Partnerships
Carl Taylor	Chief Digital Officer
Non Gwilym	Director of Corporate Governance (interim)
Kyle Page	Business Support Manager (Secretariat)

1.0.0	PRELIMINARY MATTERS	LEAD
1.1.0	**Welcome and Apologies:** The Chair welcomed attendees to the meeting and thanked Bethan Davis for providing simultaneous Welsh translation. The following apologies were noted: • Lindsay Foyster, Vice Chair; the Chair expressed condolences to Lindsay for her bereavement. • Ceri Doyle, Independent Member • Sarah Jenkins, interim Executive Director of People and Organisational Development • Gillian Knight, interim Executive Director of Nursing, AHPs and Health Scientists; the Chair informed the Board that Gillian had now been appointed substantively.	
1.2.0	**In Attendance:** The Chair extended a warm welcome to the following additional attendees: • Eleri Schiavone – Head of Blood Donation Services, Welsh Blood Service • Deborah Pritchard – Head of Transplantation Services, Welsh Blood Service • Georgia Stephens – Head of Transfusion Services, Welsh Blood Service • Amanda Jenkins – Assistant Director of Workforce Planning (deputising for Sarah Jenkins)	

	• Annie Evans – Deputy Director of Nursing, Quality & Patient Experience (deputising for Gillian Knight) • Linsay Payne, Deputy Director of Finance and Corporate Services, NHS Wales Shared Services Partnership (to be dialled in for item 7.1.0) • Alyson Thomas, Chief Executive, Llais; The Chair thanked Alyson for her work with Gillian Knight to strengthen links with Llais. • Jo Dalton, Head of Corporate Governance • Ben Leijokari-Olosunde, Aspiring Board Member	
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 30th July 2026** Sara Moseley, Chair Board members were content that the minutes of the meeting held on 30th July 2026 were an accurate reflection of proceedings.	
1.5.0	**Action Log** Sara Moseley, Chair The Board was content to close all actions marked as 'propose to close' and the remaining actions were discussed as follows: ***25/03/2026 item 9.4.0 (action 74)*** – Carl Taylor advised that confirmation of digital resource requirements had been considered by the Executive Management Board, prior to nVCC Readiness Board the following week. It was anticipated that this action would be closed following the Readiness Board meeting. ***30/07/2026 item 3.1.0 (action 85)*** – Anne Carey advised that a deep dive was in progress in relation to incidents across the Welsh Blood Service; however, this had been delayed due to Datix system issues. A monthly review had been introduced to identify outstanding incidents, and a full update (including outcomes and examples) was expected at the November Board meeting. ***30/07/2026 item 3.1.0 (action 86)*** – Amanda Jenkins advised that a request had been submitted to IBM (which manages the ESR system), and that the source of the 'Velindre Organisation' terminology within ESR was being investigated. ***30/07/2026 item 3.1.0 (action 87)*** – Matthew Bunce advised that a disconnect had been identified between the Finance team and those producing the covering narrative for the Performance Management Framework (PMF) Report and that an extension had been requested to improve the finance reporting process within the PMF. ***30/07/2026 item 3.1.0 (action 88)*** – Carl James advised that he had been in regular discussion with Hywel Jones (Welsh Government) regarding Same Day Emergency Care funding, and that formal clarification was expected imminently. ***30/07/2026 item 3.3.0 (action 90)*** – Anne Carey advised that work undertaken to address the absence of controls and assurance within the Board Assurance Framework (BAF) for the Velindre Cancer Service would require an extension	

	as this had not yet concluded. It was noted that a risk group would be established to review all relevant risks and strengthen links to make risk management more meaningful for teams and leaders. The Board **NOTED** the status of the remaining open actions.	
1.6.0	**Matters Arising**	
1.6.1	**EDI – Welsh Blood Service Brixton Blood Donation Centre Visit** Anne Carey, Chief Operating Officer Anne informed the Board that the Welsh Blood Service (WBS) had visited the Brixton Blood Donation Centre and focused on the practical learning that the blood service could apply, particularly for the new donor centre developments. The visit had demonstrated the benefits of strong community ownership, local engagement and a welcoming donor environment. Anne highlighted opportunities to apply this learning to future donor centres through enhanced community involvement, extended opening hours, improved donor experience and greater integration with local partners and community groups. Board members raised the following questions: • Whether there were opportunities for the space to be used by the community outside of its daytime clinical function. It was advised that Brixton's approach was focused less on opening the building for other uses and more on taking the service into the community. • Whether the Welsh Blood Service had considered adopting similar arrangements for local communities to the extended hours and hub-based approach observed at Brixton. It was advised that WBS wishes to explore longer opening hours, a welcoming 'coffee club' atmosphere, a potential hybrid model combining static and community sessions and developing the new donor centre as a multi-component collection site. • Whether the workforce reflected the communities it was serving and whether this had formed part of the Brixton approach. It was explained that the WBS is actively working to ensure its service better reflected the communities it serves, and that progress had been made in attracting staff from more diverse backgrounds. However, it was also recognised that more can be done in collection services. It was agreed that Brixton's staffing profile appeared to closely match its local community.	
2.0.0	**WELSH BLOOD SERVICE STORY**	
2.1.0	**Celebrating 80 Years of the Welsh Blood Service** Alan Prosser, Director of WBS Alan Prosser presented the 80th anniversary of the Welsh Blood Service as both a celebration of its history and an opportunity to recognise the generations of donors, staff, volunteers, patients and communities who had shaped and sustained the service. He outlined its development from its post-war origins into a modern, innovative all-Wales service with national and international reach, while emphasising that its fundamental purpose of connecting donor generosity with patient need had remained constant. Looking ahead, he highlighted continued innovation, partnership and donor and workforce commitment as central to meeting future patient needs.	

	The Chair commended the Welsh Blood Service's culture of continuous improvement and the pride demonstrated by both staff and donors. She thanked Alan Prosser and the wider team for their contribution and wished the Service continued success as it celebrated its 80th anniversary. Carl James also reflected on the Service's development, praising its leadership and culture. He commented on the journey from a regional service to one with a national and international reach and an excellent reputation for quality. He also highlighted the strong sense of belonging amongst donors and staff, suggesting that the service should be used as an exemplar across Wales. Carl thanked Alan Prosser, the wider team and donors for their contribution and challenged the service to continue its improvement journey with the ambition of being the best in the world.	
3.0.0	**KEY REPORTS**	
3.1.0	**Chair's Report** Sara Moseley, Chair The Chair highlighted the following key items: • **New Board Committee arrangements** – the Chair welcomed the first round of the redesigned Committees and thanked Committee Chairs, members and executive leads. The intention is to 'dive in' and learn as the new arrangements develop. It was felt that the stronger focus on finance and performance was appropriate given the operating environment. • **NHS Wales 'well-led' workshop** – The Chair reflected on the workshop between Welsh Government and NHS Wales Chairs, aimed at developing a shared understanding of what being 'well-led' means in the context of performance, escalation and Board Development. The discussion provided an opportunity for a reset as NHS Wales progresses through significant change. • **Chairs Peer Group** – It was advised that the Chair had been elected Vice Chair of the Chairs Peer Group and would lead work on leadership and leadership through change. • **Death of Professor Tom Crosby** – The Chair informed the Board of his sudden and unexpected death, describing the profound impact of his loss and his warmth, kindness, enthusiasm and passion for his work, patients and cancer services. She introduced a book of condolence for his family and invited Jacinta Abraham to reflect on his contribution. Jacinta Abraham paid tribute to Tom Crosby, reflecting on his more than 30 years of service and exceptional contribution to cancer care. She highlighted his passion and advocacy for Radiotherapy, his significant role in the early development of the new Velindre Cancer Centre, and his nationally and internationally influential research in oesophagogastric cancer. She described him as a trusted, inspirational, compassionate and accessible clinician whose influence extended across patients, colleagues and the wider cancer community, and whose legacy would continue to benefit patients and services for many years. The Board stood and a minute of applause was held in memory of Tom.	
3.2.0	**Chief Executive's Report** Carl James, Chief Executive Officer Carl James highlighted the following key items:	

	• **Executive recruitment** continues to progress, and Dr Sarah Green will commence in her post as Executive Director of People & Organisational Development on the 2nd November 2026. Additionally, Gillian Knight had been appointed as substantive Executive Director of Nursing, and the preferred candidate for the Director of Corporate Governance position had accepted the post. • A positive meeting had been held with the Health Strategy Board (HSB) regarding the new Velindre Cancer Centre project, with strong support for the programme and a focus on delivery and accountability. • The Advanced Therapies Wales Symposium held on 7th September had been a success. Carl emphasised the importance of advanced therapies to Welsh patients and noted his role as national SRO for the programme. • Following the Trust's NHS Performance and Improvement meeting with Welsh Government, the Trust remains in routine arrangements under the NHS Wales escalation framework. This is a positive outcome, and it was noted that financial pressures remain a challenge for all organisations. The Board **NOTED** the content of the update report.	
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
4.1.0	**Performance Management Framework – July 2026** Victoria Oxley, Interim Director of Strategy, Planning & Performance The Board noted that since the previous reporting period, the Performance Management Report had been subject to enhanced scrutiny through the Trust's revised Committee arrangements; in accordance with the committees' Terms of Reference, the report was considered in detail by the Performance and Finance Committee and also informed the Quality, Safety and Experience Committee's deliberations. The following key points were highlighted: • Cancer treatment standards remained under national discussion, with work underway with Welsh Government to standardise Board reporting. Despite changing baselines, Velindre intended to continue reporting against the current SACT quality standards. • SACT (Systemic Anti-Cancer Therapy) performance remained a priority and area of operational focus, with challenges to performance linked to increasing demand. A business case was being developed to support further improvement. Carl James emphasised the need for consistent standards, measurement and publication of data across Wales, including patients outside the Single Cancer Pathway. • Velindre Cancer Service currently has a 24-point SACT improvement plan in place, which the team is actually working through, alongside work to strengthen patient involvement and continued collaboration with national partners and other cancer centres to address waiting times and treatment standards and provide greater clarity on the patient promise. It was agreed that an update would be provided to the November Board regarding internal measures implemented by the Trust to support the cancer service, particularly SACT, alongside a clearer sense of the developing position on performance standards and associated discussions with Commissioners. • The relationship between increasing demand and the associated financial implications had been considered by the Finance and Performance Committee. It was advised that a deep dive on commissioning would be	**AC**

	undertaken at its November meeting to support members' understanding of the commissioning arrangements and associated challenges. • Welsh Blood Service performance remains consistent and benchmarks favourably with the four UK nations. Board members / attendees raised the following: • From a patient perspective, whether patients understood expected treatment times, delays and any harm–review processes. It was acknowledged that public –facing information was often too complicated and that the intention was to provide a clearer narrative around the standards, actual performance and what that means for patients. • How meaningful and comparable performance data was actually being used to drive action in the here and now, rather than only informing the longer-term cancer strategy. Carl James confirmed that the Trust would continue to collect and report against the existing cancer quality standards whilst national discussions progressed, emphasising that the purpose of the data was to support patient care. He highlighted the importance of providing a clear narrative alongside performance data and achieving consistent measurement and transparent reporting across Wales. The Trust Board took **ASSURANCE** from the Performance Management Framework and concurred with the individual levels of assurance noted in the report.	
4.2.0	**VUNHST Risk Register** Non Gwilym, Interim Director of Corporate Governance Non Gwilym presented the Trust Risk Register following review by the Executive Management Board and Audit Risk and Assurance Committee. The following was highlighted: • The principal risk themes remain mainly unchanged, including patient safety and service capacity. • The highest current score is 20 for the Corporate WLIMS 2.0 delay risk. wo new risks relating to the Welsh Blood Service were noted. • Two new risks relating to the Welsh Blood Service were noted, while a number of mitigating actions continue to depend on matters such as workforce capacity, business cases, procurement, national programmes and external partners. • Fourteen risk reviews remain overdue. • Both the Executive Management Board and Audit Risk and Assurance Committee had called for stronger risk management; this had also been discussed at the Quality, Safety & Experience Committee and Non thanked the Committee Chairs for work to align operational risks with strategic risks as the new Committee arrangements developed. • Further improvements are in progress, with a more comprehensive assessment due in October 2026. This improvement work was linked to the proposed Executive Risk Management Group, closer alignment with the Board Assurance Framework (BAF) and work on the new risk policy. • Carl Taylor provided assurance regarding one of the new WBS risks, relating to the technology supporting the Welsh Bone Marrow Donor	

	Registry. He advised that Welsh Government funding had been secured to undertake a procurement exercise for a replacement system. He noted that the existing technology presented a service risk, but that plans were in place, supported by collaboration between Digital Services and the Welsh Blood Service, to progress the required transformation. Board members raised the following: • It was confirmed that following the discussion at the Audit Risk and Assurance Committee, where there had been some concern regarding the risk position, improvements were now being implemented, including around Datix. • Who would lead the new Risk Management Group, when would the group likely commence and how would it operate? While a nominated lead and date was not agreed, it was noted that the proposed Risk Management Group would form part of strengthened risk-management arrangements, supporting greater triangulation of risks, assurance and mitigating actions through the new committee structure. • The proposed Risk Management Group was welcomed and the importance of triangulating risk across the new committee structure was emphasised. The need for committee papers to clearly align levels of assurance and risk with proposed mitigations was highlighted, enabling committees to focus on the substantive management and mitigation of risk rather than the process itself. The Chair supported the importance of alignment between the developing risk arrangements and the new committee structure. The Trust Board: • **NOTED** the September 2026 Trust Risk Register position. • **NOTED** the EMB discussion on new risks, consolidated Treatment Helpline risks, sub-threshold risks, overdue reviews, and the need to strengthen the quality and discipline of risk review arrangements. • **TOOK ASSURANCE** that actions arising from EMB have been identified for follow-up.	
4.3.0	**Board Assurance Framework (BAF)** Non Gwilym, Interim Director of Corporate Governance During the reporting period, strategic risks had been overseen through the Trust's revised Committee arrangements. Non indicated that three risks had be substantially reviewed since the previous report, specifically referring to BAF02, BAF06 and BAF08. Significant work had been undertaken with the Workforce team on BAF06 and a revised BAF would be presented to the People, Culture and Engagement committee in November. Board members / attendees raised the following questions / queries: • Why particular strategic risks had remained static for so long, what actions were being taken to address these risks and whether they were having an impact; additionally, where they were not working, whether anything further could be implemented. It was advised that BAF risks are strategic by nature and therefore movement is not always straightforward or immediately measurable. However, it was recognised that the Trust should be more precise about the cause-and-effect relationship between the risk, the action taken, and its impact on the score.	

	• The need to establish a clear reporting mechanism from the new committees to the Audit and Risk Assurance Committee, to provide visibility of the work undertaken by individual committees in relation to strategic risks and actions or assurances put in place. It was noted that this reporting process remained under development. • How the Risk Register and BAF align and how the two mechanisms collectively drive improvements. It was also questioned whether the relationship was sufficiently clear from a public-facing perspective. It was acknowledged that clearer alignment was required between the BAF, Operational Risk Register, strategic objectives, PMF, IMTP and associated action plans, to demonstrate how performance evidence and risk collectively drive improvement. It was noted that work remained ongoing to develop these connections, supported by integrated performance reporting and clearer committee ownership and accountability, providing a more coherent organisational narrative for staff, the Board and the public. The Board **NOTED** the current BAF and strategic risk position, the positive but qualified assurance on the developing arrangements, and the priorities identified to strengthen strategic risk oversight.	
5.0.0	**ORGANISATIONAL DEVELOPMENT**	
5.1.0	**Partnership Agreements for Cardiff Health Partners and Cardiff Cancer Research Partnership (CCRP)** Jacinta Abraham, Executive Medical Director and Lauren Fear, Director of Place, Portfolio and Partnerships Lauren Fear introduced the two agreements for Board approval and set out the key governance points. She advised the following: • Both agreements had been considered in detail at an extraordinary Research, Development & Innovation Committee. • The supporting presentation had subsequently been expanded to provide members with more context on how the partnerships were operating and their successes. • The CCRP Heads of Terms had previously been agreed at Board and that the paper explained the differences between the Heads of Terms and the final partnership agreement. • That the QIA (Quality Impact Assessment) and EQIA (Equality Impact Assessment) had been included. Additionally, Lauren highlighted three matters requiring attention prior to finalisation: • **Liability cap** - the CHP agreement contained an error (the liability cap should be £1 million), which would be corrected. • **Termination** – either partnership agreement would terminate should one of the three parties withdraw, following which the remaining parties would have to constitute a new arrangement. • **Indemnity** – It was agreed that some indemnity provisions required clearer wording. Lauren proposed that the board approve the strategic partnership arrangements, subject to the indemnity wording being reviewed between the three parties and subsequently confirmed with the Board member who had requested this.	**LF** **LF**

	Jacinta Abraham drew the Board's attention to the robust QIA that had been undertaken for the partnership agreements, stating why the agreements were critical, particularly around equity of access to research. She also referenced the transformational benefits being realised through patient participation in CCRP studies and highlighted the Trust's leadership and wider influence in developing the partnership model. Alyson Thomas (Llais) sought clarity on the tangible benefits already delivered for patients and the public through the existing partnerships and the additional opportunities that would be realised through the proposed partnership arrangements. Jacinta explained that CCRP had enabled access to complex cancer clinical trials and strengthened the link between translational research and clinical care, while Cardiff Health Partners provided opportunities to broaden the Trust's contribution to population health, prevention, care closer to home, research and innovation, and patient engagement. The partnerships were considered central to expanding access to research and improving cancer outcomes across Wales. The Board **APPROVED** the two partnership agreements, subject to the amendments discussed above.	
6.0.0	**COMMITTEE ESCALATIONS**	
6.1.0	**Audit and Risk Assurance Committee** Gareth Jones, Independent Member and Chair of ARAC This item was taken as an oral update, as the meeting of the Audit and Risk Assurance Committee had taken place on the 17th September. Gareth escalated concerns around the delay to the national LIMS (Laboratory Information Management System) programme and sought assurance on the implications and mitigating actions. The Board noted that the risk was reflected within the Trust Risk Register. Carl Taylor provided further assurance that while the Welsh Blood Service was relatively well prepared for implementation of the national LIMS blood-transfusion solution, delivery remained dependent on the national programme, with a provisional implementation date of 8th February 2027. The wider system risk, including dependencies for health boards and digital connectivity arising from the Infected Blood Inquiry, was recognised and remained subject to national Chief Executive-level scrutiny.	
7.0.0	**ITEMS FOR APPROVAL**	
7.1.0	**Shared Services Items for Approval - Fleet modernisation programme Business Justification Case 2026-27** Linsay Payne, Deputy Director of Finance and Corporate Services, NWSSP Linsay Payne presented year two of the 10-year Fleet Modernisation Programme, seeking approval for the purchase of 22 vehicles at a total value of £1.29m excluding VAT, for submission to Welsh Government for 2027-28 capital funding. She advised that the proposed mix of electric and hybrid vehicles balanced operational resilience and decarbonisation objectives with current charging, range, rural service and emergency-response requirements. Following a governance query regarding the QIA and EQIA, Linsay advised the version she had previously seen contained the Medical Director's signature and	

	suggested that the incorrect version may have been included in the Board pack; it was agreed that the appropriate version could be provided. **The Board:** • **APPROVED** the Year 2 Business Justification Case and associated capital funding request of £1.290m, excluding VAT, following approval by the Shared Services Partnership Committee and prior to submission to Welsh Government; • and in doing so, **AUTHORISED** the Chief Executive Officer to approve the associated purchase order.	**LP**
7.2.0	**Wales Infected Blood Support Scheme (WIBSS) Annual Report 2025-26** Lauren Fear, Director of Place, Portfolio and Partnerships The report provided an update on delivery and the governance arrangements in place to support ongoing oversight of the Scheme. Lauren Fear advised the following: • Over the course of the year, WIBBS had continued to support 171 beneficiaries, comprising people infected through contaminated blood products and affected family members or estates. • This represented a reduction of 57 beneficiaries compared to the previous year, as a number of individuals had opted to receive compensation through the UK-wide compensation scheme. • WIBBS will continue to provide support until the Infected Blood Compensation Authority (IBCA) becomes fully operational, with a target date of January 2027. • IBCA will not provide the wider set of support systems; therefore, Velindre had agreed with Welsh Government that it would continue dedicated psychology and counselling support for a further year after the scheme closes, allowing beneficiaries time to transition into mainstream services if required. Board members raised the following questions: • Where else the report may be shared (i.e. across all Health Boards). Lauren advised that the report is shared via the national partnership governance arrangements and had already been considered by the Shared Services Partnership Committee. • The governance and approval arrangements for the report. Lauren explained that the report had already been approved by the cross-partnership group comprising the Trust, Welsh Government and NWSSP representatives before being presented to the Board. The Trust Board **NOTED** the WIBBS Annual Report 2025-26 for assurance purposes.	
7.3.0	**Annual Assurance report on compliance with the Nurse Staffing Levels (Wales) Act 2016** Annie Evans, Deputy Director for Nursing, Quality & Patient Experience The report provided the Trust's annual position as at 31st March 2026. Annie advised the following:	

	• The Trust had 49.3 whole-time equivalent (WTE) nursing staff on the first floor ward. • Nursing fill rates were reported at 96.9%. • The required six-monthly reviews of nurse staffing levels would continue, with the new review scheduled for October. • Based on the reviews undertaken, there was confidence that the staffing establishment remained sufficient to meet patient care needs. The Trust Board **APPROVED** the 2025/26 Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016.	
8.0.0	**CONSENT ITEMS FOR NOTING AND ASSURANCE**	
8.1.0	**Trust Seal Report** Non Gwilym, Director of Corporate Governance (Interim) The Trust Board is asked to **NOTED** the content of the Trust Board Seal Register **for ASSURANCE.**	
8.2.0	**Trust-wide policy approvals update** Executive Sponsor: Non Gwilym, Interim Director of Corporate Governance The Board queried the level of assurance attached to the report, noting that whilst Committees had reviewed and approved individual policies, they had not received information on overdue policies, policy gaps or overall policy management arrangements. It was suggested that assurance on the wider policy framework should be strengthened to enable to Board to assess the effectiveness of policy governance across the Trust. **Action:** NG to ensure governance route for consideration of the wider policy framework is clarified. The Trust Board **NOTED for ASSURANCE** the Trust wide policies and other written control documents that had been approved during the period August 2026 to September 2026.	**NG**
8.3.0	**NHS Wales Shared Services Partnership Committee Assurance report (16 July 2026)** Provided by Linsay Payne, Deputy Director of Finance and Corporate Services, NWSSP The Trust Board **NOTED** the content of the Shared Services Partnership Committee Assurance Report.	
8.4.0	**Shared Services Partnership Audit Committee Highlight Reports (15th June and 7th July)** Provided by James Quance, Assistant Director of Corporate Services The Trust Board **NOTED** the content of the Shared Services Partnership Committee Highlight Reports.	
8.5.0	**Winter Preparedness 2026/27 – Stress Testing** Anne Carey, Chief Operating Officer	

	Anne advised that the paper was part of a strengthened national approach, led by NHS Performance and Improvement, to assess winter readiness across NHS Wales; although winter pressures are generally associated with acute hospitals and front-door services, the Trust had been asked to participate in the national process and complete the required self-assessment. The report outlined the process the Trust had followed and was aligned with approaches used elsewhere in the NHS. The paper had been brought directly to Board for review prior to submission to NHS Performance and Improvement the following day. Board members raised the following: • The paper had not been sighted at any of the Trust Board's committees prior to Board. Anne explained that the paper had been brought directly to Board due to the time constraints of the national submission timetable and the requirement for it to be submitted to NHS Performance and Improvement the following day. • Where future papers should sit within the hierarchy of decision-making and assurance. For future papers of this nature, the Chair suggested that the Board would benefit from a clearer explanation of why the paper is presented at Board, where it sits within the wider governance structure, which Committee or assurance route sits beneath it, and whether it is being presented for approval, assurance, information or due to an external reporting requirement. **Action:** To confirm governance route for future reports. The Trust Board: • **RECEIVED** and **NOTED** the divisional stress-testing outcomes, actions and residual risks set out in Appendix 1. • Took reasonable **ASSURANCE** on divisional preparedness for likely demand and extreme-pressure scenarios. • **SUPPORTED** the proposed Trust-wide priorities for EPRR development and winter resilience during 2026/27. • **NOTED** that the Board-assured information will support the national submission due on 25 September 2026.	**AC**
9.0.0	**ANY OTHER BUSINESS** Sara Moseley, Chair The Chair formally thanked Sarah Jenkins, Interim Executive Director of People and Organisational Development, who was leaving the Trust to assume a role with West Wales Fire and Rescue Service. She reflected on the significant contribution that Sarah had made during her time with the Trust, bringing energy, innovation, strong value and commitment to improving the organisation. She had helped the Board think differently about workforce, culture, staff wellbeing and engagement issues, in addition to providing valued advice and support to the Board, the Executive team and colleagues across the organisation. Carl James supported the Chair's comments, describing Sarah's contribution during a challenging period for the organisation as making a big difference. The Board agreed to send Sarah a letter to formally record its thanks.	**CEO**

10.0.0	**DATE OF NEXT MEETING** The next public meeting of the Board will take place on Thursday, 26th November 2026 at Trust Headquarters, Nantgarw.	
11.0.0	**CLOSE**	
12.0.0	**ITEMS FOR DISCUSSION AT PART B**	
	• Minutes and actions from the previous private Board meeting • Legal Matters Update • Input into National Cancer Strategy • nVCC Beneficial Access Requirements • nVCC Progress on outstanding issues • Whitchurch Hospital Grounds next steps • Emergency Preparedness, Resilience and Response Annual Report 25-26 • Winter Preparedness • Trust Integrated Improvement Plan • Private Trust Risk Register • Board Assurance Framework • Items for escalation via Committees • Shared Services items for approval • nVCC Clinical Systems • WBS First Floor Lease Approval • Committee Highlights	

ACTION LOG	Column1	Column2	Column3	Column4	Column5	Column6	Column7
MEETING DATE	**AGENDA ITEM**	**Action number**	**ACTION**	**LEAD**	**DEADLINE DATE**	**UPDATE (including date)**	**STATUS**
26/03/2026	**9.4.0**		**Public Strategic Development Highlight Report**				
		74	Update to be brought back to Board regarding Digital (resource) requirements for both divisions over the next 6-12 months, including an update on the bid submitted to secure additional capital monies.	Chief Digital Officer	~~**21/05/2026**~~ ~~**24/09/2026**~~ **26/11/2026**	**Nov Update -** Digital plan is now agreed and governed through the nVCC Readiness Board and was presented to nVCC Scrutiny Board Committee. Further updates will be provided through this governance route. **September update -** Confirmation has been provided to the Executive Management Board. Awaiting final confirmation from the nVCC Readiness Board via Gardiner & Theobold. **Update at July Board** - Welsh Government has approved requests for additional and repurposed resources. Discussions with service divisions had indicated a positive position, with a final report to be presented at the September Board meeting.	**PROPOSE TO CLOSE**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		85	Provide assurance regarding overdue incident and audit actions within the Welsh Blood Service; While progress is being seen, particularly through improved process compliance and staff training, further examples to be provided.	Chief Operating Officer	~~**24/09/2026**~~ **26/11/2026**	**November 2026:** incident position and delays within datix report has significantly improved, using the new process. **September update** - A deep dive was in progress in relation to incidents across the Welsh Blood Service; however, this had been delayed due to Datix system issues. A monthly review has been introduced to identify outstanding incidents, and improvements are expected in the November PMF, as part of the Board reporting.	**OPEN**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		86	Clarify use of the term "Velindre Organisations" within the Workforce heatmap and associated graphs, as this is not an organisational descriptor; this is an error in the report to be corrected.	Interim Director of POD	~~**24/09/2026**~~ **26/11/2026**	**November Update -** A change on the national system has been requested but as the system is changing this cannot be done. A manual override is now in place for the interim to ensure correct descriptors on reports.	**PROPOSE TO CLOSE**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		87	Error in the way the risks within the finance report had been represented within the paper under the risk section of the cover paper. No risks had been noted when there are many risks pertaining to performance that should be noted here. It was advised that this would be corrected under the risk section noted on p82 of papers.	Executive Director of Finance	~~**24/09/2026**~~ **26/11/2026**	**November update** - The Head of Financial Planning & Reporting updated the PMF cover paper when adding September 2026 content. Within the cover paper, the financial implications are clearly annotated and within the risks section, reference to the BAF4 Finance risk is described.	**PROPOSE TO CLOSE**
30/07/2026	**3.1.0**		**Performance Management Framework (May 2026)**				
		88	Update to be provided on the risk relating to Same Day Emergency Care funding. While the Board was assured that the funding allocation had already been identified, CEO advised that this appeared to be an administrative issue and agreed to pursue confirmation.	Chief Executive Officer	~~**24/09/2026**~~ **26/11/2026**	**November update** - CEO discussed with Director of Finance Welsh Govt on a number of occasions. Trust has communicated with Health Board raising issue to convey WG position that the funds have been approved by the Minister in the HB Allocations as payable to the Trust to support the SDEC service. Health Board requested written confirmation from WG which was requested as part of the month 7 Monthly Monitoring Return (MMR) commentary. WG have directed Finance colleagues to the Policy Lead in WG.	**OPEN**
30/07/2026	**3.3.0**		**Board Assurance Framework (BAF)**				
		90	It was noted that there was an absence of controls and assurance for Velindre Cancer Service and that this information had only been included for the Welsh Blood Service. It was agreed to address this, although may take time to resolve properly.	Chief Operating Officer	~~**24/09/2026**~~ **26/11/2026**	**November 2026:** the BAF has been updated. **September update** - there is a set Risk Group to be set up as part of the Line of Sight work. The individual meetings with WBS took place resulting in the changes that have fed through. VCS has not occurred due to the formal group being arranged.	**OPEN**
24/09/2026	**4.1.0**		**Performance Management Framework (July 2026)**				
		93	Provide an update to November Board regarding internal measures implemented by the Trust to support the cancer service, particularly SACT, alongside a clearer sense of the developing position on performance standards and associated discussions with Commissioners.	Chief Operating Officer	**26/11/2026**	**November update** - SACT Business Case being presented to Board. Acceptance across Welsh Government (27 Oct) and NHS P&I (2 Nov) regarding the need to clarify the mandated and quality standards.	**OPEN**
24/09/2026	**5.1.0**		**Partnership Agreements for CHP and CCRP**				
		94	Amend liability cap to read £1 million.	Director of Place, Portfolio and Partnerships	**26/11/2026**	**November update** - Complete and confirmed with the two other parties.	**PROPOSE TO CLOSE**
24/09/2026	**5.1.0**		**Partnership Agreements for CHP and CCRP**				
		95	Review and amend wording in relation to indemnity provisions and share with Independent Member who had requested this (GJ).	Director of Place, Portfolio and Partnerships	**26/11/2026**	**November update** - Engaging with Legal IM to review drafting. Expected to be completed between the publishing of this action log and the Board - verbal update to be provided.	**OPEN**
24/09/2026	**7.1.0**		**Shared Services Items for Approval - Fleet Modernisation Programme BJC**				
		96	Provide correct version of QIA / EQIA containing required signatures.	Deputy Director of Finance and Corporate Services, NWSSP	**26/11/2026**	**November update** - NWSSP have confirmed Directors' e-signatures have been applied as approval of the Quality Impact Assessment (QIA), and the documents have been shared with the Trust Board Secretariat.	**PROPOSE TO CLOSE**

24/09/2026	**8.2.0**		**Trust-wide policy approvals update**				
		97	Ensure governance route for consideration of the wider policy framework is clarified.	Interim Director of Corporate Governance	**26/11/2026**	Historically policy compliance has been reported to the Quality, Safety & Performance Committee as the majority of the Trustwide policies fell within its remit. However, following the committee restructure a gap has been identified in the new terms of reference relating to policy matters. This is to be addressed in the review of the terms of reference following the implementation of the new committee structure. Once the gap in policy matters has been addressed within the committee terms of reference, Appendix 3 of the Trust's Policy on Policies will be updated to reflect the governance route for policy approvals. It is anticipated that ARAC will have oversight of policy compliance.	**PROPOSE TO CLOSE**
24/09/2026	**8.5.0**		**Winter Preparedness 2026/27 - Stress Testing**				
		98	COO to confirm governance route for future reports.	Chief Operating Officer	**26/11/2026**	The two final signed QIAs on the agenda for the 26 November Trust Board meeting have been sent to Kyle for inclusion, accordingly.	**OPEN**

TRUST BOARD		
CHAIR'S UPDATE REPORT		
DATE OF MEETING	26th November 2026	
STATUS	Public	
REPORT AUTHOR	Sara Moseley, Trust Chair	
PRESENTED BY	Sara Moseley, Trust Chair	
REPORT SPONSOR	I, **Sara Moseley, Chair,** confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	N/A
	DD/MM/YYYY	N/A
	N/A	
ONWARD SCRUTINY ROUTE	No further scrutiny required.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)	
EXECUTIVE SUMMARY	This paper provides the Trust Board with an overview of the Chair's activity since the September Trust Board meeting.	
ACTION / DECISION	The Board/Committee is asked to **NOTE** the content of the Chair's Update Report for **ASSURANCE** purposes.	
ADDITIONAL RESOURCES	N/A	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
None		
RELEVANT TRUST WELLBEING GOALS		

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

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Chair's Report

KEY CONSIDERATIONS

1. SITUATION

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

2. BACKGROUND

2.1 This report is for information and assurance only.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 Board Development Sessions

One Board Development Session took place during the period (15th October 2026). The focus included a continuation of the programme agreed to strengthen Board effectiveness and culture and discussed the following:

- NHS Wales Accountability Framework and Well Led Expectations and the Boards role in and preparation for this.
- Learning from the Cardiff and Vale Well Led Review and relevance to Velindre in terms of the areas covered.

- Key themes from first round of Committees observations following their review and re-focus. This supported the agreed approach of continuous reflection, learning and improvement and will be followed by a second round of observations and adaptation.
- Deep dive into Risk Management, having identified developing our approach as a priority, including active use and management of risks to improve and a risk policy.
- Deep dive: Performance Reporting and Integrated Performance Report having identified the need to align this with new committees' structures, simplify reporting and ensure key areas of concern and success are sufficiently clear and prioritised. A revised PFI is now in development and will be brought to future Board meetings.
- Reflections, Actions and Next Steps.

3.1.2 Private Trust Board meetings

24th September 2026 (regular) – Discussions at this private meeting of the Trust Board included the following items:

- The Trust's Input into the new National Cancer Strategy. This included our response to the consultation questions and further work undertaken to look at cancer systems globally that have succeeded in supporting better outcomes for patients.
- Progress on the building of the new Velindre Cancer Centre and a consideration of outstanding issues.
- Whitchurch Hospital and Grounds disposal: next steps.
- Emergency Preparedness, Resilience and Response Annual Report 25-26.
- Winter Preparedness.
- Trust Integrated Improvement Plan.
- Private Trust Risk Register.
- Private Board Assurance Framework.
- Items for escalation via Committees.
- Shared Services items for approval.
- nVCC Clinical Systems.
- WBS First Floor Lease Approval.
- Committee Highlights.

3.1.3 Other meetings of note

- Public Bodies Chair Group meeting (30th September 2026). Of note was the focus on resilience and preparedness in the face of multiple threats and risks to the continuity of public services. The Welsh Blood Service is fundamentally important in this respect.
- Meeting between Welsh Government Health and Care Ministers and NHS Leaders (6th October 2026). This was an opportunity for the three Ministers to set out where they felt we were after the first 100 days and for a conversation with Chairs about working together to face challenges to healthcare.
- ARC Board Meeting (8th October 2026). Advancing Radiotherapy Cymru continues to play an important national role in research, training and the development of a networked approach. The Velindre Oncology Academy, a new provider of cancer-specific education across Wales, reported on how we are working across Velindre, Swansea and North Wales cancer centres to strengthen and develop our cancer

workforce and give the best possible care. Agreed also was the business case for a project that will develop Molecular Radiotherapy Treatment capacity (MRT) within NHS Wales enabling more patients to access innovative radiopharmaceutical therapies.

- NHS Board Members Induction: I presented on behalf of Chairs, sharing my own and colleagues' perspectives and giving examples of challenges and successes for me.
- Women's Network Coaching and Mentoring (14th October 2026). I was very pleased to share my own experiences as an ILM 7 Coach, especially working with healthcare professionals and academics from very different cultures and backgrounds to my own, providing guidance to enable them to access their potential for development, change and problem-solving.
- NHS Wales Chairs Closed Session (27th October 2026), which is an opportunity for learning, peer support and discussions about priorities.
- NHS Wales Joint Chairs and Vice Chairs Peer Group Meeting (27th October 2026) which this time focused, amongst other things, on how we develop and support Independent Members who play such a crucial role.
- Meeting the Chair of CEO of Cardiff & Vale (5th November 2026), one of our closest partners in NHS Wales, to discuss cooperation on behalf of patients.
- Structured Assessment 2026 with Audit Wales (12th November 2026). This year, the focus is on our IMTP – its development, delivery and impact. Audit Wales are also currently looking at cancer services in each of the Health Boards; at screening services run through Public Health Wales; and at our SACT service in Velindre. All reports are published on the Audit Wales website as they become available and are an important resource for all of us.

Visits of note

- Visit to Maggie's (13th October 2026). I've been a supporter of Maggie's for many years and very aware of the supportive, calm and constant place it gives our patients on our doorstep in Velindre. Clinicians are able to refer patients and families for advice, exercise, counselling, a wig service and much more. The hope is that Maggie's will be able to relocate to the site of the new hospital in time and the Velindre charity has promised some support in enabling them to do so. I met Maggie's CEO, Dame Laura Lee, and their Development Director Sarah Beard, to talk about ever closer work for patients and plans for the future.

3.1.4 Events

- Velindre Pearl Ball (8th October 2026). The 30th anniversary of our Velindre charity was an occasion of warmth, remembrance and connection as well as celebration. As well as raising tens of millions for patients and donors, it's a focus for belonging and joining together. Our Patron, Jonathan Davies, CBE, was thanked especially for his immense contribution and energy.

- Funeral of Professor Tom Crosby OBE (12th October 2026). Llandaff Cathedral was full to celebrate the life of and say goodbye to Tom who made such an impression on so many. All three of his children read or spoke movingly about their father and colleagues, friends and fellow fundraisers from across the UK came to pay their respects.
- The Sinclair Gala Dinner (Craig Maxwell) (29th October 2026). Craig and Tracey Maxwell set up the Maxwell Family Fund to support cancer patients when Craig was diagnosed four years ago. He embarked on an epic quest – cycling, running and, most of all, inspiring and moving others to give. His target was to get to £2million at this dinner. That was exceeded with immense generosity from so many, especially Andy Sinclair of the Sinclair Group, who contributed tens of thousands to make this amazing event such a success. In the new year, Craig has set an 'Everest Challenge' where dozens of work teams (including myself and Carl) will climb the equivalent of Everest in Principality Stadium steps. So far, Craig's efforts have contributed to breakthroughs in cancer care including liquid biopsies and greater efficacy of breast cancer treatment. What a legacy.
- Welsh NHS Confederation Annual Conference & Exhibition (3rd & 4th November 2026). The two days were an intensive opportunity to hear from, work with and better understand the perspectives of colleagues across NHS Wales; also to hear from the Chief Executive of the NHS and Cabinet Secretary for Health and Care who set out the strategic direction for the health service : Reset; Modernise; Transform. Attached is a link to the NHS Wales Alliance response and the content of the speech itself: read://https_thenhsalliance.org/?url=https%3A%2F%2Fthenhsalliance.org%2Fnews%2Fwelsh-nhs-confederation-relaunches-as-the-welsh-nhs-alliance-with-enhanced-support-for-nhs-leaders-in-wales
- Lauch of 'Arwain' (10 November). This is the new National School for Government in Wales, replacing and building on the work of Academi Wales. The purpose, as set out by Dafydd Trystan Davies AS, Cabinet Minister for Government, Effectiveness and the Constitution, is to develop a community of leaders who work together to make outcomes better for people in Wales. There will be opportunities for Board members to take part in development support with others in the public service, and IMs will have access to a standard induction offer as well. You can sign up to alters from Arwai's site: https://arwain.gov.wales/
- Armistice Day Remembrance Event (11th November 2026). Given events in Europe and across the world, as well as remembrance of conflicts past, this was a particularly poignant reminder of those who give so much for freedom. A greater number of colleagues than ever joined us on a cold, sunny morning and the time for reflection was valued.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None.

3.3 LEGAL IMPLICATIONS

3.3.1 None.

3.4 PEOPLE IMPLICATIONS

3.4.1 None.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

3.6.1 Relevant Strategic Risk - Board Assurance Framework (BAF)

Not Applicable

Operational Risks

3.6.2 Not Applicable

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

4. RECOMMENDATIONS FOR ACTION / DECISION

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

TRUST BOARD		
CHIEF EXECUTIVE'S UPDATE REPORT		
DATE OF MEETING	26/11/2026	
STATUS	Public	
REPORT AUTHOR	Kyle Page, Business Support Manager	
PRESENTED BY	Carl James, Chief Executive Officer	
REPORT SPONSOR	I, **Carl James, Chief Executive Officer**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	N/A
	DD/MM/YYYY	N/A
	N/A	
ONWARD SCRUTINY ROUTE	No further scrutiny required.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)	
EXECUTIVE SUMMARY	This paper provides the Trust Board with an overview of the Executive's activity since the September Trust Board meeting.	
ACTION / DECISION	The Board/Committee is asked to **NOTE** the content of the Chief Executive's Update Report for **ASSURANCE** purposes.	
ADDITIONAL RESOURCES	N/A	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
None		
RELEVANT TRUST WELLBEING GOALS		

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

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	CEO Report

KEY CONSIDERATIONS

1. SITUATION

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

2. BACKGROUND

2.1 This report is for information and assurance only.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

EXECUTIVE RECRUITMENT

i. I am pleased to confirm that following appointment to the role of Director of Corporate Governance during September, Pam Wenger will join the organisation in the new year. Pam joins us from Betsi Cadwaladr University Health Board, where she has been in the role of Director of Corporate Governance for over two years. Pam brings over 20 years of Board level leadership experience across NHS Wales, NHS England and Independent Healthcare, in addition to a strong track record of strengthening governance, assurance, organisational performance and Board effectiveness.

ii. Interviews for the position of Executive Medical Director took place on the 19th November and the role has been accepted by the preferred candidate. The Executive Director of Strategy, Planning, Performance and Communications process is live with final panel interviews on 14th December 2026.

MEETINGS OF NOTE

i. **VCS Divisional Strategic Review – 22nd September**
I chaired the VCS Divisional Strategic Review, which considered the National Cancer Strategy, Velindre Cancer Strategy, the Clinical Model and SACT performance.

ii. **Readiness Senior Leadership Workshop – 5th October**
The Readiness Senior Team meeting took place at the Village Hotel, Cardiff, to consider nVCC move planning options, explore benefits and risks and approve a way forward. It also shared current progress and workstream alignment, in addition to reviewing and approving priority service business cases.

iii. **Chief Executive Management Team meetings – 6th October and 19th November**
I attended the October meeting of the Chief Executive Management Team (the November meeting was attended by the Deputy CEO), where discussions focused on the National Cancer Programme CEO Lead Roles, National Clinical Plan, NHS performance and impact of waiting on patients and population health outcomes, lung cancer screening, and updates from Health Education and Improvement Wales.

iv. **NHS Wales Leadership Board meetings – 20th October and 17th November**
I attended the October and November NHS Leadership Board meetings, held at the Welsh Government Offices and Swansea Bay University Health Board Headquarters respectively, with fellow CEOs and Welsh Government Colleagues; the meetings focused on the following areas:

- Finance position and Operational Performance
- Urgent & Emergency Care improvement plan update
- Information Governance
- National Programmes forward look (including National Stroke Programme)
- Health Outcomes Framework for Wales
- Healthcare Quality Improvement Board progress, risks and next steps
- AI Governance and Assurance Framework
- National Data Resource and Information Products
- National sickness absence and resilience planning

v. **Cardiff Health Partners (CHP) Executive Management Board meeting – 28th October**
The October Executive Management Board meeting of the Cardiff Health Partners took place to discuss the following:

- Events for approval (away day / launch)
- Health Transformation Strategy
- Proposed CHP Recruitment

- Programme updates and escalations

vi. **Cardiff Health Partners (CHP) Away Day – 10th November**
Additionally, a CHP away day took place at Cardiff Business School. Workshop objectives included agreeing a focused set of priorities from the existing workplan over the next 24 months, defining collaborative approaches and ways of working to allow delivery of these priorities, agreement of governance, leadership, accountability and delivery arrangements to support implementation, and agreement of next steps, responsibilities and milestones.

vii. **nVCC Project Board and Project Readiness Board meetings – 28th October**
While I was not present at the September meetings of the nVCC Project Board and Project Readiness Board, the October meetings focused on key programme milestones and readiness for go-live. Discussions covered Programme changes and notices, contract approval, equipment approvals and benefits. Finance, comms and engagement updates and the change controls process were also considered.

viii. **Health Strategic Board (HSB) quarterly meeting – 10th November**
An HSB meeting was held with Welsh Government Colleagues to review the current nVCC programme position, a 3-month forward look, and legal and commercial items such as derogations, finance, compensation and delays.

ix. **Planned Care, Cancer & Diagnostics (PCCD) Board – 16th November**
As CEO for cancer across Wales, I am pleased to report that the inaugural PCCD Board met, which I co-chair with the CEO of Aneurin Bevan University Health Board. The purpose of the newly established PCCD Board is to provide strategic leadership, oversight and assurance for planned care, cancer and diagnostic service delivery and improvement across NHS Wales. It also supports the delivery of Welsh Government priorities by monitoring system performance against agreed trajectories and standards, identifying risks and barriers to delivery and collaboration to improve outcomes for patients and populations. This meeting considered the Terms of Reference, membership and delivery against the plan.

WALKAROUNDS

My programme of weekly walkarounds has progressed well and I have been able to visit a range of services and Departments across the Trust over the last few months.

Since the beginning of October, I have visited Quality & Safety, Digital Services, Blood Donation Services, and Transplantation Services at the Welsh Blood Service, and the Inpatient Service, the Assessment and Ambulatory Unit and the Radiotherapy Department at Velindre Cancer Service. The time spent listening to staff about their experience, how we improve our services and support them is invaluable in developing our culture and service offer.

TRUST BUSINESS

i. **NWSSP Governance and Accountability Implementation Group meeting – 23rd September**

I attended the Shared Services Partnership Implementation Group meeting with Shared Services and Welsh Government colleagues, the purpose of which was to update on the development of a prioritised work programme, consider information from a governance review workshop and agree next steps, and to consider a number of recommendations around Governance and Accountability arrangements for services commissioned from the NWSSP.

ii. **National Cancer Strategy for Wales – 25th September**
This meeting was intended to engage the Trust on the development of the National Cancer Strategy for Wales. The discussion focused on questions that had been provided in advance, such as the Trust's overall organisational perspective, delivery architecture, governance and accountability, national, regional and local service roles, and implications and next steps.

iii. **NHS Wales Performance and Improvement Performance meeting – 2nd October**
For NHS Wales Performance and Improvement to develop a rapid and fundamental understanding of the organisation's planning and delivery position, monthly meetings have been established to create a holistic assessment of the organisation across the four pillars (operational performance, quality and safety, finance and workforce), in line with the new operating and accountability framework. The meeting focused on the top 3 strategic priorities for 2026/27, assessment across the 4 pillars, key contracting requirements for 2026/27 and agreed actions, issues and decisions.

iv. **Joint Strategic Education Training Meeting – 5th October**
I attended the Joint Strategic Education and Training (previously known as 'commissioning') meeting with members of the Executive Team and a number of other senior staff, to discuss an overview of objectives, nVCC transition, education strategy, finance and resources and Trust Priorities for 2026.

v. **Cardiff & Vale / Velindre University NHS Trust Executive Partnership Group – 22nd October**
I chaired the Executive Partnership Group, which provided a summary of progress during the first year of the refreshed partnership, highlighted key learning and contextual information and supported discussion on emerging priorities and areas of focus for the next phase of partnership working (2027/28).

vi. **Structured Assessment – 27th October**
I met with Audit Wales colleagues, who are currently delivering their structured assessment 2026 review. The objective for the audit is to assess the effectiveness and impact of the Trust's arrangements for planning, delivering and overseeing its 2025-2028 Integrated Medium-Term Plan (IMTP).

vii. **Trust Accountability meeting – 27th October**
The bi-annual accountability meeting took place at the Welsh Government Offices to discuss the Trust's key achievements over the past six months and risks to delivery in the remaining six months across five key areas (leadership, delivery / performance, quality, workforce, and finance / planning). These meetings replace JET meetings, which were stood down with effect from 1st April 2026. The end-year Public Accountability meeting will take place on the 19th April 2027 and will be chaired by the Cabinet Minister.

EVENTS

STAR Awards – 22nd October

I attended the STAR awards which took place at the Village Hotel, Cardiff. Colleagues and teams from across the Trust were celebrated for their dedication, innovation and passion. It was amazing to see so many colleagues come together to honour each other's contributions and successes. Formerly the 'Employee Excellence Awards', the STAR Awards drew more nominations than previously, with 361 received in total.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None.

3.3 LEGAL IMPLICATIONS

3.3.1 None.

3.4 PEOPLE IMPLICATIONS

3.4.1 None.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

Not Applicable

Operational Risks

3.6.2 Not Applicable

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

4. RECOMMENDATIONS FOR ACTION / DECISION

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

Trust Board		
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR SEPTEMBER 2026		
DATE OF MEETING	25/11/2026	
STATUS	Public	
REPORT AUTHOR	Caitlin Davies, General Management Graduate Trainee.	
PRESENTED BY	1. Victoria Oxley, Director of Strategy, Planning & Performance (Interim) 2. Anne Carey, Chief Operating Officer, 3. Kate Hannam, Divisional Director of VCS, 4. Alan Prosser, Director of WBS, 5. Carl Taylor, Chief Digital Officer, 6. Lauren Fear, Director of Place, Portfolio & Partnerships, 7. Matthew Bunce, Executive Director of Finance	
REPORT SPONSOR	I, **Vicki Oxley, Interim Director of Strategy, Planning & Performance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	14/10/2026	WBS SLT / Performance Review
	20/10/2026	VCS OMB / Performance Review
	26/10/2026	Executive Management Board
	12/11/2026	Performance and Finance Committee
	17/11/2026	Quality, Safety and Experience Committee
	The report has been considered and endorsed at the VCS and WBS Performance Review meetings, the Executive Management Board, the Performance & Finance Committee and the Quality, Safety and Experience Committee. It is presented to the Trust Board for assurance on the Trust's performance for September 2026.	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 3 - AMBER (Some measurable impact evident from actions initially taken and an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement)	
	Velindre Cancer Service – Level 3 Welsh Blood Service – Level 3 Workforce & Wellbeing – Level 4 Digital Services - Level 3 Estates, Infrastructure and Sustainability – Level 4 Health and Safety – Level 3	

	Financial Performance – Level 4
EXECUTIVE SUMMARY	The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in appendix two which focuses on the key issues to be raised and discussed for September 2026. Key issues highlighted for attention are located in appendix two in the format of PowerPoint Slides. Please note the PMF process is currently being revised, following the Board Development Session, towards an Integrated Performance Report in line with NHS Wales Accountability and Support Framework (2026). However, while the Integrated Performance Report is under development, the existing PMF process will continue as per the current process for the remainder of this financial year. The Integrated Performance Report should allow for a more focused report for the Performance & Finance Committee, the Quality, Safety and Experience Committee and the Trust Board.
ACTION / DECISION	The Board/Committee is asked to: Take assurance from the Performance Management Framework for the month of September 2026.
ADDITIONAL RESOURCES	N/A

RELEVANT TRUST STRATEGIC GOALS

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

- Outstanding for quality, safety, and experience

RELEVANT TRUST WELLBEING GOALS

This report addresses the following wellbeing goal(s):

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

QUALITY AND SAFETY IMPLICATIONS

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

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

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision

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

Status: Not required - There are no specifc equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Key Considerations
	Appendix 2	Trust-wide Scorecards & Key Issues Highlighted by Exception

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION & BACKGROUND

1.1 The attached report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides which focus on the key issues to be raised and discussed for September 2026.

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

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

2. MATTERS FOR CONSIDERATION

2.1 ASSESSMENT

Key issues highlighted for attention are located in appendix two in the format of PowerPoint Slides. WBS matters of consideration consist of PowerPoint slides detailing WBS Red Cell Stock Levels, Quality Assurance, Time Expired Platelets, New Whole Blood Donors and Inclusion across the Whole Blood Donor Panel and Stem Cell Register. For VCS matters of consideration, these PowerPoint slides detail Single Cancer Pathway (SCP), SACT and Radiation Services performance.

2.2 FINANCIAL IMPLICATIONS

The core Trust is currently expecting to achieve all four financial targets set by Welsh Government:

- Breakeven position at 31st March 2027
- Payment of 95% non NHS invoices within 30 days
- IMTP approved by WG
- Adherence to Capital Expenditure Limit (CEL) at year end

Further information is provided within this report, narrating risks to the above in fuller detail. A comprehensive Finance report with wider commentary is also provided as a separate report for the meeting attendees.

2.3 LEGAL IMPLICATIONS

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

2.4 PEOPLE IMPLICATIONS

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

2.5 WELSH LANGUAGE IMPLICATIONS

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

2.6 RISKS / REPUTATIONAL IMPLICATIONS

2.6.1 Relevant Strategic Risk - Board Assurance Framework (BAF)

08 - Governance - Governance Strategic Risk is directly relevant to the Trust Performance Management. In addition, all nine BAF Strategic Risks are indirectly relevant to the Trust Performance Management.

04 – Finance – Individual financial risks are discussed where relevant in this document, and in the wider financial commentary available separately to meeting attendees. The overall financial sustainability and value risk assessment is reflected in BAF 04.

2.6.2 Operational Risks: None applicable.

3. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to take ASSURANCE from the Performance Management Framework for the month of September 2026.

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

Quality Domain	Trust-wide Safety Scorecard			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safe	Total Number of Velindre Acquired Infections (VAIs) across all bacteraemia types **(WHC 2024 (38) target)** Cumulative 25/26 versus 24/25	**National**	**Monthly**	**23/24 Base 13**	**<13 24/25**	**0 26/27**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Curative**	**Monthly**	**2.00%**	**2.00%**	**0.14% August 26**	✓	➔	
	Inpatient Mortality: Target under development/to be agreed	**Inpatient**	**Monthly**	**N/A**	**N/A**	**6**	N/A	N/A	
	Number of National Reportable Incidents	**National**	**Monthly**	**0**	**0**	**0**	✓	➔	
	WBS Serious Adverse Blood Reactions & Events (SABRE) incidents reported to regulator / licensing authority	**Local**	**Monthly**	**0**	**-**	**0**	N/A	N/A	Page 15
	Overdue Actions from open Serious Adverse Blood Reactions & Events (SABRE) / Serious Adverse Event or Reaction (SAEARs) actions	**Local**	**Monthly**	**New**	**<5%**	**7.6%**	✗	➔	Page 15
	Number of incidents triggering Duty of Candour	**National**	**Monthly**	**0**	**0**	**1 Sep 3 cum**	N/A	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗				**Cumulative data trend (15 months) = Improving ➔ stable ➔ fluctuating ▯ deteriorating ➔**					

Quality Domain	Trust-wide Timeliness Scorecard			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timely	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	11% 74%	✗	↑	Pages 27-32
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 76%	✗	↑	Pages 27-32
	Emergency Radiotherapy Patients Treated 80% within 1 day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	97% 97%	✗	↑	
	% Patients Beginning Non-Emergency (Routine) SACT within 21 days	National	Monthly						
	% Patients Beginning Emergency SACT within 2 days	National	Monthly						
	WBS Turnaround times – antenatal	Best Practice	Monthly	96%	90%	95.7%	✓	↑	
	WBS Turnaround times – Red Cell Reference Serology	National	Monthly	70%	90%	97%	✓	→	
	WBS Turnaround times – Foetal RHD Screening	Best Practice	Quarterly	New	90%	99%	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ▯ deteriorating ↓					

Quality Domain	Trust-wide Effectiveness Scorecard			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effective	Number of Cancer Pathway of Care Delays	National	Monthly	1	0		N/A		
	Clinical demand for red cells met (% manufactured to issued) ***met clinical demand – within tolerance**	Best practice	Monthly	104%	100%	101%*	✓	🡻	Page 17
	Clinical demand for platelets met (% manufactured to issued)	Best practice	Monthly	133%	100%	112%	✓	➔	Page 16
	New stem cell volunteers	National	Monthly	3341	333	671	✓	🡻	
	New Apheresis Donors	Local	Quarterly	21	14	22	✓	🡻	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating ▯ deteriorating 🡻					

Quality Domain	Trust-wide Efficient Scorecard			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 26	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	N/A	99%	N/A	N/A	N/A	
	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	£33k	£0	£12k	✓	➔	
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£346k	£93k	£209k	✗	🡻	Page 42
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻					

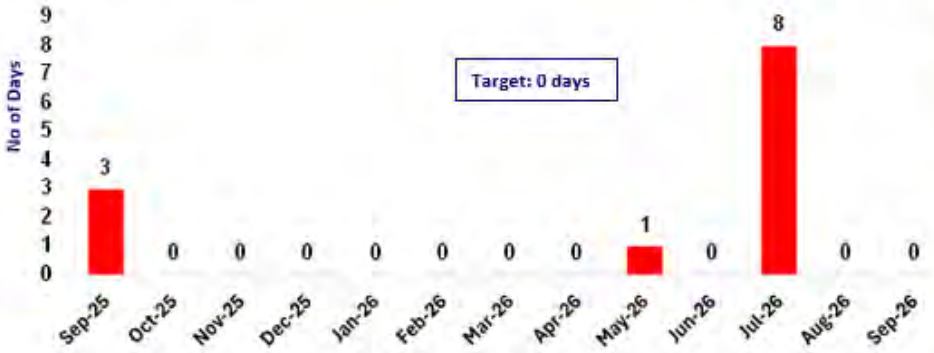
Quality Domain	Trust-wide Equitable Scorecard – Trust-wide position			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	7.91% Sep 26	✓	➔	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	7.66% Sep 26	✗	➔	
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	97.45% Sep 26	✗	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓					

Quality Domain	Trust-wide Experience Scorecard			Performance at September 2026			Compliance against Target		Slide Ref
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Person Centred	% of Patients Who Rate Experience at VCS as good or very good	Prof. Std.	Monthly	95	85%	95%	✓	➔	
	% of 'formal' VCS concerns responded to within 30 working days	Local	Monthly	100	85%	90%	✓	➔	
	Whole blood donors that rate their experience as excellent	UK Blood Services	Monthly	95%	85%	91.2%	✓	➔	
	WBS Resolution of formal concerns within *Listening to People* process timescales	National	Monthly	100%	100%	100%	✓	➔	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	79%	✗	➔	Pages 33-35
	% Rolling average Staff sickness levels	National	Monthly	6.22%	4.70%	5.98%	✗	↑	Pages 33-35
	Number of Incidents of violence and aggression to staff Trust-wide for 2025/26	Local	Monthly	N/A	27 25/26	5 Sep 24 cum	✓	➔	Pages 33-35
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓					

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2026



Key Issues / Risks:

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

Updates on last month:

- Red cell stock level did not drop below 3 days supply and all clinical demand for O, A & B+ groups was met in September.
- Red cell manufacturing slightly exceeded demand (101%) indicating a growing stock position through the month.
- There were no advisory alerts to hospitals and no mutual aid required in September

Action / Mitigation Underway:

- Daily operational oversight through Resilience Meetings to manage current stock pressure and emerging risks.
- Enhanced medium- and long-term planning through Blood Supply Chain Planning Group. Focussing on forecast demand, collection requirements and resilience.
- Delivery of a planned stock build ahead of winter to strengthen supply resilience.
- Actions underway to optimise collection capacity, including workforce, venue utilisation and donor attendance.

Forecast / Next Month:

- Stock position remain on track to reach target, with continued focus on priority group appointments and stock build.

Quality Assurance – Incidents & Audits

September 2026

Gwasanaeth Gwaed Cymru
Welsh Blood Service

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

↓ **1** exceeding target date for closure (in reporting month)	Target: 0
↓ **1** that remains overdue at month end	Target: 0
↓ **7.6 %** overdue actions from open incident action plans	Target: <5%

Quality (GMP) Incidents:

↑ **5** exceeding target date for closure (in reporting month)	Target: 0
↑ **5** that remain overdue at month end	Target: 0
↑ Age of oldest open overdue incident – **43 days**	No target set

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

↓ **1** from internal audits in the last month	No target set
→ **0** from external audits in the last month	No target set
↑ **8.6%** overdue actions from open audit action plans	Target: <5%

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

Action / Mitigation underway:

- Performance has improved in some areas; however, a small number of overdue incidents and audit actions continue to drive exception position.
- Overdue actions and incidents are subject to enhanced monitoring and escalation through Quality Assurance and SLT oversight processes.
- A Service Improvement project is addressing underlying process, governance and system issues supported by root cause analysis, SOP review and staff training.

Time Expired Platelets

September 2026

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Updates on Last Month:

- Time expired platelets increased from 10% to 12.5%, resulting in performance falling outside of the 10% target.
- Platelet supply remained sufficient, with manufacture equivalent to 112% of issues.
- Performance reflects the challenge of balancing supply resilience against variable clinical demand and the short shelf life of platelets.

Key Issues / Risks:

- Demand fluctuations and short shelf life increase the risk of wastage.
- Reducing production to minimise expiry must be balanced against maintaining supply resilience and avoiding shortages.

Action / Mitigation Underway:

- Platelet production and demand are continually reviewed to minimise expiry while maintaining supply resilience.
- Review of the Platelet Operational plan continues, including optimisation of apheresis clinic timing.
- Validation of a forecasting tools in underway to support production and decision making.

Forecast / Next Month:

- Performance is expected to improve towards target, although some variation is likely due to fluctuating clinical demand and the short shelf life.

New Whole Blood Donors (Quarterly Reporting)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2026

Updates on Last Quarter:

- 1736 new whole blood donors were recruited in Q2, against a target of 2750.
- Recruitment increased from 1615 in Q1, but cumulative performance remains below target at 3351 against 5000.
- Record hot weather disruption resulted in 2920 cancellations, 78% higher that in Q2 2025/26. An estimated 127 new donors were not recruited as a result.

Key Issues / Risks:

- Donor retention, priority blood groups and stem cell recruitment reduce capacity for new donor recruitment.
- Collection disruption, including adverse weather, can significantly affect performance.

Action / Mitigation Underway:

- Review new donor targets to ensure alignment with current demand, supply requirements and future service needs.
- Increase new donor appointments through schools, business and educational settings.
- Continue balancing recruitment with donor retention and priority blood group requirements.

Forecast / Next Quarter:

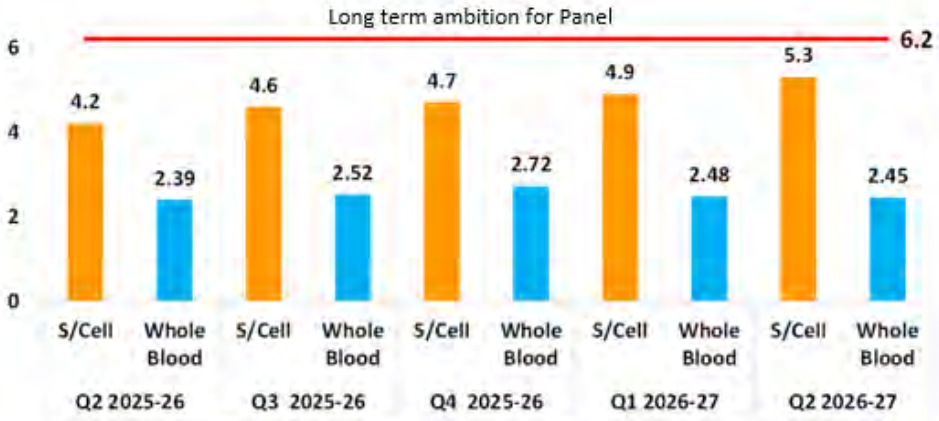
- Recruitment is expected to increase with the return of school donation opportunities; however, performance is likely to remain below the current target pending completion of the target review.

Inclusion across Whole Blood Donor Panel / Stem Cell Register

Gwasanaeth Gwaed Cymru
Welsh Blood Service

September 2026

Whole Panel Position 2026/27



Key Issues / Risks:

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

Stem cell recruitment exceeded target in September; whole blood recruitment improved to 10.06% but remained below target.

Recruitment Performance from Ethnic Minority Groups

Panel gender split for Q4: **Whole Blood -** Male: 63%; Female: 37%
Stem Cell - Male: 40%; Female: 60%

Forecast / Next Quarter:

- Performance is expected to remain in Q3 2026/27.

UK Census Benchmark (Wales): 6.2%

- **Whole Blood Donor Panel:** 2.45% of donors who reported ethnicity identify as being from an ethnic minority, below the 6.2% UK Census (Wales) benchmark.
- **Stem Cell Register:** 5.3% of volunteers who reported ethnicity identified as being from an ethnic minority, slightly below the 6.2% UK Census (Wales) benchmark, but improving on last quarter.

SCP and Non SCP Referrals by Health Board

Sep 2026

Number of SCP-related referrals received by Velindre

All Orgs | All Diagnosis Types | All Treatment Pathways | Oct 2025 – Sep 2026

Over the 12-month period shown, Velindre received an average of **179** SCP-related referrals per month. This represents 32% of the total average referrals per month

Number of Non SCP-related referrals received by Velindre

All Orgs | All Diagnosis Types | All Treatment Pathways | Oct 2025 – Sep 2026

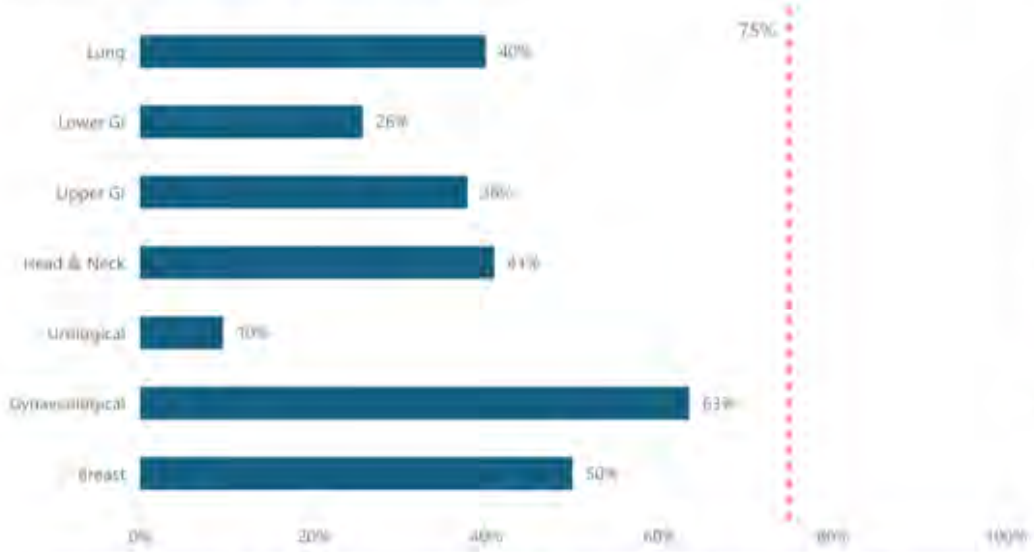
Over the 12-month period shown, Velindre received an average of **376** Non-SCP-related referrals per month. This represents 68% of the total average referrals per month.

SCP Performance per SST

Sep 2026

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

Treatment between October 2025 - September 2026



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

Treatment between October 2025 - September 2026

- Against the 62-day SCP pathway standard, where patients had their first definitive treatment at VCS, 33% of patients commenced first definitive treatment within the 62-day SCP standard against a target of 75% target.
- Within this group of patients, for those whose referral was sent to VCS by day 38, the performance improved to 72% (where VCS were then able to provide first definitive treatment by day 24).
- Whilst fewer than half of patients met the target, 75% were treated within 35 days and 90% within 47 days.
- An improvement plan at SST level (and HB) is being developed with support from data and insights to understand the key causes of breaches at SST level and identify mitigations to reduce delays.

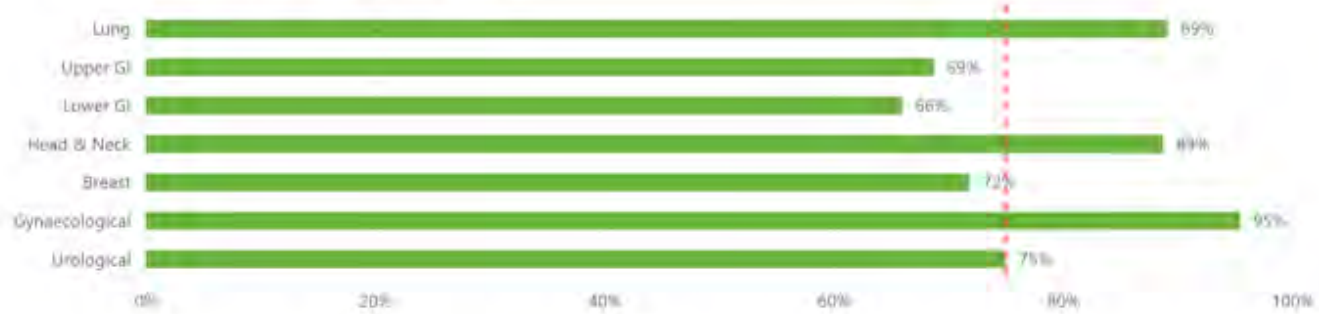
SCP Pathway Analysis (38 Day)

Sep 2026

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

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

Treatment between October 2025 - September 2026



38-days (SCP patients received to VCS)

- In Sept - 72% of patients were treated within the 62 day pathway when the referral was received by day 38

Tumour sites achieving the standard:

- Urological
- Gynaecological
- Head and Neck
- Lung

A deep dive for those tumour sites not achieving this target is in progress with support from data and insight to identify key causes of breaches and opportunities to mitigate against this – Q3 completion

Non-SCP Pathway Analysis (24 Day)

Sep 2026

**Non SCP Includes new referrals with no previous activity and patients with previous HB treatment history; excludes subsequent SCP treatments not captured on the central PTL*

Percentage of patients starting treatment at Velindre within 24 days of decision to treat

Local 24-Days Target (Non-SCP patients received to VCS)

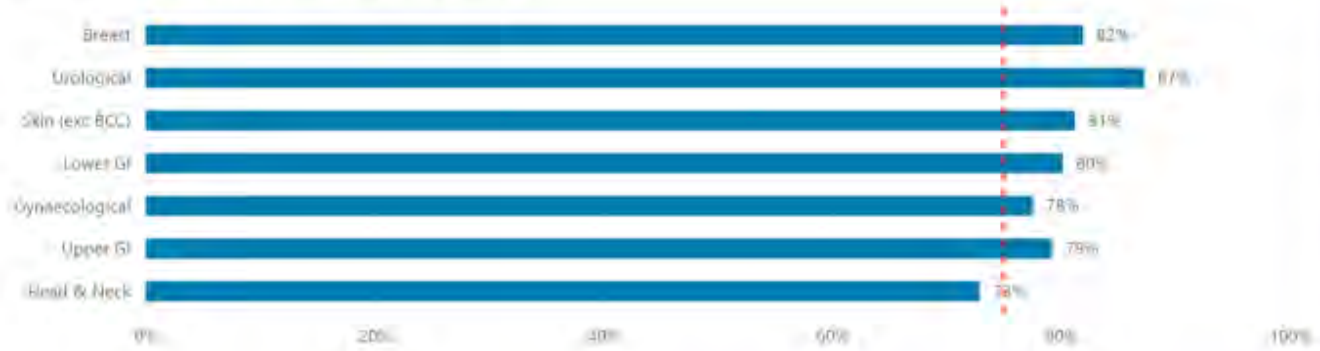
- 83% of patients treated vs the 75% target.

Tumour sites achieving the standard:

- Lower GI
- Urological
- Breast
- Skin (excluding BCC)
- Upper GI
- Gynaecological

Percentage of patients starting treatment at Velindre within 24 days of decision to treat by tumour site (ordered by most to fewest referrals)

Treatment between October 2025 - September 2026



Head & Neck Performance – Key Factors

- Increasing demand, with continued growth in H&N patient numbers.
- Greater pathway complexity and additional oncology / SACT requirements from newer treatments.
- Limited clinical capacity / headroom within the current service model.
- Clinically necessary delays, including dental preparation and patients not medically fit to commence treatment.
- Performance reflects a combination of demand, complexity and patient readiness, rather than service capacity alone.
- Deep dive underway at SST level with support from data and insights to clarify the opportunities for improvement.

SACT Quality standards – Performance (all treatment intents)

Sep 2026

Total

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	316	256	276	297	247	296	271	300	320	306	291	279
Total Breaches	170	110	128	172	131	164	145	152	161	154	151	129
% Compliance	46.2%	57.0%	53.6%	42.1%	47.0%	44.6%	46.5%	49.3%	49.7%	49.7%	48.1%	53.8%

IV First Treatment

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	261	213	224	226	203	235	219	244	260	251	244	219
Total Breaches	151	97	112	144	116	144	128	144	147	147	144	123
% Compliance	42.1%	54.5%	50.0%	36.3%	42.9%	38.7%	41.6%	41.0%	43.5%	41.4%	41.0%	43.8%

Oral First Treatment

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	55	43	52	71	44	61	52	56	60	55	47	60
Total Breaches	19	13	16	28	15	20	17	8	14	7	7	6
% Compliance	65.5%	69.8%	69.2%	60.6%	65.9%	67.2%	67.3%	85.7%	76.7%	87.3%	85.1%	90.0%

New Validation arrangement have been introduced since July 2026. Specific changes for September 2026 data includes:

- 41 Exclusions of patients who have SACT, as part of pathway where RT is the first treatment (9 Oral and 32 IV. Of the 32 IV exclusions 29 P2:Curative 1 P2:Neo-adjuvant and 2 P3: Adjuvant)
- No adjustments for incorrect emergency treatment intent this month
- Manual revision of DTT where incorrect DTT assigned (1 IV Palliative case)

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

SACT Quality Standards (National SACT group)

Sep 2026

P1 - Emergency - within 2 days

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

P2 - First definitive - 14 days

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	24	25	19	13	20	18	6	12
Total Breaches	15	17	15	8	14	6	3	5
% Compliance	37.5%	32.0%	21.1%	38.5%	30.0%	66.7%	50.0%	58.3%

P2 - Neo adjuvant - 14 days

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	32	31	40	58	51	46	44	53
Total Breaches	22	20	23	37	37	34	25	33
% Compliance	31.3%	35.5%	42.5%	36.2%	27.5%	26.1%	43.2%	37.7%

P2 - Palliative - 14 days

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	105	120	102	111	122	117	127	115
Total Breaches	63	77	58	72	70	82	89	74
% Compliance	40.0%	35.8%	43.1%	35.1%	42.6%	29.9%	29.9%	35.7%

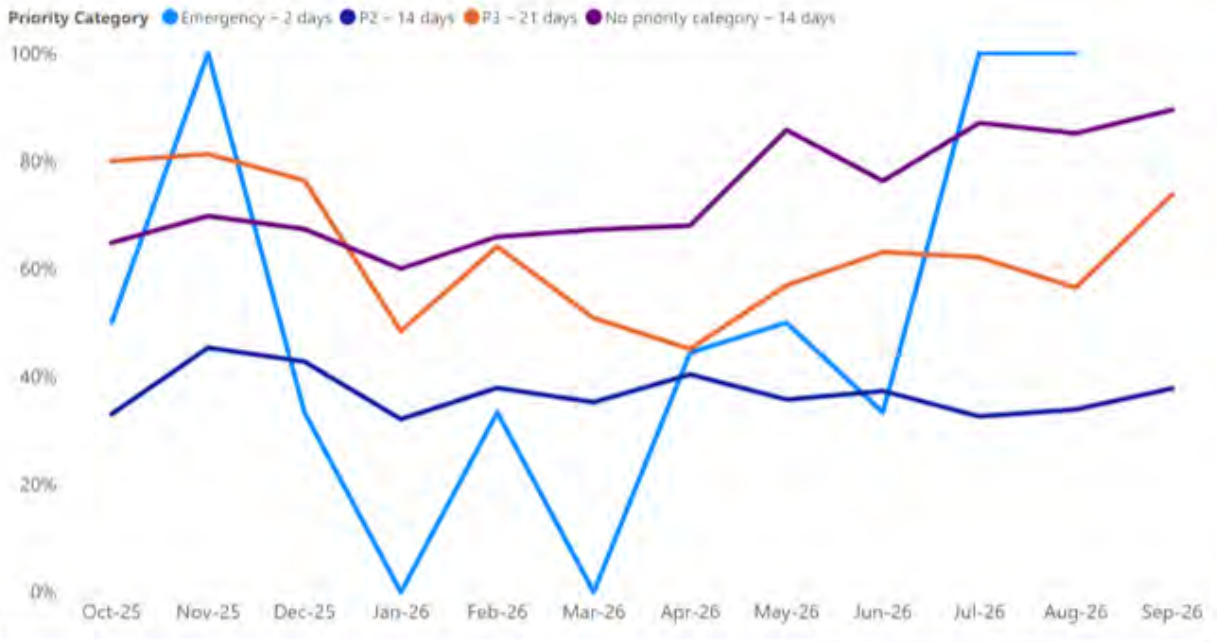
P3 - Adjuvant - 21 days

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	39	61	51	58	65	66	62	42
Total Breaches	14	30	28	25	24	25	27	11
% Compliance	64.1%	50.8%	45.1%	56.9%	63.1%	62.1%	56.5%	73.8%

No Priority Assigned - 14 days

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Referrals	44	58	50	56	59	54	47	57
Total Breaches	15	19	16	8	14	7	7	6
% Compliance	65.9%	67.2%	68.0%	85.7%	76.3%	87.0%	85.1%	89.5%

SACT Performance by Priority Category



P2 - First definitive – 4 pts treated day 15-18 (33%) 92 % treated by day 18. Longest wait hospital reason 19 days
P2 - Neo adjuvant –19 pts treated day 15-18 (36%) – 74% treated by day 18. longest wait hospital reason 21 days.
P2 - Palliative – 25 pts treated day 15-18 (22 %) –56% treated by day 18. Longest wait hospital reason 28 days.

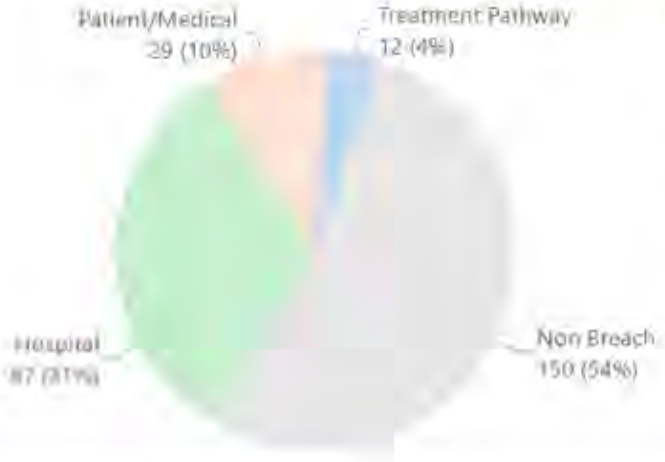
P3- Adjuvant – Longest wait hospital reason 23 days.

No Priority assigned. These are all Oral SACT. The 6 Oral Breaches relate to Medical/ Patient reason(4))After Radiotherapy (1) No Breach reason (1) .

SACT Quality Indicators (all treatment intents) – Breach Analysis

Sep 2026

Percentage Breakdown By Category



SST Level Performance

	GI - Lower	Breast	Lung	Urological	GI Upper	Gynae	Skin	Sarcoma	Head & Neck
Total Treatments	75	49	44	36	22	20	17	5	5
SACT Performance - Sept	**54.7%**	**53.1%**	**45.5%**	**61.1%**	**45.5%**	**55.0%**	**76.5%**	**40.0%**	**40.0%**
SACT Performance - Aug	36.4%	51.1%	40.4%	61.1%	51.7%	57.9%	65.0%		53.3%
Hospital Reasons	29.3%	18.4%	38.6%	36.1%	50.0%	30.0%	5.9%	60.0%	40.0%
Medical/Patient reasons	14.7%	24.5%	9.1%	2.8%	0.0%	10.0%	17.6%	0.0%	20.0%
Treatment Pathway Reasons	0.0%	4.1%	6.8%	0.0%	0.0%	5.0%	0.0%	0.0%	0.0%

For noting

- **Breach reasons** – the SACT team analyse breach reasons in detail to identify themes which are then incorporated into the improvement plan to focus on areas where improvements can be made within the pathway to reduce risks of delays to treatment
- **Demand is outstripping capacity-** New SACT referrals (Cycle 1) have increased significantly in September, average of 130 per week (27% growth on 2025/2026) and up from average of 107 in August 2026. 8% growth level for 26/27 is 108 referrals per week which was included in the IMTP.
- The number of **patients in escalation is increasing**. These are patients on active treatment (cycle 2+) who need a treatment slot following deferral, but currently no capacity available for the date required. The service are submitting datix incidents where patients in escalation are not able to booked in to the correct day for treatment, and where we are exceeding pharmacy capacity.
- **Pharmacy capacity constraints** are linked to resource and QA audit. This is being addressed via the SACT business case for expansion, and the team will be starting recruitment process in Oct 2026. Additional QA resource was approved earlier in the year (28 July) and the 8a post will start w/c 19 October.

Pharmacy capacity is the primary breach reason. However the service is also aware of chair/nurse limitations, which has also been detailed within the SACT business case.

SACT Updates/Actions

Sep 2026

Update from last month

- Pembro switch roll out – September 2026 38.5 %, August 38.5%, July 27.4% (Target 50% by December, 70% by March 2027. Current patient numbers of ~450). Access to scheduling capacity impacting on implementation timeline.
- New Validation changes for SACT PTL confirmed, date for testing to be confirmed by Vitalhub.
- Chair Utilisation and SACT Performance Deep Dive Dashboards developed by Data and Insight and released to SACT Operational Team for testing.

Actions for next period

- **Pembro Switch** – Meeting scheduled in October to revist options for improving the pace of switch roll out.
- Data and Insight resolving escalated issues re **sharepoint Booking** List. Training of staff end of Oct 2026. Implementation moved from Sept to Nov 2026 (due to capacity constraints within digital team)
- **Review of Chair Utilisation** and SACT Performance Deep Dive Dashboard being undertaken. Team to review during October.
- **Decoupling** – progressing with recruitment into the 1.5 wte posts. Meeting scheduled for 13th November 2026 to start process of prioritisation of Protocols to be decoupled.
- **Finalisation of business case for SACT** for executive review complete – Home First trial requested to be included by Exec DoN
- **Revised Booking Rules** to be launched in October

Key risks/issues

- **Workforce:** Pharmacy workforce challenges with shortages across team (short term sickness/maternity leave)
- Bank shifts being carried out by nursing team to address increase in demand/increase in chair utilisation.
- **Capacity Constraints:** capacity and demand imbalance across the SACT delivery service resulting in breaches against clinical indicators. (Risk #3747 – 20)
- **Data & Digital Gaps:** issues with data quality and digital systems hinder effective scheduling and tracking and management information to inform deep dives. (Risk #3337 – 16)

Mitigation

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

Radiation Services – COSC Quality standards: Mandatory and Optimal Targets

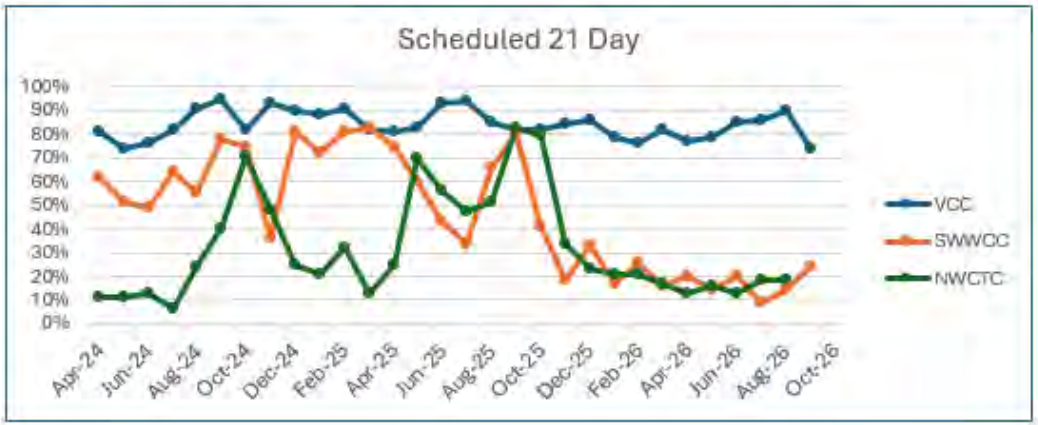
Sep 2026

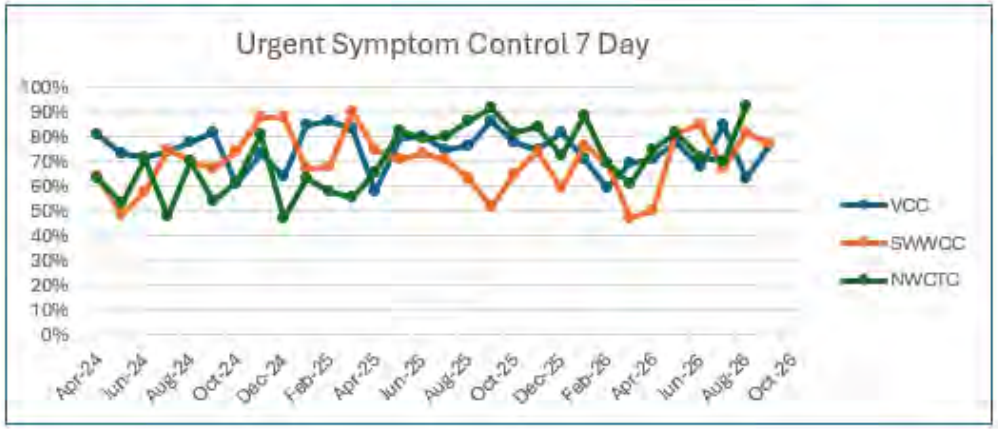
Mandated Quality Indicator	Target	July	August	September	Movement
Scheduled radiotherapy patients to begin treatment within 21-days of decision to treat	100%	66%	90%	74% (171/230)	↓
Urgent symptom control radiotherapy patients to begin treatment within 7-days of decision to treat	100%	86%	63%	76% (35/46)	↑
Emergency radiotherapy patients to begin treatment within 2-days of decision to treat	100%	100%	94%	97% (31/32)	↑
Elective delay radiotherapy patients to begin treatment within 14-days of decision to treat	100%	100%	96%	99% (67/68)	↑
Optimal Quality Indicators					
Scheduled radiotherapy patients to begin treatment within 14-days of decision to treat	80%	13%	10%	11% (25/230)	↑
Urgent symptom control radiotherapy patients to begin treatment within 2-days of decision to treat	80%	7%	5%	11% (5/46)	↑
Emergency radiotherapy patients to begin treatment within 1-day of decision to treat	80%	100%	94%	97% (31/32)	↑
Elective delay radiotherapy patients to begin treatment within 7-days of decision to treat	80%	97%	95%	97% (66/68)	↑

Scheduled performance reduced to 74% during September, with the ARIA outage and machine availability contributing to delays. **Urgent Symptom Control** improved to 76%, while **Emergency** and **Elective Delay** performance remained comparatively strong at 97% and 99%. Scheduled and Urgent Symptom Control performance remain the principal areas for improvement.

COSC Quality Standards – Scheduled and USC Performance

Sep 2026





Performance Target: Scheduled radiotherapy

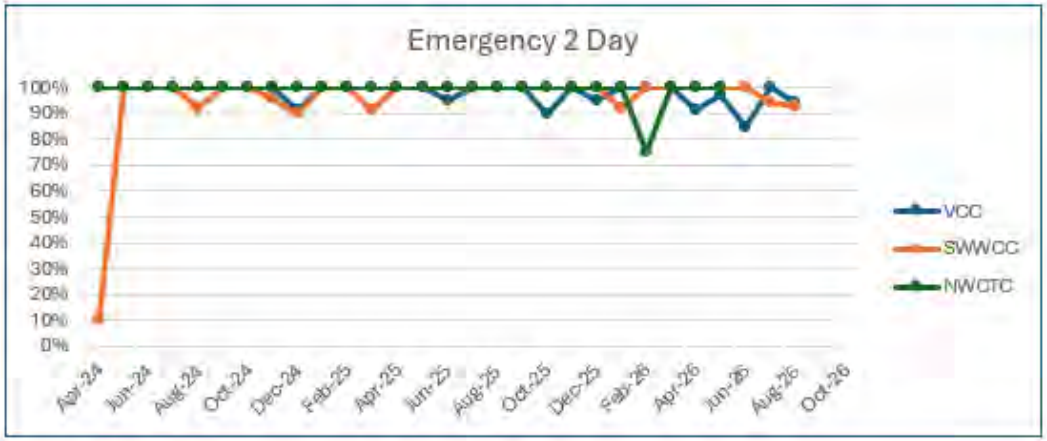
- **21 days target**; 74% (171 patients out of a total of 230 referrals) vs 90% August
- **Longest wait** = 42-days - the wait attributed to the requirement to develop a complex treatment plan
- The breaches were due to patients being medically unfit for RT and patient choice (see breach slide for more detail)

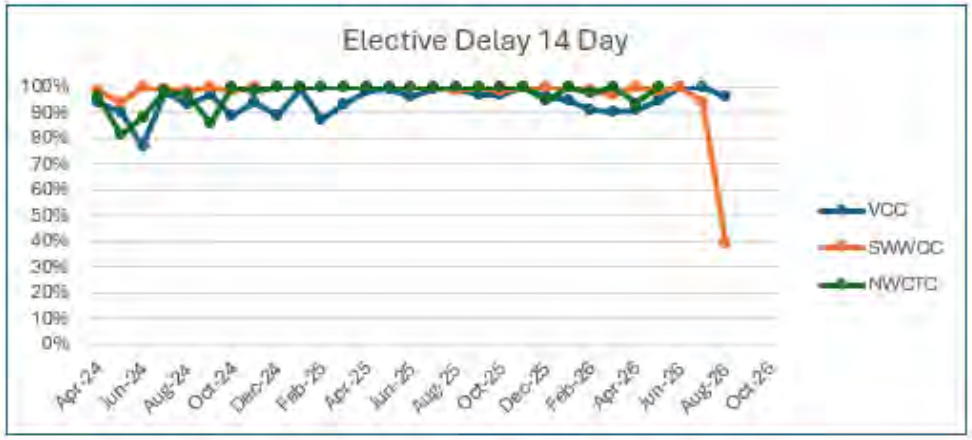
Performance Target: Urgent Symptom Control

- **7-day target**; 76% (35 patients out of 46 referrals) vs 63% August
- The breaches were due to ARIA outage, machine downtime and patient specific complexities (see breach slide for more detail)

COSC Quality Standards – Emergency and Elective Performance

Sep 2026





Performance Target: Emergency

- 2 days target; 97% (31 patients out of a total of 32 referrals) – the one patient who breached (seen at day 3) was considered medically unwell until that day

Performance Target: Elective Delay

- 14 days standard; 99% (67 patients out of a total of 68 referrals) – the one patient who breached the 14 days was due to late plan delineation.

Radiotherapy – COSC Quality Standards - Breach Analysis

Sep 2026

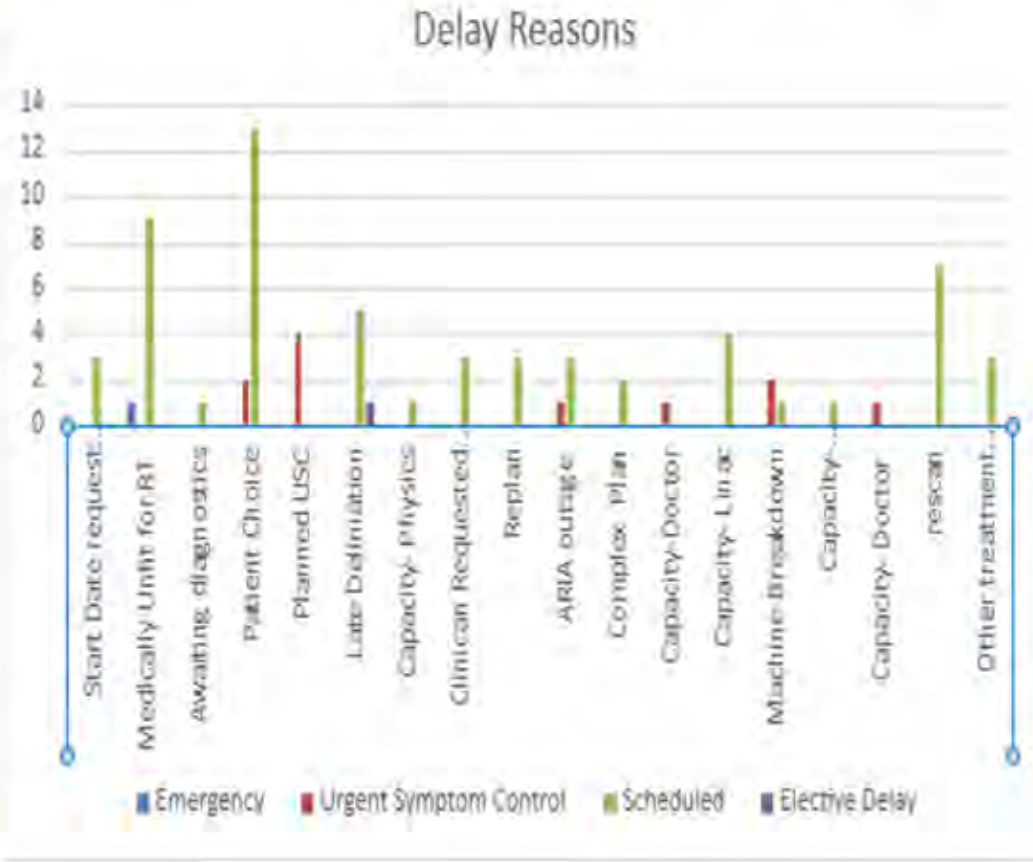
The main reasons for the 72 breaches in September were:

Scheduled (59 breaches) (24% of scheduled referrals) – the largest number of breaches were attributed to patient choice and to instances when patients were deemed to be medically unfit to commence treatment within target. The longest wait to start treatment was reported as 42-days. This was attributed to the need to develop a complex treatment plan.

USC (11 breaches) (24% of USC referrals) – the largest number of breaches were attributed to machine downtime and ARIA outage and to the need to address patient specific plan complexity. The longest wait to start treatment was reported as 14-days. This wait was due to patient specific plan complexity.

Elective (1 breach) (1% of Elective delay referrals) – one breach was attributed to late plan delineation due to referrer failing to comply with agreed referral processes.

Emergency (1 breach) (3% of emergency referrals) – the longest wait to commence emergency radiotherapy was 3-days. The patient was considered medically unfit to undergo radiotherapy treatment within the target.



Radiotherapy COSC - Updates/Actions

Sep 2026

Update from last month

- **Capacity and Performance** - CT planning capacity remained stable. Overall schedule performance 82%; Emergency 100% within 2days.
- **Pathway and Technology** - HyperArc SRS, Gynae Eclipse and Breast IMN solutions implemented. Ethos palliative treatments delivered at V@NHRU.
- Business continuity plans developed to utilise SRU to mitigate loss of activity through Varian upgrades planned over the coming months.

Key risks/issues

- **Demand/capacity imbalance and data issues** limiting full performance assurance – especially on USC pathway.
- **Activity reporting and assurance –** gaps in activity and income reporting reduce assurance and benchmarking capability.

Actions for next period

- **Capacity and Performance** - Resolve data issues and continue V@NHRU ramp-up, including Urgent Symptom Control.
- **Pathway and Technology** - Implement Partial Breast Irradiation and Lower GI pathways; continue Ethos development.
- **Activity, reporting and assurance** - Complete RT and brachytherapy reporting and progress benchmarking and Aria Core Insights readiness.

Mitigation

- A **radiotherapy improvement plan** is in place to address the main causes of breaches – of the 7 key actions in the plan, all are currently in progress with some actions relating to the IRS programme.
- **Demand/capacity –** escalation and clinical prioritisation in place.
- **Activity reporting and assurance –** joint work with data and insights, finance and physics to strengthen Aria data and reporting. Inaugural workshop is being arranged for November 2026, which will look at areas including the ability to make data issues easier to diagnose, expand the range of activity data available, and increase data refresh frequency beyond the current once-daily update.

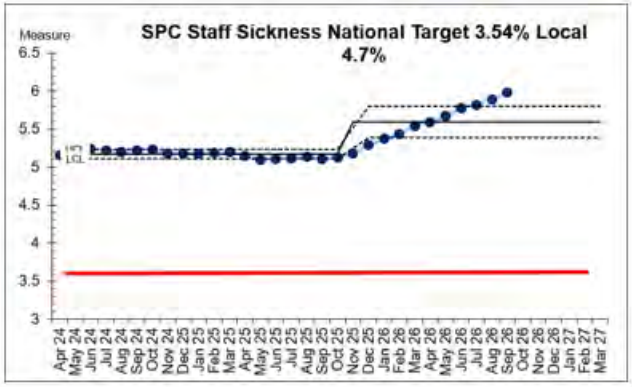
Sep 2026

Assurance

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

People, Wellbeing & Organisational Development

Sept 2026



Action / Mitigation Underway:

- **Sickness absence** Targeted focus groups have been established in Divisions. A co-ordinated group including WOD and service managers are focusing on the reasons for sickness to diagnose issues to then establish a clear action plan to support issues. This will take time and outputs expected in January 2027 with a report to People Committee
- **Health and wellbeing** Service now extended until April 2028 to support continued service delivery and focus on service development
- **Statutory and Mandatory Training** monitoring and compliance against target will be maintained as part of business as usual People Management practice.
- **PADR compliance** has a continued focus on improving PADR completion, with performance monitored through existing governance arrangements and targeted follow-up in areas where compliance is below the required level.

Forecast / Next Month:

- **PADR:** compliance is expected to improve , supported by ongoing management focus, targeted follow-up and monitoring of areas below the required level.
- **Sickness:** absence remains an area of concern, actions are in place to address as noted. Comprehensive update in People Committee in January

Key Issues / Risks:

- Capacity of management time to undertake effective people management activities alongside clinical workload. Attendance of FOMs has increase with key modules such as Managing Attendance, recruitment & Selection and Effective PADR's all over 85%
- Capacity of People and OD to support the growing demand for People Management support. Additional 2 HR Advisors now appointed

People KPIs Heatmap

Sep 2026

	PADR	Sickness Absence FTE Rolling	Stat & Mand	Welsh Language Awareness	Anti Racism	Turnover FTE Rolling	Job Plan
Corporate	59.15	4.80	85.96	83.33	90.43	10.75	N/A
Research, Development & Innovation	78.33	4.54	86.16	80.82	93.15	13.50	N/A
Velindre Cancer Services	83.01	6.09	89.75	82.95	91.67	8.05	80.41
Welsh Blood Service	83.21	7.12	93.49	89.52	97.82	9.57	100.00
nVCC	85.72	0.89	92.08	81.25	93.75	7.20	N/A
Velindre (excluding Hosted Organisations)	79.35	5.98	90.02	84.49	93.10	9.02	81.19
Target	85%	3.54%	85%	90%	85%	7%	90%

People - NHS Staff Survey Culture Metrics – 2024 and 2025

Sep 2026

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

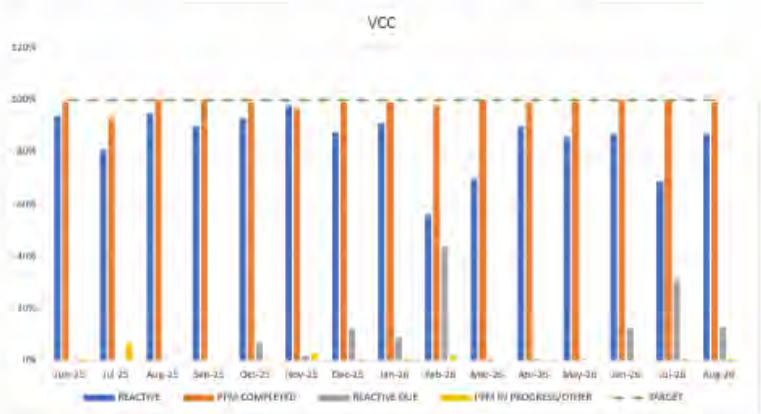
This data is from the NHS Wales Staff Survey 2025.

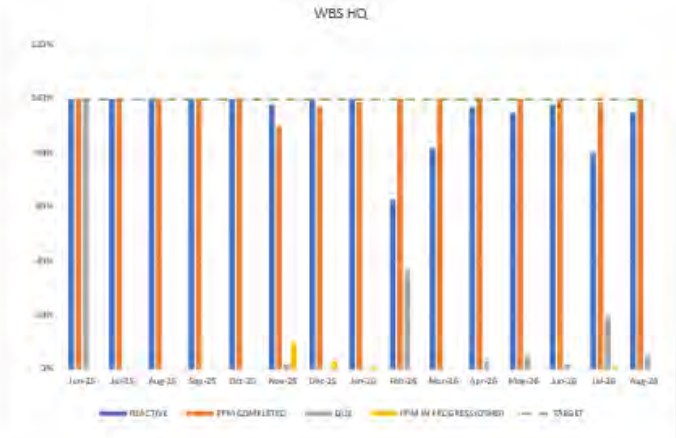
- The green represents percentages higher than the NHS Wales average and the pink represents a percentage lower than NHS Wales average.

*benchmarking average for Health Boards

Estates and Infrastructure

Sept 2026





Updates on Last Month:

VCC – PPM = 100% - Reactive = 86 %
Trust HQ – PPM = 100% - Reactive = 96%
WBS HQ - PPM = 100% - Reactive = 100%
Dafen – PPM = 100% - Reactive = 100%
Wrexham – PPM = 100% - Reactive = 100 %
Bangor – PPM = 100% - Reactive = 100%

Action / Mitigation in Progress:

- A recovery plan is in place, including targeted technician overtime and prioritisation of outstanding reactive tasks against agreed completion dates. The remaining workload primarily relates to low-risk water safety improvement actions and is being actively managed, with continued oversight to maintain PPM compliance and restore reactive performance.

Forecast / Next Month: October 2026

- PPMs September planned for VCS - 536
- PPMs September planned for Trust HQ - 15
- PPMs September planned for WBS sites - 160

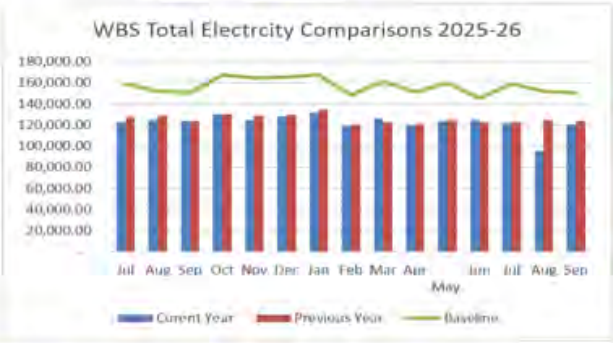
Main Issues / Risks:

- **VCC Reactive Maintenance:** 86% completion reflects the prioritisation of a significantly increased PPM workload during the reporting period. The remaining 14% of reactive tasks primarily relate to **low-risk water safety improvement works associated with soap dispensers**. These actions remain under active management and are being progressed alongside the planned maintenance programme.

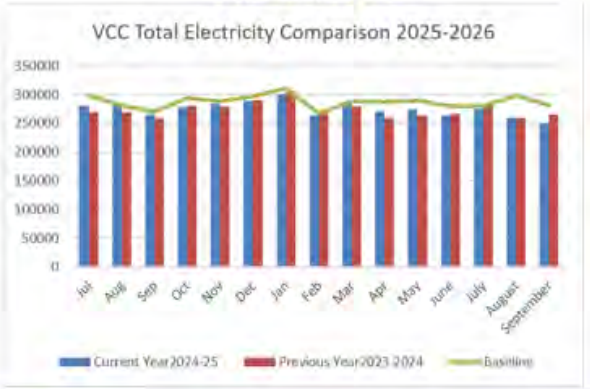
Estates Sustainability

Sep 2026

Elec – Total WBS



Elec – Total WBS



Updates on Last Month:

- **Gas consumption:** Gas consumption down across all sites to reflect the warmer weather and switching off of heating. AMR fault with VCC Hospital meter which is skewing data.
- **Electricity use:** As expected.
- **ISO14001 External Audit:** Completed successfully, providing positive assurance on our Environmental Management System and highlighting the strong environmental work taking place across the organisation.
- **Welsh Government Energy Service Ynni Grant**: Trust awarded grant funding for WBS Bangor and Wrexham sites to have SLES renewable energy infrastructure upgrade. Completion of this work will ensure Trust meet our Sustainability Implementation Plans.

Action / Mitigation Underway:

- **Energy Management:** Deliver internal audits, BMS monitoring, and monthly Estates reviews to identify inefficiencies, and track ongoing energy reductions. To be completed monthly.
- **Waste & Recycling:** Roll out WBS waste upgrade projects: complete audits across all Wales sites by Q2 2026, with improvement actions implemented by Q1 2027 while maintaining VCS BAU before nVCC.

Forecast / Next Month:

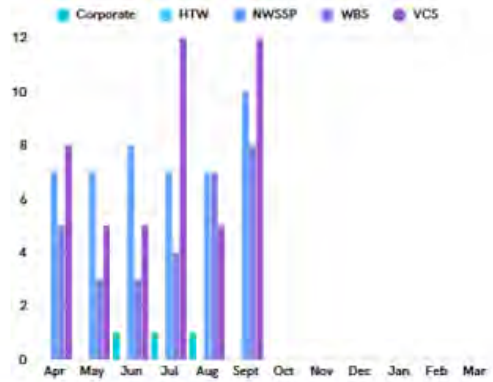
- Bin replacements across WBS are expected to increase recycling rates.
- Energy costs continue to be monitored via WEOG, with potential price increases linked to Middle East geopolitical factors. April marked the start of NHS Wales contract move to Variable 30 contract.
- Focus on EV chargers to promote and increase staff use – policy currently going through
- nVCC transitions planning making good progress.
- The 2026 Staff Travel Survey received 442 responses, more than double the number received in 2025. The findings will inform the development of the Trust's next Staff Travel Plan (2027-2032), support travel planning requirements for the nVCC, and help deliver the Trust's sustainability and decarbonisation objectives.

Key Issues / Risks:

- None to note.

Health & Safety

Incidents by Division 26/27



Sept 2026

Updates on Last Month: Total of incidents

- NWSSP – 10
- VCS - 14
- WBS – 8
- Corporate - 0
- MIM (Trust Managed) - 0
- RIDDOR – 0

Forecast / Next Month:

- Complete the first phase of the Corporate Headquarters credible-scenario assessment.
- Progress the business-impact assessment and testing requirements for identified scenarios.
- Continue development of service-specific Principle 10 arrangements across Corporate Headquarters, Velindre Cancer Service and Welsh Blood Service.
- Continue incident trend analysis and targeted follow-up of recurring themes.
- Progress wider HSMS assurance and implementation activity.

Action / Mitigation Underway:

- Continued monitoring of incident trends, with learning and actions managed through established governance arrangements.
- Development of the Health & Safety Management System assurance framework and supporting evidence requirements.
- Progression of the Principle 10 framework, including credible-scenario identification, business-impact considerations and links to plans and response arrangements.
- Continued focus on violence and aggression, sharps safety and manual-handling controls.

Key Issues / Risks:

•Violence and aggression remains the most reported incident theme, particularly within Blood Donation and patient-facing services.
•Recurring sharps injuries continue to require reinforcement of safe handling and disposal practices.
•Manual-handling injuries continue within Radiotherapy, particularly during patient transfers and positioning.
•Further work is required to ensure emergency arrangements are service-specific, supported by credible scenarios and subject to appropriate exercising and testing.

Health & Safety

Sept 26

Incident Severity - Heinrich's Triangle

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

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

WELSH BLOOD SERVICE

	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	0
2	1	3
1	7	22
0	0	4
Total Incidents:	8	29

VELINDRE CANCER SERVICE

	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	1
2	1	2
1	6	24
0	7	22
Total Incidents:	14	49

VUNHST - TRUST TOTAL

Total of all

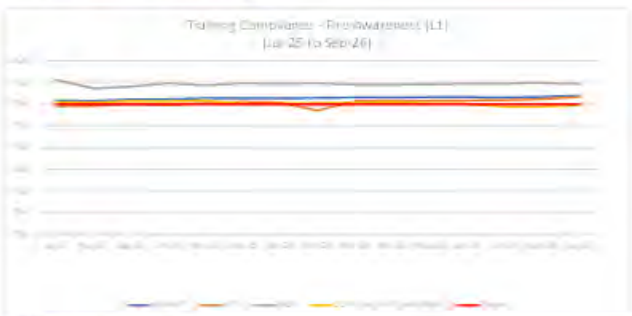
	Monthly Total (This month)	Running Total (Year to Date)
5	0	0
4	0	0
3	0	1
2	0	5
1	8	49
0	4	26
Total Incidents:	22	81

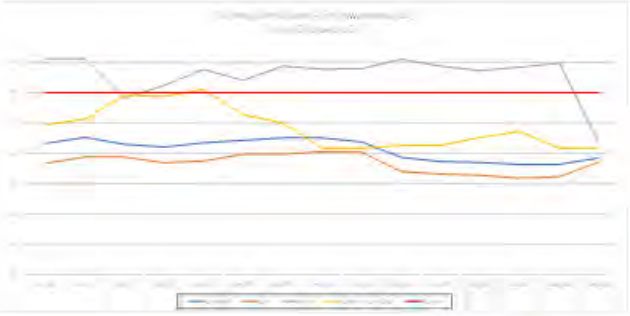
Notes: Corporate Services recorded 0 incidents during September 2026 and 3 incidents year-to-date. All three year-to-date incidents were classified as Minor (Level 1); no Moderate, Severe, Major or Catastrophic incidents were recorded within Corporate Services.

PMF LINK

Fire Safety

Sept-26





Updates on Last Month:

STRATEGIC

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

VCS

- Number of FRA actions on FARS increased but number of actions closed also increased; however, further engagement with Risk Handlers required to ensure actions are taken within acceptable timescales.
- Continued improvements with training compliance but Clinical compliance still below accepted minimum benchmark. Plan agreed to achieve 85% benchmark for Clinical [L2] training compliance by end of *SEPTEMBER 2026*, however, there has been a marked improvement in compliance and several VCS departments have been in contact to arrange training, but compliance for VCS still has not achieved the 85%. Efforts have been made to discuss with VCS senior management, but no conversations have been had to develop a coordinated service-wide plan; however, engagement with individual departments has been more productive.

WBS

- Further engagement with Risk Handlers required to ensure actions are taken within acceptable timescales.
- Continued improvements with training compliance; compliance for both Non-Clinical and Clinical both above minimum benchmark.
- Training of Evacuation Wardens completed for WBS fixed sites.

Corporate

- Development of action plan for nVCC transition and ongoing partial operation of existing VCC site

Action / Mitigation Underway:

STRATEGIC

- Revise strategy for delivery of fire safety and other emergency response training to focus on essential information and record participation in drills & exercises on ESR to support improvement in training compliance- ongoing with P&OD [Ed & Dev team].
- Develop FRA dashboard to provide more granular data on progress with FRA, Audit and Inspection actions.
- Work with Trust WOD to review and update fire safety training competencies on ESR to support delivery of quality training and clearer competencies; activity includes innovation to develop digital training offering to increase accessibility of training material to staff.

VCS

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

WBS

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

CORPORATE

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

Forecast / Next Month:

STRATEGIC

- Continuation of work on Principle 10 [Emergency Procedures] of HSMS including consideration ofnVCC
- Review and align fire safety KPIs with new Firecode Management document
- Initiate development of fire safety KPI dashboard to support alignment of KPIs with Firecode [HTM 05]
- Develop better guidance for fire risk handlers identified in FRAs
- Support with implementation of HSMS P10 [Emergency Preparedness and Response]

VCS

- Anticipate improvement in training compliance but target to achieve agreed benchmark by end of September 2026 missed. VCS need to discuss and agree tangible target for compliance of 85% [end of Q3].
- Schedule evacuation exercise for First Floor wards
- Schedule evacuation exercise for Main OPD
- Formation of VCS Evacuation & Security 'group' as sub-group of VCS Cynefin to support implementation of Principle 10 and transition to nVCC.

WBS

- Fire training for BDT staff ongoing with completion date of end of **October 2026.**

CORPORATE

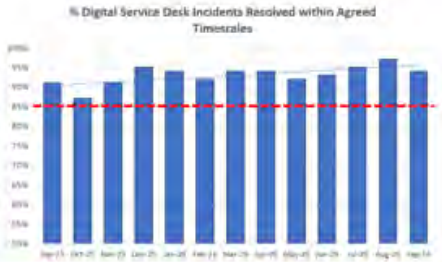
- Further work on FRA actions.

Key Issues / Risks:

- Continued low compliance for fire safety training; especially VCS Clinical [L2]; Service needs to take ownership, develop and execute plan to achieve benchmark. Progress towards compliance is at risk due to limited engagement from relevant service areas despite requests for input. The issue has been escalated and will be discussed at the next Cynefin Group meeting to agree actions and support delivery of the planned approach.
- Need for evacuation drills and exercises in all Services
- Ongoing issues around closure of risks identified in fire risk assessments and use by risk owners / further education on new FARS fire risk assessment module required.
- Alignment of emergency evacuation procedures with requirements of the Terrorism (Protection of Premises) Act 2025 and transition to nVCC; this will include additional training burden which the Trust need to consider as part of HSMS P10.

Digital Services

Sep 2026



Updates on Last Month:

- Service performance remains above the agreed percentage; Incidents performance remained stable in September.
- No Major Incidents recorded.
- Percentage of Cyber Security mandatory training above target again this month.
- Development underway on Halo ITSM to improve reporting capabilities.
- Capital funding approved to replace legacy Server infrastructure.

Forecast / Next Month:

- Digital Service improvement work ongoing to configure and adopt the contract and supplier management aspect of the HALO IT Service Management solution with support from 3rd Party.
- Technical refresh - Quotation and purchase new server infrastructure.
- Capital investment request from Welsh Government for the Desktop technical refresh Programme.
- Complete installation of PSBA Network circuits at nVCC site in readiness for Varian installations.
- Continue to test and advise on Live Connectivity for WBS collections.
- Implement Single Sign on Imprivata pilot solution in Inpatient VCC areas, strengthens Cyber security and reduces staff logon times.

Action / Mitigation Underway:

- Capacity and demand across Digital Services continues to be reviewed, with a focus on balancing BAU and project activity.

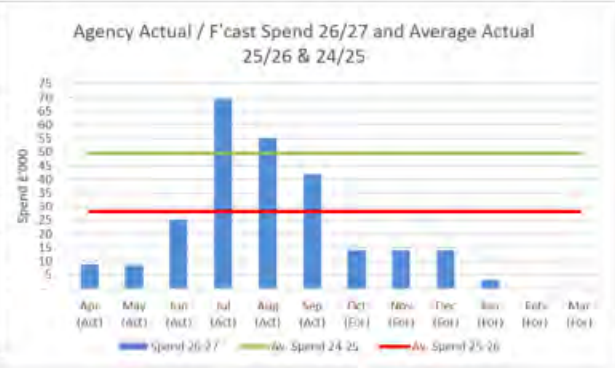
Key Issues / Risks:

- Increasing digital capacity pressures, compounded by changes to solutions, scope and planned delivery dates across key Programmes, creating competing priorities.

Financial Performance

Sept 2026

Trust Revenue Position (core)	25/26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual Cum £k	33	2	3	6	8	4	12						
Target		0	0	0	0	0	0						
Trust Capital Position	**25/26**	**Apr 26**	**May 26**	**Jun 26**	**Jul 26**	**Aug 26**	**Sep 26**	**Oct 26**	**Nov 26**	**Dec 26**	**Jan 27**	**Feb 27**	**Mar 27**
Actual Cum £m	20.593	0.395	1.938	2.534	6.542	8.197	9.285						
Target £67.702m CEL		0.395	1.938	2.534	6.542	8.197	9.285						



Updates on Last Month:

- The Trust has reported a small underspend up to 30 September 2026 of £0.012m which is in line with the 2026-27 IMTP plan.
- The Trust has met the Public Sector Payment Performance (PSPP) target of paying 97% of Non-NHS invoices within 30 days for September 2026.
- The Trust is on track to achieve the Capital Expenditure Limit (CEL) for 2026-27.
- All saving schemes for 2026-27 have been identified and are now rated green. They will require close monitoring as the year progresses.

Forecast Year End Position:

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

Action / Mitigation Underway:

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

Key Issues / Risks:

- Non delivery of full saving plans for 2026/27.
- Commissioners not supporting Service investments above 1.11% core uplift funding.
- VCS Service Transformation Investment.
- Ability for Divisions to manage new / emerging cost pressures.
- Confirmation from WG received that the Same Day Emergency Care recurrent funding was agreed by the Minister in the Allocation letter on a recurrent basis.

EXECUTIVE MANAGEMENT BOARD		
Finance Report: Month 6 (September 2026) 2026/27		
DATE OF MEETING	26/11/2026	
STATUS	Public	
REPORT AUTHOR	Claire Bowden, Head of Financial Planning & Reporting & Steve Coliandris, Deputy Director of Finance	
PRESENTED BY	Matthew Bunce, Executive Director of Finance	
REPORT SPONSOR	I, **Matthew Bunce, Executive Director of Finance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	26/10/2026	Executive Management Board (EMB)
	12/11/2026	Performance & Finance Committee (P&F)
	The paper was noted by EMB: particularly the September forecast, year-to-date income and the rebase discussion. The position remained subject to receiving Welsh Government's confirmation of recurrent SDEC funding, which the Trust would continue to pursue. The P&F Committee noted the report and particularly discussed the lack of funding by JCC of WBS business cases, and the potential future impact of fixed term contracts ending.	
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR DISCUSSION	
	• Long term agreement (LTA) financial values, contract rebase & VCS LTA financial performance • Integrated Medium Term Plan (IMTP) financial plan / forecast • Key financial targets / performance indicators	
EXECUTIVE SUMMARY	The attached report sets out the Trust's financial position and performance for the period ended 30 September 2026. It highlights the key issues affecting delivery of the 2026-27 financial plan: LTA financial values and contract rebase, the IMTP financial plan and forecast, and performance against key financial targets and KPIs. The three main issues are highlighted below:	

1. Long Term Agreement (LTA) financial values, contract rebase & VCS LTA financial performance

LTA Financial Values:

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

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

Contract Rebase:

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

VCS LTA Financial Performance:

- The IMTP planned overperformance against 2019/20 baseline contract levels in 2026-27 is £10.590m. This represents an increase in contract income of £0.282m against the 2025-26 outturn and the plan set through the IMTP. The forecast marginal income overachievement is being held to support the underachievement on radiotherapy activity and underlying cost pressures within VCS.

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

- A balanced three-year IMTP financial plan covering 2025-28 was approved by Welsh Government. The 2026-29 plan was submitted to Welsh Government on 31 March 2026 and was approved on 26 August 2026.

- The Trust has achieved a minor underspend of £0.012m for the four-month period ended 30 September 2026 and is currently forecasting a breakeven position at 31 March 2027.

	• Maintaining a balanced underlying position remains challenging because of the significant cost pressures and risks facing the Trust. Despite this, the 2026-29 IMTP reflected a balanced brought-forward position, which is expected to be maintained over the course of the plan. **3. Key Financial Targets / KPIs** • Revenue Balance: The Trust has reported a year-to-date underspend of £0.012m at 30 September 2026. • Public Sector Payment Performance (PSPP): The Trust has achieved the PSPP target of paying 95% of Non-NHS invoices within 30 days. • Capital Expenditure Limit (CEL): The Trust is forecasting achievement of its CEL in 2026-27. • Savings Target: All schemes are now rated green. It is important that these are closely monitored and if fully delivery is not deemed achievable, they are replaced with alternative schemes.
ACTION / DECISION	The Trust Board are asked to note the contents of the September 2026 financial report and, in particular: • The year-to-date and forecast revenue and capital outturn position, and Public Sector Payment Performance (PSPP). • The latest position on VCS LTA income for 2026-27 from the Trust's commissioners. • The position with commissioners on the contract rebase agreement, noting that the LTA issue with Hywel Dda UHB has now been resolved. The current position of the Trust savings plans.
ADDITIONAL RESOURCES	N/A
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:	
• Outstanding for quality, safety, and experience	
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):	

- A Prosperous Wales

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

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

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

Status: QIA not required - not a strategic decision

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

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

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

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

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

2. BACKGROUND

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

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

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

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.008	0.012	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.088	9.285	68.188
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.3%	96.8%	95.0%

3.2 FINANCIAL IMPLICATIONS

The core Trust has reported a minor overspend of £0.008m for September 2026, leading to a year-to-date underspend of £0.012m. This is in line with the IMTP planning assumptions and supports the current year-end forecast of breakeven. However, delivery remains challenging given the cost and service pressures outlined in the plan, together with the additional commissioner funding required for service developments that has not been secured.

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

Savings

The overall Trust savings performance at September 2026 shows that in-month planned savings of £0.224m were overachieved by £0.093m, with £0.317m delivered.

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

LTA Income

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

LTA Contract Position

Commissioners agreed no additional funding in 2025-26 above the 1.77% uplift for WBS or VCS, and no additional funding above the 1.11% uplift has currently been agreed for 2026-27. The Trust continues to manage capacity pressures across outpatients, ambulatory care, SACT and imaging to meet rising demand and cancer waiting times. Although the Velindre Collective Commissioning Group for Cancer planned a further review of the SACT business case, no commitment was made in 2025-26. The financial risk of the additional implemented capacity therefore remains with the Trust. Growth investments were resubmitted on 22 October 2025 for 2026-27, but all Commissioners confirmed that no funding support would be provided.

LTA Contract Rebase

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

3.3 PSPP Performance

During September 2026 the Trust (core) achieved a compliance level of **95.3%** (August 96.4%) of non-NHS supplier invoices paid within the 30-day target. The Trust year to date compliance (including NWSSP) is **96.9%** compared to the target of 95%.

3.4 Reserves

The financial strategy for 2025-26 and previous years included an emergency reserve of £0.500m, established on the assumption that expected income would be received, planned savings schemes would be delivered, and emerging cost pressures would be managed. As part of the 2026-29 IMTP planning process, Welsh Government directed the

Trust to use this reserve recurrently to support the underlying position. As a result, the reserve is no longer available from 2026-27 onwards.

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

3.5 **Financial Risks & Opportunities**

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

- Commissioners not supporting Service Investment / Growth in VCS and WBS - *likelihood: medium, value £TBC*
- Radiotherapy Activity Income Underachievement – *likelihood: medium, value £0.300m*
- Management of Operational Pressures – *likelihood: medium, value £0.500m*
- Non-Delivery of Savings - *likelihood: medium, value £0.500m*

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

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

3.6 Capital

All Wales Programme

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended 31st March 2027 is currently £67.702m (2025-26 £20.603m). This includes All Wales Capital funding of £65.456m, and discretionary funding of £2.246m.

A further £8.644m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as and when required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. The nVCC project team has requested a £0.250m drawdown against this contingency fund (Quantified Risk Assessment) in addition to a separate request to release £0.236m to support the sale of the Whitchurch Hospital site. While approvals are awaited, the year-end forecast is reported as an overspend.

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

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

allocation of £2.246m represents an increase of 12.3% on the £2.000m provided during 2025-26 which was fully spent.

In line with usual practice, Welsh Government will consider the values on the CEL fixed at 31st October 2026. The Trust submitted a return required by Welsh Government on 16th October 2026 highlighting amendments required and requesting further funds for discrete items. Further information is provided within the main report.

3.7 LEGAL IMPLICATIONS

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

3.8 PEOPLE IMPLICATIONS

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

3.9 WELSH LANGUAGE IMPLICATIONS

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

3.10 RISKS / REPUTATIONAL IMPLICATIONS

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

04 - Finance

Individual financial risks are discussed in section 2.7 of the report, and the overall financial sustainability and value risk assessment is reflected in the Board Assurance Framework (BAF 04).

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

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

Operational Risks

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

4. RECOMMENDATIONS FOR ACTION / DECISION

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

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

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

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

4.1.4 The current position of the Trust savings plans.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Gwasanaeth Canser Felindre
Velindre Cancer Service

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 30 SEPTEMBER 2026

TRUST BOARD
26 NOVEMBER 2026

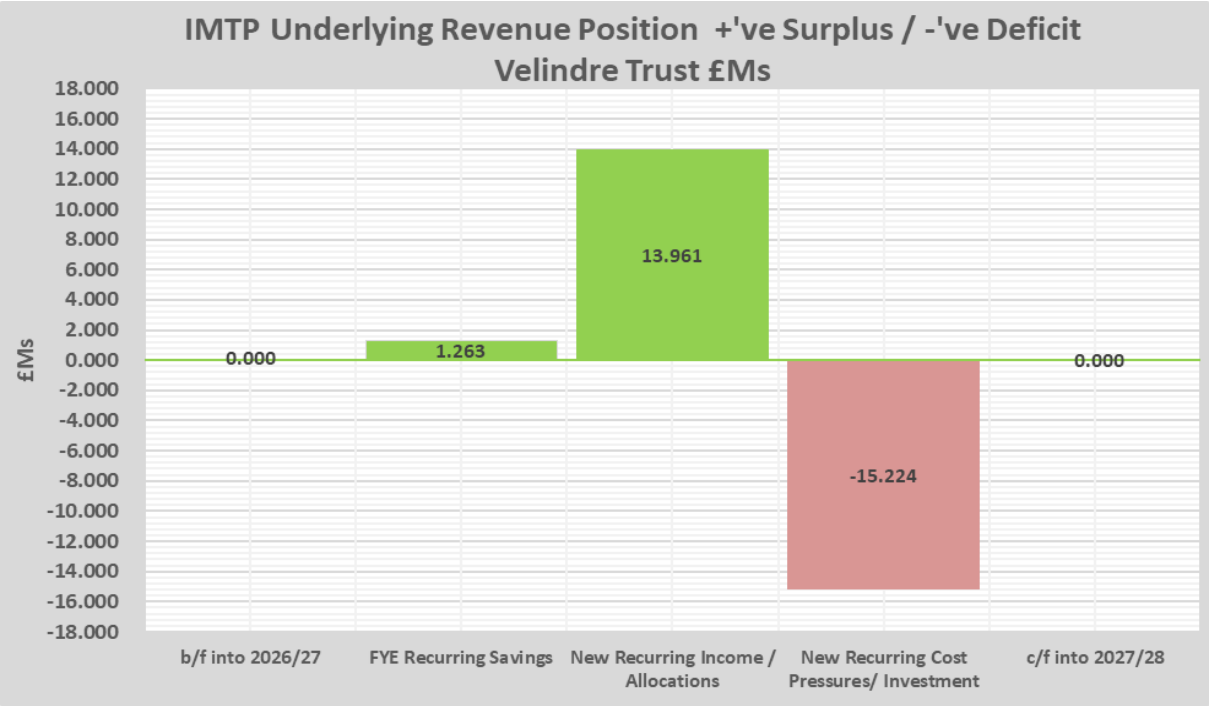
1. Introduction

This report summarises the Trust's financial position for 2026-27 for the period 1st April to 30th September 2026. It highlights performance against the revenue, capital, cash and savings targets; sets out the key risks to delivery of the breakeven forecast; and identifies the actions being taken to manage those risks through divisional plans, Trust reserves and engagement with Commissioners and Welsh Government.

2. Background / Context

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

- The Trust submitted a balanced three-year IMTP covering 2026-27 to 2028-29 to Welsh Government on 31 March 2026. This was approved by Welsh Government on 26th August 2026.
- For 2026-27 the Plan included:
  - A balanced position brought forward from 2025-26;
  - Full-year effect of new cost pressures and investment of **£15.224m;**
  - Offset by **new recurrent income of £13.961m;**
  - Recurrent full-year effect **savings schemes of £1.263m;**
  - A **balanced position** to be carried forward into 2027-28.
- The 1.11% core discretionary uplift will be required to fund the significant underlying cost pressures, investment in capacity beyond marginal cost, and the revenue investment decisions in relation to the Trust's major infrastructure and equipment projects.
- **To deliver a balanced financial position, the Trust must achieve the 2026-27 savings target, secure all anticipated income, and ensure that any emerging cost pressures are either mitigated at divisional level or managed through Trust reserves.**



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

3. Executive Summary

Key message: the Core Trust is reporting a small year-to-date underspend of £0.012m and continues to forecast breakeven at year end. Delivery remains dependent on achieving the £2.647m savings target, securing anticipated income, and managing emerging cost pressures through divisional plans or Trust reserves. The main risks requiring Board and Committee oversight are savings delivery, commissioner funding for service growth, radiotherapy activity income, capital delivery before 31 March 2027.

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	0.008	0.012	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.088	9.285	68.188
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.3%	96.8%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to Date £m	Year End Forecast £m
Efficiency / Savings	Variance	0.093	0.048	0.000

Revenue

The core Trust reported an underspend of £0.008m in September 2026 and a year-to-date underspend of £0.012m. This remains consistent with the IMTP assumptions and supports the current breakeven forecast. Delivery will remain challenging because planned cost and service pressures still need to be managed and additional Commissioner funding for service development has not yet been secured.

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

Capital

The approved Capital Expenditure Limit (CEL) for 2026-27 is £67.702m, comprising £65.456m of All-Wales capital funding and £2.246m of discretionary funding. The year end forecast spend shown in the table above of £68.188m is £0.486m higher than the current CEL, reflecting the nVCC QRA Contingency drawdown and Whitchurch Hospital Disposal Contingency drawdown requests described later in the report. Capital expenditure to 30th September 2026 was £9.285m: 14% of the current CEL value, and all approved funding is expected to be fully utilised during 2026-27.

A significant volume of equipment and deliveries, valued at approximately £30m and relating to the nVCC project, are scheduled for receipt during the final quarter of the year. These items will require close management to ensure all assets are received by 31st March 2027, enabling funding to be recognised within the 2026-27 financial year in line with Welsh Government funding availability. Service leads have been asked to expedite agreed discretionary capital purchases where possible to aid pressure in the final quarter of the year.

Some All-Wales scheme funding remains subject to Welsh Government confirmation. The nVCC project team has also requested a £0.250m drawdown from the QRA contingency held by Welsh Government, and a similar request for £0.236m has been made in respect of the Whitchurch Hospital Disposal site.

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

Approved CEL	Opening CEL £m	Movement £m	Current CEL £m
All Wales Capital:			
Integrated Radiotherapy Solution	17.115	-1.047	16.068
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.000	1.142
nVCC - Project	37.825	0.000	37.825
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.000	0.059
nVCC - Enabling Works	0.393	0.000	0.393
Welsh Blood Service Fleet Replacement Programme 2025-26	0.882	0.367	1.249
Fees to develop the OBC/FBC for the PET at the nVCC	0.256	0.000	0.256
Digital Resource for the nVCC Project	0.550	0.000	0.550
Digital Backlog funding 2026-27	0.000	0.149	0.149
Estates Backlog funding 2026-27	0.000	0.400	0.400
Whitchurch Hospital Fees - Contingency	0.000	0.007	0.007
DPIF - Medicines and Prescribing: ePMA	0.025	0.000	0.025
DPIF - Transforming WBMDR software	0.000	0.166	0.166
DPIF - Transforming WBMDR software stage 2	0.000	0.167	0.167
Total All Wales Capital Programme	**65.247**	**0.209**	**65.456**
Discretionary Capital	**2.246**	**0.000**	**2.246**
Total Approved CEL Items	**67.493**	**0.209**	**67.702**
Currently Shown in Unapproved Section of CEL	QRA to be Drawn £m	Decision Awaited £m	Funding Confirmed £m
nVCC – Project - Quantified Risk - MIM	3.243		
nVCC – Project - Quantified Risk - Public Sector	4.716		
nVCC – Enabling works – QRA	0.449		
Whitchurch Hospital Fees - Contingency	0.236		
Total Unapproved CEL Items	**8.644**	**0.000**	**0.000**

In line with usual practice, Welsh Government will consider the values on the CEL fixed at 31st October 2026. The Trust submitted a return required by Welsh Government on 16th October 2026 highlighting amendments required and requesting further funds for discrete items. Further information is provided later in this report.

PSPP

During September 2026 the Trust (core) achieved a compliance level of **95.3%** (August 96.4%) of non-NHS supplier invoices paid within the 30-day target, leading to a cumulative year to date compliance of **96.8%**. The Trust year to date compliance, including NWSSP, is **96.9%** compared to the target of 95%.

Efficiency / Savings

An in-depth review of the Trust's savings plans was undertaken during the IMTP process. For 2026-27, a savings target of £2.647m was set and allocated across the Trust's core divisions. Whilst a gap was identified at the submission of the IMTP, schemes have now been identified forecasting full delivery by 31st March 2027:

Savings Plan by Division	Target £m	Identified (Green) at submission of IMTP £m	Savings Target Gap at submission of IMTP £m	Identified (Green) at 31/08/2026 £m	Savings Target Gap at 31/08/2026 £m
Welsh Blood Service	**0.879**	0.879	0.00	**0.879**	**0.000**
Velindre Cancer Service	**1.303**	0.500	0.80	**1.303**	**0.000**
Corporate Services	**0.178**	0.078	0.10	**0.178**	**0.000**
Research, Development & Innovation	**0.287**	0.000	0.29	**0.287**	**0.000**
Total	2.647	1.457	1.190	2.647	0.000

During September 2026, in-month planned savings of £0.224m were over achieved, primarily due to earlier than planned income generation by WBS in relation to Plasma for Medicines. Delivery was £0.317m leading to a surplus of £0.093m in month and a YTD overachievement of £0.048m. It is important to note that the overall value of the savings planned for the year has not increased; it has simply achieved this element of the plan earlier than expected.

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

Revenue Position

Cumulative Breakeven				Forecast Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(138.743)	(139.105)	0.363	(286.319)	(287.335)	1.016
Pay	58.319	57.335	0.983	116.493	115.483	1.010
Non Pay	80.424	81.758	(1.334)	169.826	171.852	(2.026)
Total	**0.000**	**(0.012)**	**0.012**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of September 2026 is an underspend of £0.012m, with a year-end outturn forecast of breakeven.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

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

VCS have developed business cases for investment into their core services which have been endorsed by the Executive Management Board, and will be submitted to the next Performance & Finance Committee, for onward consideration by the Trust Board.

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

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

Income

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

Cumulative (£0.363m overachieved)			
Type	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)
Core Income - HB / JCC	58.916	58.968	0.052
Nice/ High Cost Drugs	36.382	36.382	0.000
WBS Wholesale Blood Products	15.312	15.219	- 0.093
WBS Transplantation Services	0.026	0.026	0.000
WBS Blood Components	0.025	0.483	0.458
Home Care Drugs	0.662	0.718	0.056
Private Patient	0.671	0.508	- 0.163
VCS Over Activity	5.295	5.295	0.000
Radiotherapy Activity Income	1.632	1.351	- 0.281
IRS Programme	0.581	0.581	0.000
Radiation Protection	0.621	0.649	0.028
Staff Recharges	0.559	0.546	- 0.013
One Wales Palliative and EOL Care	0.734	0.739	0.005
Velindre Charity	1.839	1.715	- 0.124
Other Charity	0.042	0.048	0.007
RD&I*	3.018	2.777	- 0.241
HTW	0.909	0.842	- 0.067
Other Operating Income	11.520	12.258	0.738
Total	138.743	139.105	0.363

*RD&I full year budget includes £2.225m of income from the Velindre Charitable Fund

The £0.095m underachievement in WBS Wholesale Blood Products income relates to reporting issues following the eProgressa outage at year end, which created an imbalance in charges to Health Boards. This non-recurring impact will be addressed through non-recurrent mitigations during the financial year.

The Blood Components overachievement of income is a non-recurring timing issue in the recovery of wholesale blood products from Health Boards in respect of the receipt of product pricing. This is forecast to net off to a nil balance at the end of the year. The small budget of £0.025k is in relation to one off expenditure costs that cannot be recharged to Health Boards.

The year to date Private Patients income is presently understated due to the timing of accruals. These will be corrected in period 7 based on the forecast income to the end of the financial year, which is currently forecast to overachieve, supported by the agreed additional tariffs.

The variance reported against Radiotherapy Activity income is partially offset by vacancies, non-recurrent funding support, contract performance income for wider services (resulting in a nil variance shown in the above table for VCS over activity), and non-pay reductions. These are non-recurring mitigations to address the underperformance against planned contract income levels set out in the IRS business case. The income underperformance will be recurrently offset in part

through the allocation of contract income from wider cancer services and anticipated growth in future financial years.

The year to date RD&I income is presently understated due to the timing of income receipt based on delivery of milestones to release payment. Based on the forecast income to the end of the financial year, full delivery of the income target is anticipated. Currently the income underachievement is fully offset by underspends on pay and non pay costs resulting in a breakeven position being reported.

The over achievement in other operating income is primarily due to additional bank interest being received above that budgeted and planned to contribute to the non recurrent increase in legal costs in the Corporate division this year.

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

Commissioners are expected to pass through the 2025-26 Agenda for Change, Medical and Senior Manager staff costs through LTAs in line with the Welsh Government pay award matrix. The 2026-27 pay inflation is expected to be funded by Welsh Government and passed to the Trust through the Health Board commissioning model once the allocation is confirmed, based on actual staff in post. Any shortfall, including staff increments or bank staff costs, will need to be met through the discretionary uplift, further savings, or divisional absorption.

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

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

VCS Long Term Agreement (LTA) Contract Performance

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

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

To ensure Commissioners fund the full cost of Velindre cancer services from 2026-27 onwards, Commissioners will need to agree a change in commissioning principles from historic shares, based on 2004-05 activity and NICE consumption, to a current activity and NICE consumption baseline. The way Commissioners manage the resulting financial impact is for them to determine; however, this should not prevent the Trust from moving to charging based on current activity and

consumption from 2026-27. Without collective agreement on how the financial impact will be managed across Wales, the current dispute between the Trust and Hywel Dda UHB is likely to transfer to a dispute between the Trust and other Health Boards.

As the Trust is keen to move to a cost recovery based on actuals, rather than historic shares, there is a contract rebase exercise now underway, which will be presented to the Commissioners upon completion. Currently, there is an aim to complete this exercise in the final quarter of 2026-27 and to present it at the established Commissioners' meeting upon completion. The exercise has been communicated as part of the Collective Commissioners meeting.

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

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

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Hywel Dda	0.749	0.017	0.766	2%	-0.019	0.035
Swansea Bay	0.512	-0.017	0.528	-3%	0.007	-0.023
Cardiff & Vale	17.707	3.697	22.320	21%	3.516	0.181
Cwm Taf Morgannwg	15.997	2.672	19.634	17%	2.688	-0.016
Aneurin Bevan	22.177	3.854	27.352	18%	3.779	0.075
Powys	1.210	0.310	1.592	25%	0.312	-0.002
NHS Wales Joint Commissioning Committee	2.438	0.282	2.855	12%	0.306	-0.024
Total	**60.791**	**10.816**	**75.047**	**18%**	**10.590**	**0.226**

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 income table presented earlier in this document therefore reports a nil variance in respect of VCS over activity in recognition of this reallocation.

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

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Performance £m	Projected Outturn Total Contract £m	Projected Variance (%)	IMTP Planned Performance £m	Movement From IMTP £m
Radiotherapy Planning	6.588	0.510	7.099	8%	0.319	0.191
Radiotherapy Delivery	15.071	0.120	15.191	1%	0.007	0.113
Nuclear Medicine	1.150	-0.050	1.101	-4%	-0.046	-0.003
Radiology Imaging	3.513	0.758	4.271	22%	0.745	0.014
Preparation for Systemic Anti-Cancer Therapy	3.255	1.224	4.480	38%	1.147	0.077
Delivery of Systemic Anti-Cancer Therapy	7.680	2.155	9.835	28%	2.333	-0.178
Ambulatory Care Services	1.567	0.576	2.144	37%	0.521	0.055
Outpatient Services	11.665	4.986	16.651	43%	5.043	-0.057
Inpatient Admitted Care	6.875	0.535	7.410	8%	0.520	0.015
Contract Adjustments	3.426	0.000	6.867	0%	0.000	0.000
Total	**60.791**	**10.816**	**75.047**	**18%**	**10.590**	**0.226**

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

Activity Performance Per Contract Currency	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Radiotherapy Planning	3,916	4,128	212	5%	3,957	171
Radiotherapy Delivery	53,586	50,928	- 2,658	-5%	49,781	1,147
Nuclear Medicine	1,738	1,551	- 187	-11%	1,563	- 12
Radiology Imaging	9,103	14,998	5,895	65%	14,991	8
Preparation for Systemic Anti-Cancer Therapy	25,262	42,022	16,760	66%	41,049	974
Delivery of Systemic Anti-Cancer Therapy	31,867	49,847	17,980	56%	51,087	- 1,240
Ambulatory Care Services	7,874	11,701	3,827	49%	11,291	410
Outpatient Services	59,960	98,364	38,404	64%	100,180	- 1,816
Inpatient Admitted Care	9,072	10,555	1,483	16%	10,530	24
Contract Adjustments	-	-	-	0%	-	-
Total	**202,378**	**284,093**	**81,715**	**40%**	**284,429**	**- 335**

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

This activity is shown below on a Commissioner basis:

Activity Performance Per Commissioner	Baseline 2019/20 Contract Model Activity Performance	Projected New Contract Model Activity Performance	Projected Outturn Activity Variance	Projected Activity Variance (%)	IMTP Planned Performance	Movement From IMTP
Hywel Dda (7A2)	1,202	1,321	119	10%	1,127	194
Swansea Bay (7A3)	1,200	1,146	-54	-4%	1,379	-232
Cardiff & Vale (7A4)	60,809	89,801	28,992	48%	88,916	885
Cwm Taf Morgannwg (7A5)	59,964	79,138	19,174	32%	79,199	-60
Aneurin Bevan (7A6)	74,098	104,779	30,681	41%	105,584	-804
Powys (7A7)	3,619	5,913	2,294	63%	5,915	-1
NHS Wales Joint Commissioning Committee	1,486	1,994	508	34%	2,310	-315
Total	**202,378**	**284,093**	**81,715**	**40%**	**284,429**	**- 335**

Although now resolved through the agreed and signed 2026-27 LTA, Hywel Dda UHB requested a recurrent reduction in LTA value from 2026-27, citing reduced activity where patients had been redirected to Swansea Bay UHB. The Trust challenged this position. While activity from Hywel Dda UHB reduced between 2019-20 and 2024-25, activity levels have now returned to 2019-20 levels and represent only a 13% reduction against the baseline. On this basis, moving to an actual charge basis should result in minimal, if any, loss of income from Hywel Dda UHB.

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

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

VCS general managers are currently developing business cases to reflect service needs going forward which have been presented to EMB and endorsed to be taken through the Performance & Finance Committee and Trust Board in November. The total investment requirement over three years is £5.4m (£2.7m in phase 1 and £2.7m in phase 2), which if approved with be largely funded from marginal income growth, service re-design and discretionary capital for equipment. Investment in the service will need to align to activity growth.

WBS Position Update

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

These cases were:

Area	Cost Pressure	2026/27 £k	Recurrent/ Non-Recurrent
Plasma for Medicines	Implementation of the Welsh Government Policy for the collection, processing and supply of plasma for the manufacture of Immunoglobulin and Albumin products. *Note: Presently intended to be financed as a deduction: cost of delivery offset against the benefits of wholesale pricing*	See note	R
Red Cell Immuno-Haematology Laboratory	Additional capacity 24/7 for the Red Cell Immuno-Haematology Laboratory	251,000	R
Haemoglobin S Screening	Implementation of Haemoglobin S (HbS) testing to comply with national guidance	52,000	R
Blood Component Development	Investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns	703,000	R
Buccal Swab Pathway	Introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel	259,000	R (excl £45k implementation costs)
Blood Donation Team Resilience	Additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered.	266,000	R
	Total	**1,531,000**	

JCC has not approved additional funding for any of the cases. This creates significant financial risk, as the investments are needed to maintain and improve quality and safety; the Trust has therefore made some investments at financial risk. The cases were resubmitted to JCC on 8 October 2025 for consideration in the 2026-29 IMTP process, but no funding was provided. Funding will therefore need to be pursued via Welsh Government in response to the IBI recommendations. Recent discussions with JCC have agreed closer working with the Trust during 2026-27 to improve engagement and commissioning arrangements.

The investments made to date in WBS are being managed in 2026-27 through non-recurrent mitigations, including vacancy management, income generation and service curtailment. This provides assurance that the current-year costs can be covered. The recurrent impact on the underlying position remains under review while discussions continue with JCC. If recurrent funding is not secured, the Trust will need to consider disinvestment.

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

NWJCC and WBS met in June 2026 to discuss commissioning arrangements for the service and the business cases submitted for 2026-27 funding. NWJCC indicated that they identified WBS as being one of their top four priorities to consider how the commissioning model should be designed going forward, with proposal options to be developed by NWJCC for discussion over the coming months.

While funding continues to be discussed, the investments made to date in WBS are being managed in 2026-27 through non-recurrent mitigations, including vacancy management, income generation and service curtailment. This provides assurance that the current-year costs can be covered. The recurrent impact on the underlying position remains under review while discussions continue with JCC. If recurrent funding is not secured, the Trust will need to consider disinvestment.

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

Pay Highlights / Key Issues

As referenced above, Commissioners are expected to pass through, as additional income to the LTAs, the 2025-26 Agenda for Change, Medical and Senior Manager (VSM) staff costs, in line with the Welsh Government pay award matrix. The 2026-27 pay inflation is expected to be funded directly by Health Boards following Welsh Government confirmation of the allocation based on actual staff in post. Any shortfall, such as staff increments or use of bank staff, will need to be met through the discretionary uplift, additional savings, or absorption by Divisions. The current expectation is that funding will be provided in quarter three.

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

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

Non Pay Key Issues

Each Division holds both a general reserve to meet unforeseen costs and a savings target / cost improvement Plan (CIP). The Trust savings target for each division in 2026-27 has been set at VCS £1.303m, WBS £0.879m, RD&I £0.287m and Corporate £0.178m.

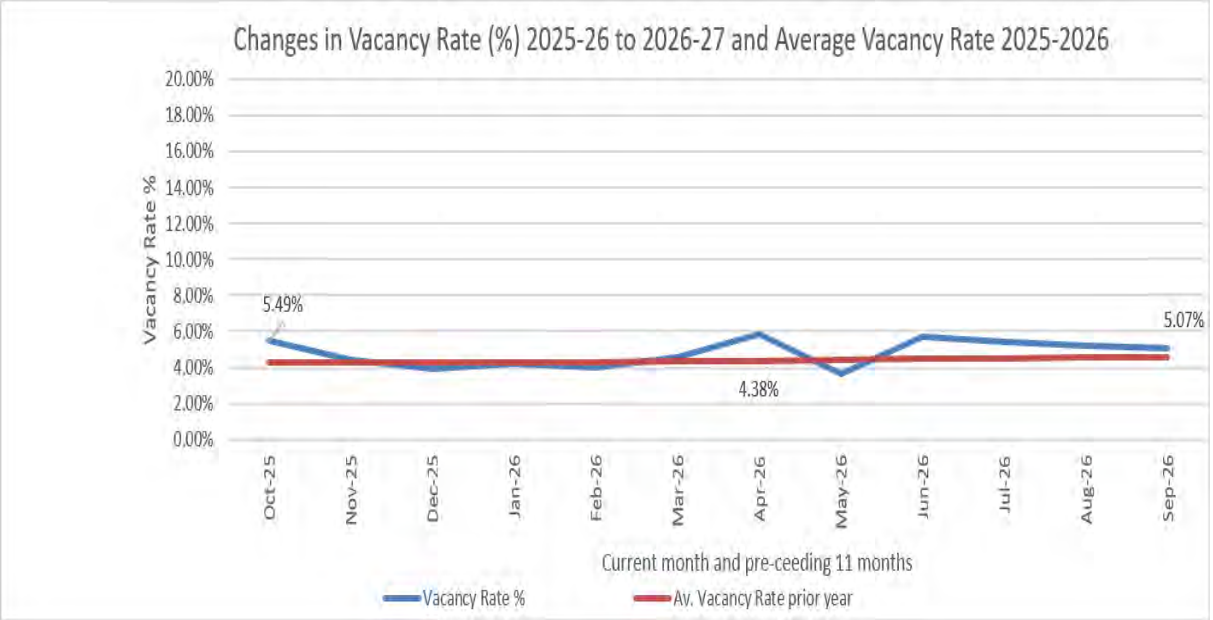
The Trust reserves are held in month 12 and will be released into the position to match pre-approved spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

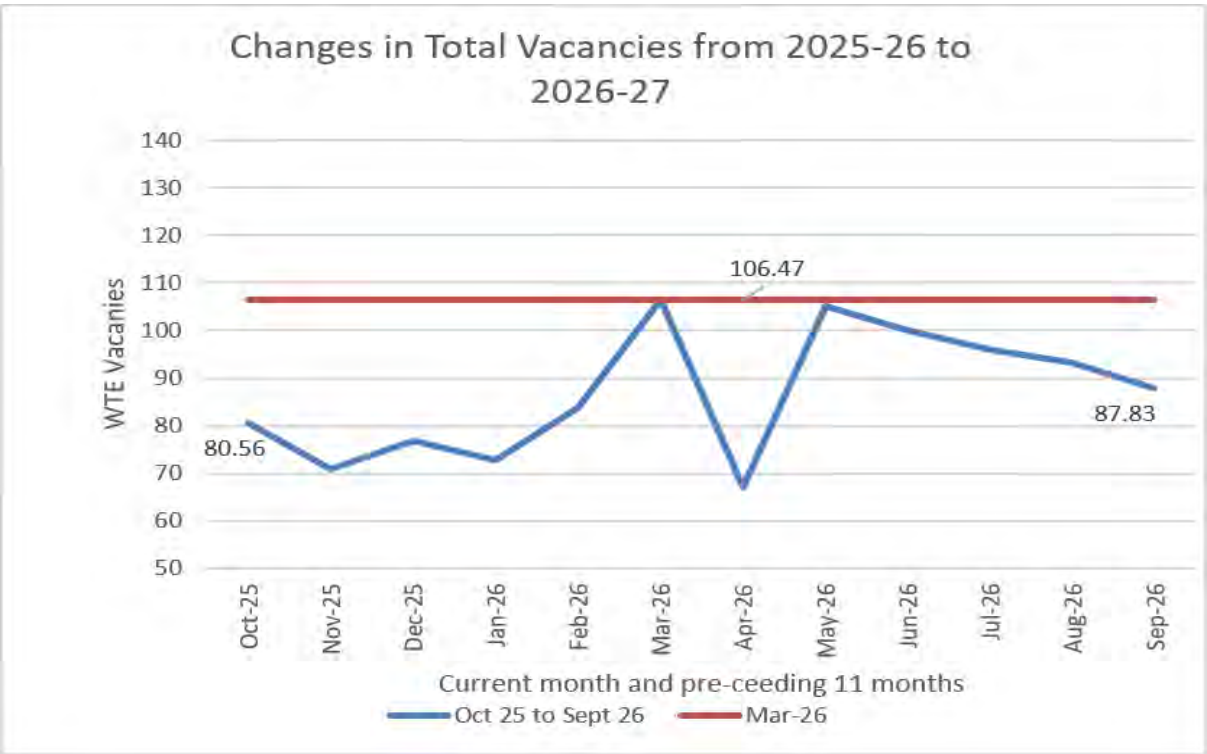
A summary analysis of staff in post and vacancies at 30th September 2026 compared with 31st August 2026, is shown in the table below. The vacancy gap is largely being met using overtime or bank staff and is also supporting each of the division's vacancy factor savings target.

Staff in post WTE		Vacancies WTE		Budgeted WTE		Vacancy rate %	
This month	Prior month	This month	Prior month	This month	Prior month	This month	Prior month
1,753.01	1,747.79	**87.83**	93.36	**1,840.84**	1,841.15	**4.77%**	5.07%

The previous 12 month number of vacancies is compared to the average vacancy rate for 2025-26 in the graph below:



The WTE Vacancies per month over the last twelve months can be seen in the graph below, with a marker included for comparison against the WTE vacancies as at 31st March 2026:



The total Trust vacancies at 30th September 2026 were 88 WTE, a reduction of 5 WTE from 31st August 2026. This is shown on a divisional basis below:

	Vacancies WTE (including unfunded posts)	
Division	This month	Prior month
Corporate	24.52	21.52
HTW	1.61	2.27
RD&I	10.32	13.33
VCS	49.59	60.03
WBS	1.79	- 1.29
TOTAL	**87.83**	**95.86**

The largest in month movement is within VCS: there has been a decrease in 5 WTE vacancies; 3 of these are in the Medical & Dental category due to rotations in Acute posts.

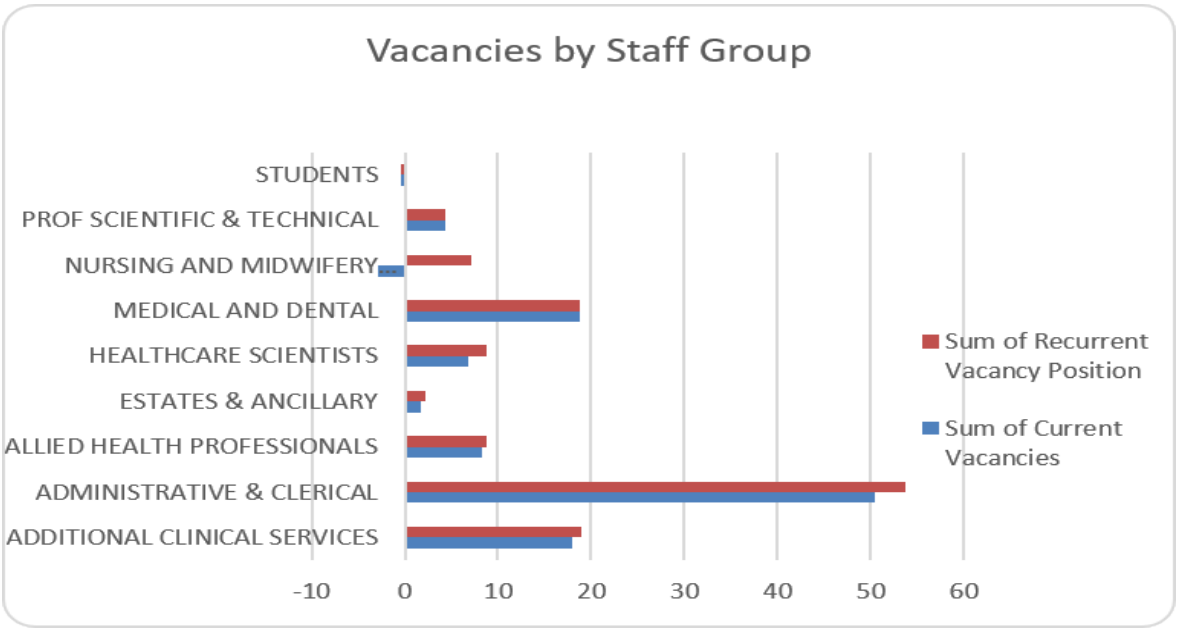
Analysis of vacancies within WBS and VCS is provided below by staff group:

	WBS					VCS				
Staff Category	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts	Vacancies	Unfunded Posts	Vacancy Position Excl Unfunded Posts	Recurrent Unfunded Posts	Vacancy Position Excl recurrent Unfunded Posts
ADMINISTRATIVE & CLERICAL	3.44	5.60	9.04	1.00	8.04	10.38	4.11	14.49	3.71	10.78
MEDICAL AND DENTAL	0.90	-	0.90	-	0.90	13.34	4.07	17.41	4.07	13.34
NURSING AND MIDWIFERY REGISTERED	- 0.11	3.35	3.24	1.55	1.69	- 0.45	18.45	18.00	9.45	8.55
PROF SCIENTIFIC & TECHNICAL	-	-	-	-	-	3.93	0.10	4.03	0.10	3.93
ADDITIONAL CLINICAL SERVICES	6.14	4.60	10.74	3.60	7.14	10.08	1.02	11.10	0.20	10.90
ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	4.92	2.11	7.03	2.11	4.92
HEALTHCARE SCIENTISTS	- 8.57	8.20	- 0.37	6.20	- 6.57	5.64	1.00	6.64	1.00	5.64
ESTATES & ANCILLARY	- 0.01	0.50	0.49	-	0.49	2.12	-	2.12	-	2.12
STUDENTS	-	-	-	-	-	- 0.38	-	- 0.38	-	- 0.38
PAY BUDGET ADJUSTMENTS	-	-	-	-	-	-	-	-	-	-
TOTAL	1.79	22.25	24.04	12.35	**11.69**	49.59	30.86	80.45	20.64	**59.81**

The largest number of vacancies is within VCS. Whilst 50 vacancies are reported, there are 31 WTE unfunded posts that are offsetting other vacancies. If these unfunded posts were excluded from the analysis, VCS would report 80 WTE vacancies.

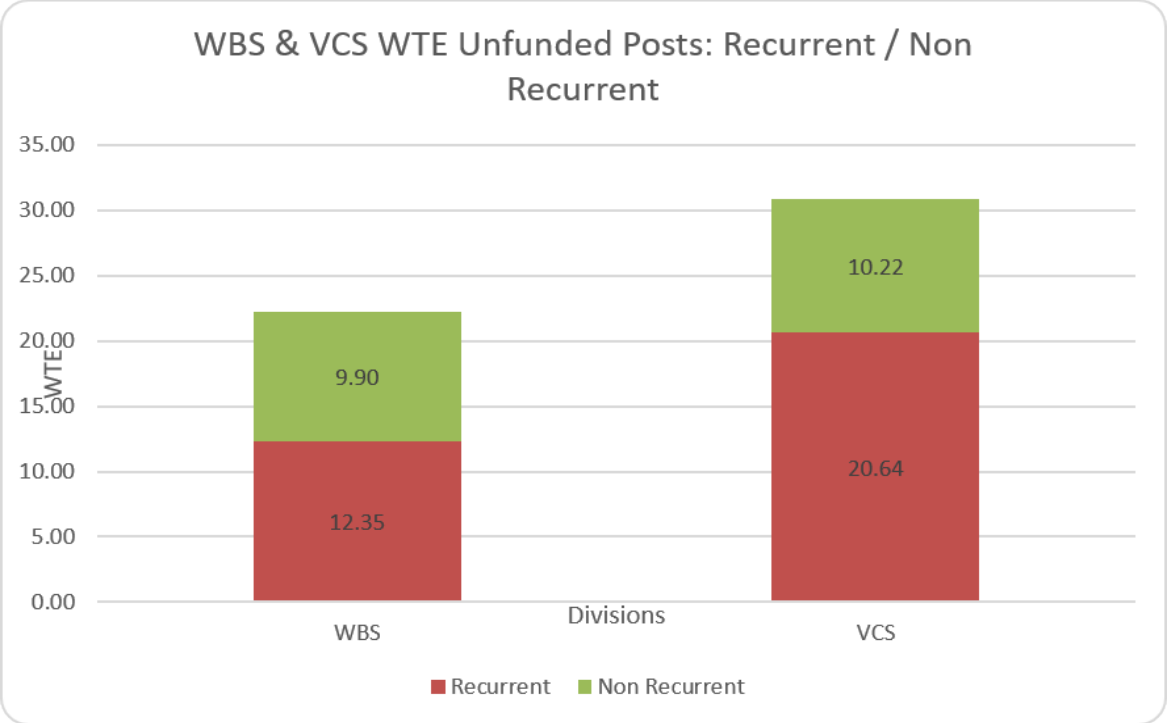
WBS report vacancies of -2 WTE. Similarly, there are 22 WTE vacancies that are offset by 24 WTE unfunded posts. 13 WTE are linked to business cases submitted to JCC that have not yet been approved.

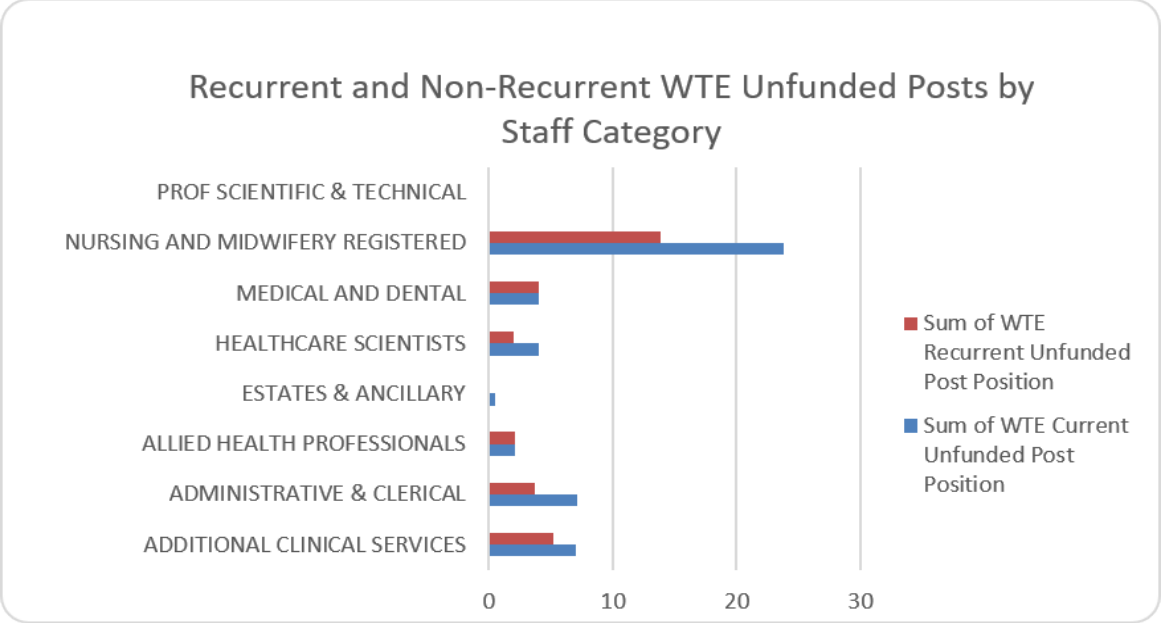
The table above shows the current and recurrent vacancy position by staff group for both WBS and VCS, and this has been translated into a summary graph:

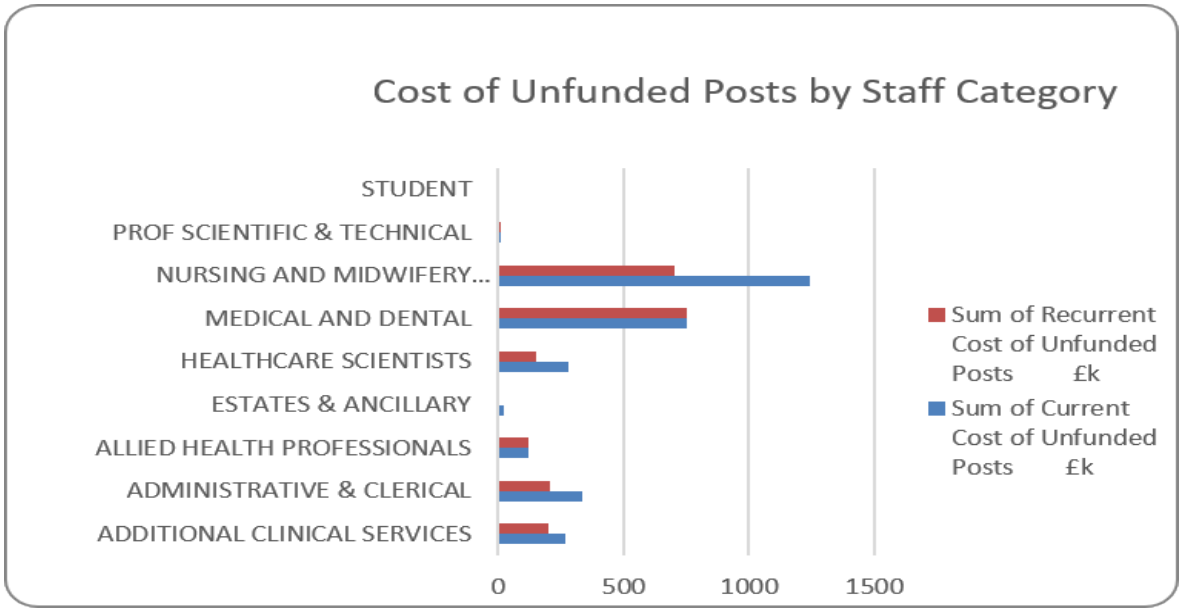


Unfunded posts are shown in more detail below for WBS and VCS. The total unfunded posts at 30th September 2026 is 53 WTE (31st August 2026 = 54 WTE) at a cost of £3.619m, with 33 WTE at a cost of £2.526m being recurrent. For WBS the staff category with the highest number of recurrent unfunded posts is Healthcare Scientists (6 WTE) and in VCS it is nursing and midwifery registered (9 WTE).

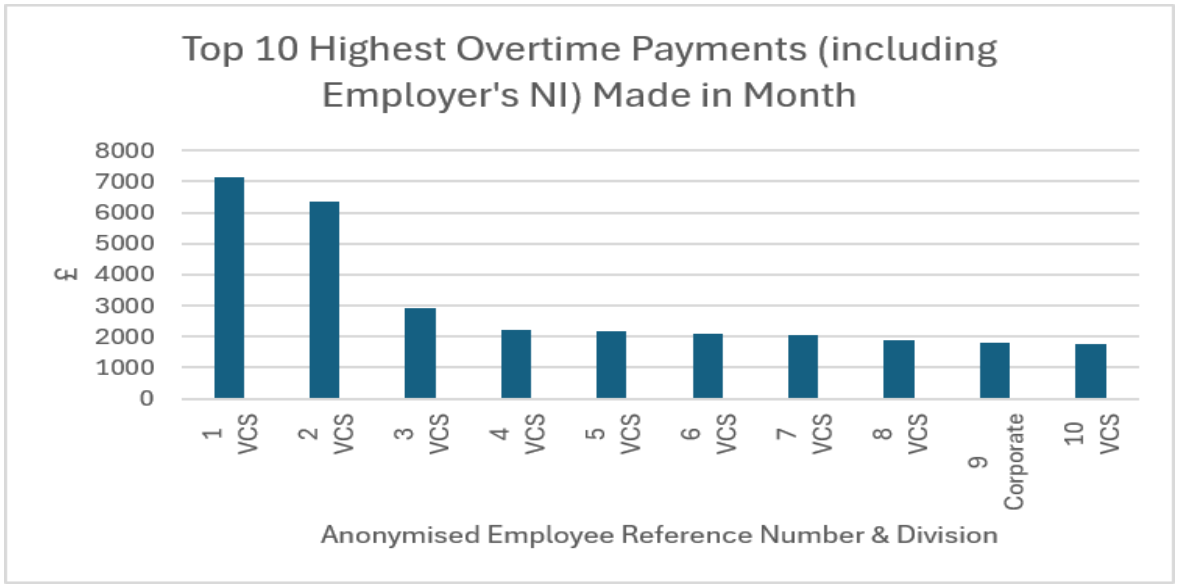
	Total WBS & VCS			
Staff Category	WTE Current Unfunded Post Position	Current Cost of Unfunded Posts £k	WTE Recurrent Unfunded Post Position	Recurrent Cost of Unfunded Posts £k
ADMINISTRATIVE & CLERICAL	9.71	518	4.71	245
MEDICAL AND DENTAL	4.07	752	4.07	752
NURSING AND MIDWIFERY REGISTERED	21.80	1,191	11.00	604
PROF SCIENTIFIC & TECHNICAL	0.10	8	0.10	8
ADDITIONAL CLINICAL SERVICES	5.62	220	3.80	154
ALLIED HEALTH PROFESSIONALS	2.11	123	2.11	123
HEALTHCARE SCIENTISTS	9.20	772	7.20	641
ESTATES & ANCILLARY	0.50	37	-	-
STUDENTS	-	-	-	-
TOTAL	**53.11**	**3,619**	**32.99**	**2,526**


WBS & VCS WTE Unfunded Posts: Recurrent / Non Recurrent
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
WTE
9.90
12.35
10.22
20.64
WBS
Divisions
VCS
Recurrent
Non Recurrent


Recurrent and Non-Recurrent WTE Unfunded Posts by Staff Category
PROF SCIENTIFIC & TECHNICAL
NURSING AND MIDWIFERY REGISTERED
MEDICAL AND DENTAL
HEALTHCARE SCIENTISTS
ESTATES & ANCILLARY
ALLIED HEALTH PROFESSIONALS
ADMINISTRATIVE & CLERICAL
ADDITIONAL CLINICAL SERVICES
0
10
20
30
Sum of WTE Recurrent Unfunded Post Position
Sum of WTE Current Unfunded Post Position



In line with the Trust's financial Grip & Control reviews, analysis of the highest 10 overtime payments made to individuals plus the corresponding Employer's NI contributions, is shown below:



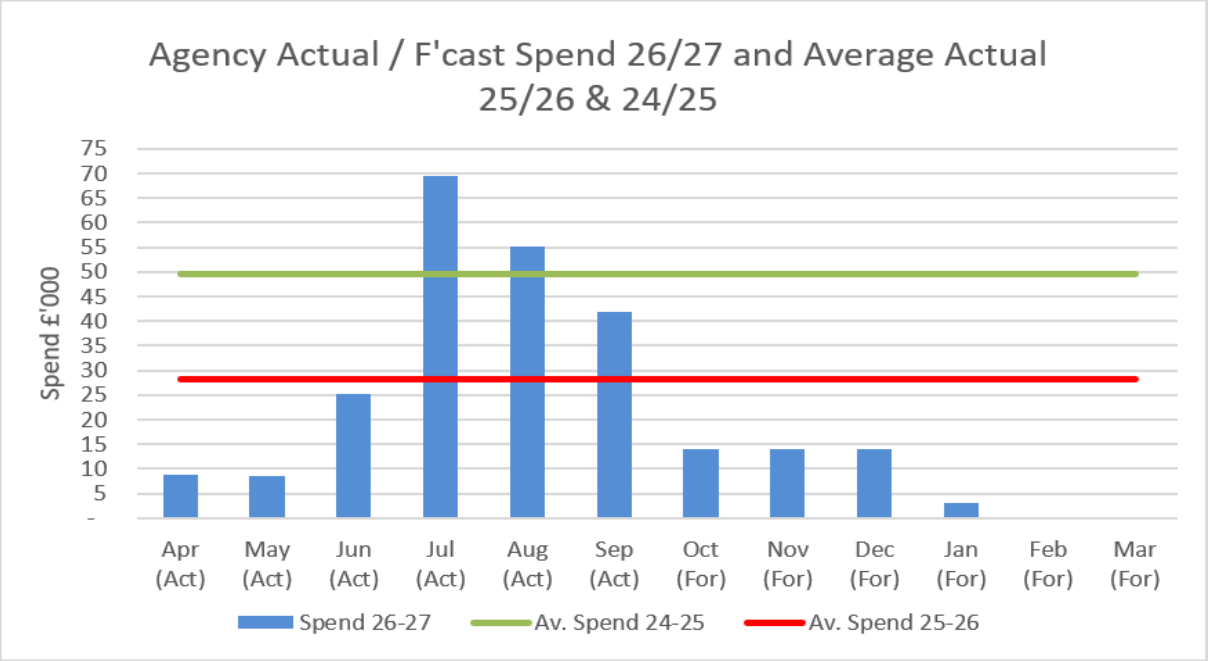
Divisional Finance leads are engaging with Service leads in the corresponding areas to understand the requirements for these payments.

The spend on agency staff for September 2026 was **£0.042m** (August 2026 = £0.055m) with a year-end forecast currently of **£0.254m** (2025-26 = £0.337m).

Under the Value & Sustainability agenda, the Trust has reduced reliance on agency staffing with more of a focus on utilising bank staff.

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 essential to maintain services.

However, it is recognised that, if fixed term or bank contracts cannot be made to support essential nVCC readiness requirements, there is a potential that agency staff may need to be used, and therefore this year's forecast in this area may increase.



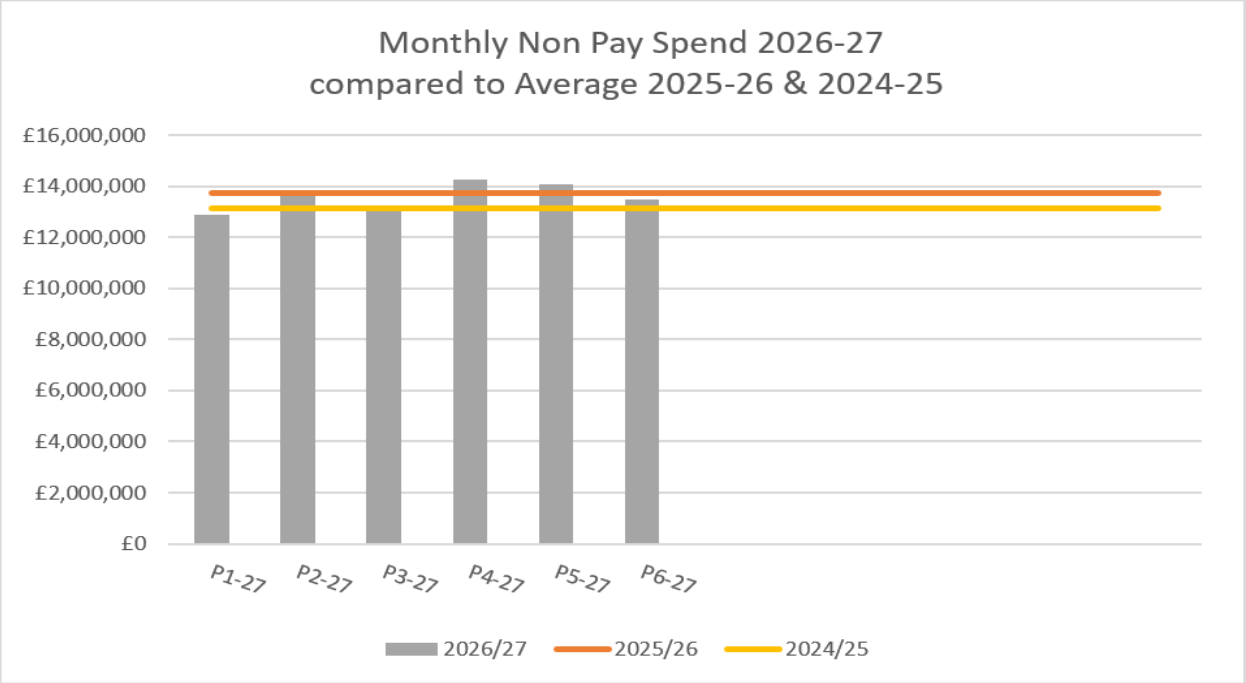
4.3 Non Pay

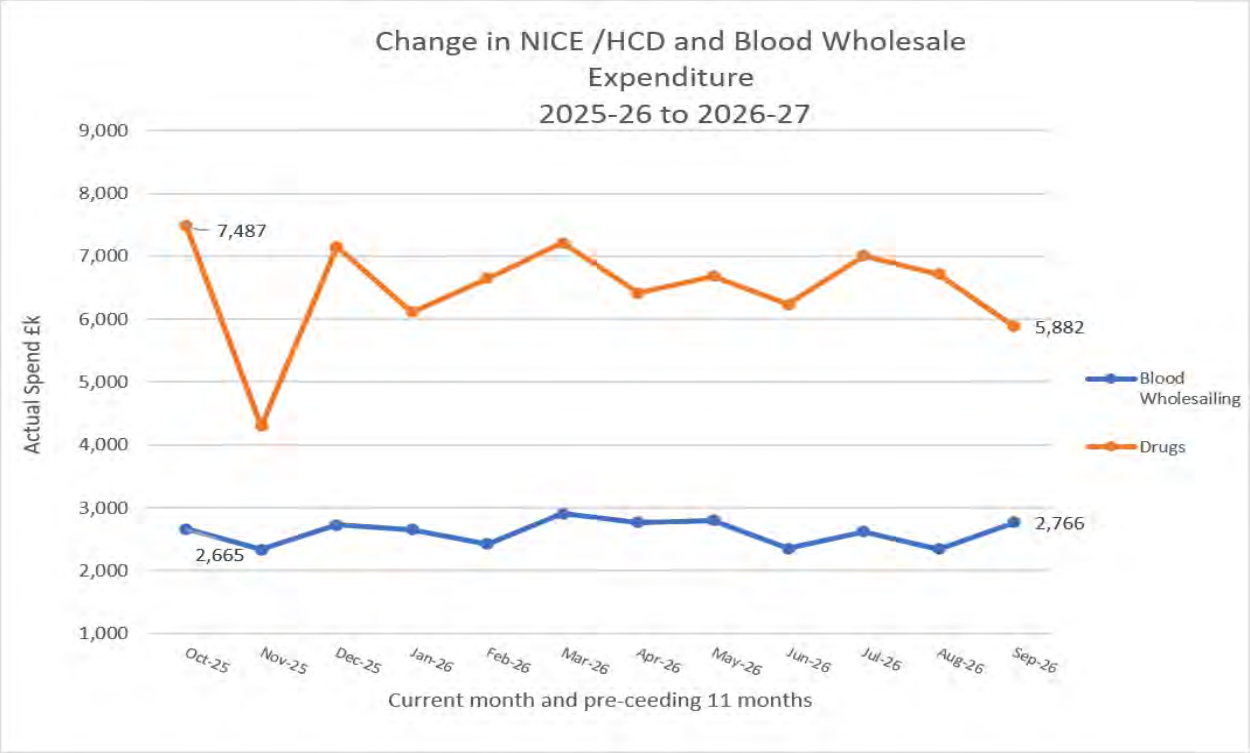
Non-Pay average spend for 2025/26 was £13.741m per month which was a £0.603m increase from the previous financial year. The largest movement was in relation to NICE and HC drugs that saw an increase in average monthly spend of £0.620m, and which were offset by income recharges to Health Boards. Non-cash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

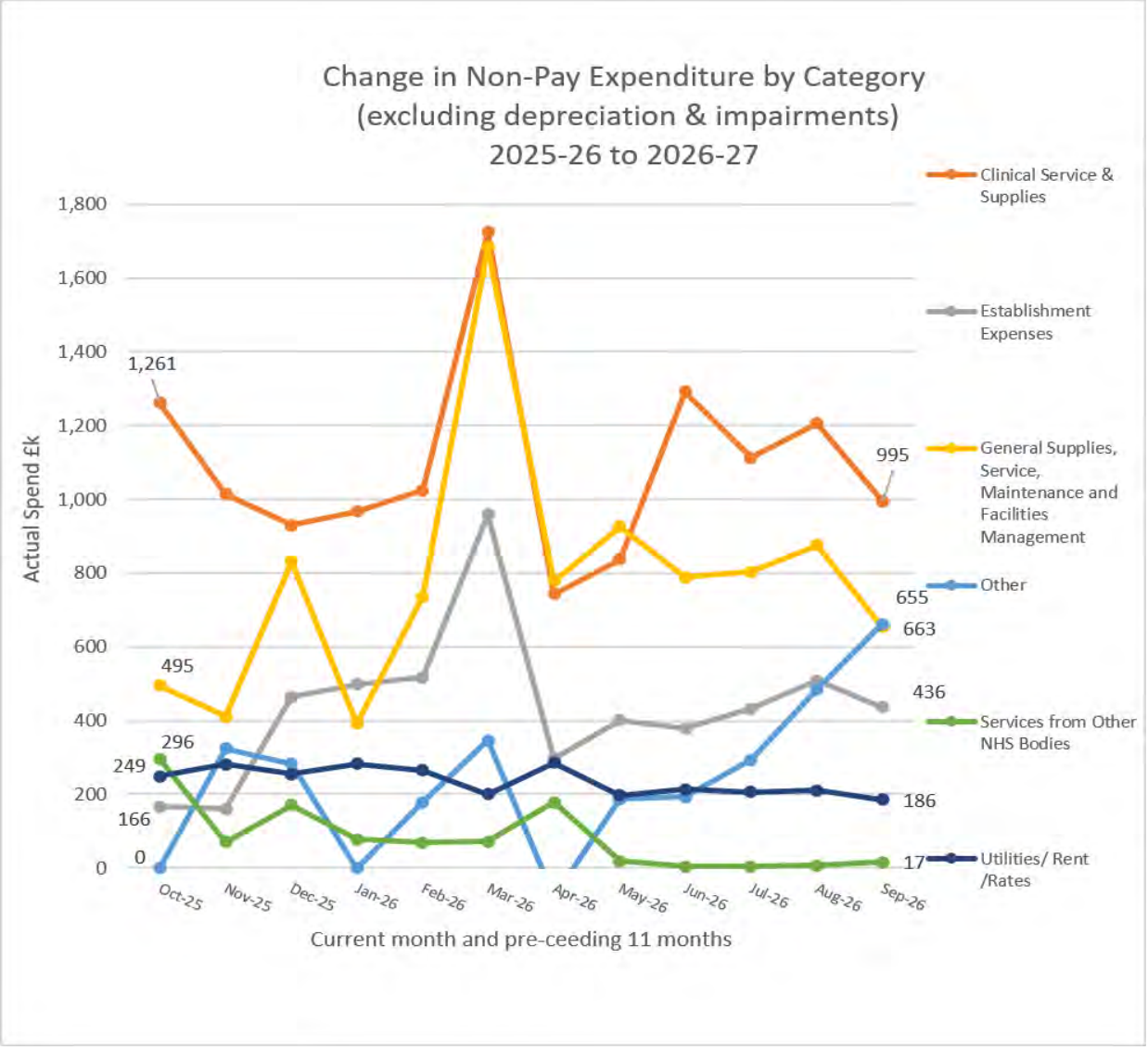
The non-pay average monthly spend for 2026-27 currently stands at £13.626m. Whilst this is a reduction from the average spend seen across the full year 2025-26, at this point in the year in 2025-26, the average spend was less than that seen across the full year, so the trend is comparable.

The average spend to date on NICE and HCD drugs is higher than the full year average from 2025-26 by £0.315m and blood wholesale costs have increased by a minor £0.005m, both of which will be offset by an income increase / reduction in recharges to Health Boards.

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


Monthly Non Pay Spend 2026-27
compared to Average 2025-26 & 2024-25
£16,000,000
£14,000,000
£12,000,000
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0
P1-27
P2-27
P3-27
P4-27
P5-27
P6-27
2026/27
2025/26
2024/25


Change in NICE /HCD and Blood Wholesale Expenditure
2025-26 to 2026-27
Actual Spend £k
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
7,487
5,882
2,665
2,766
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26
Jun-26
Jul-26
Aug-26
Sep-26
Blood Wholesailing
Drugs
Current month and pre-ceeding 11 months



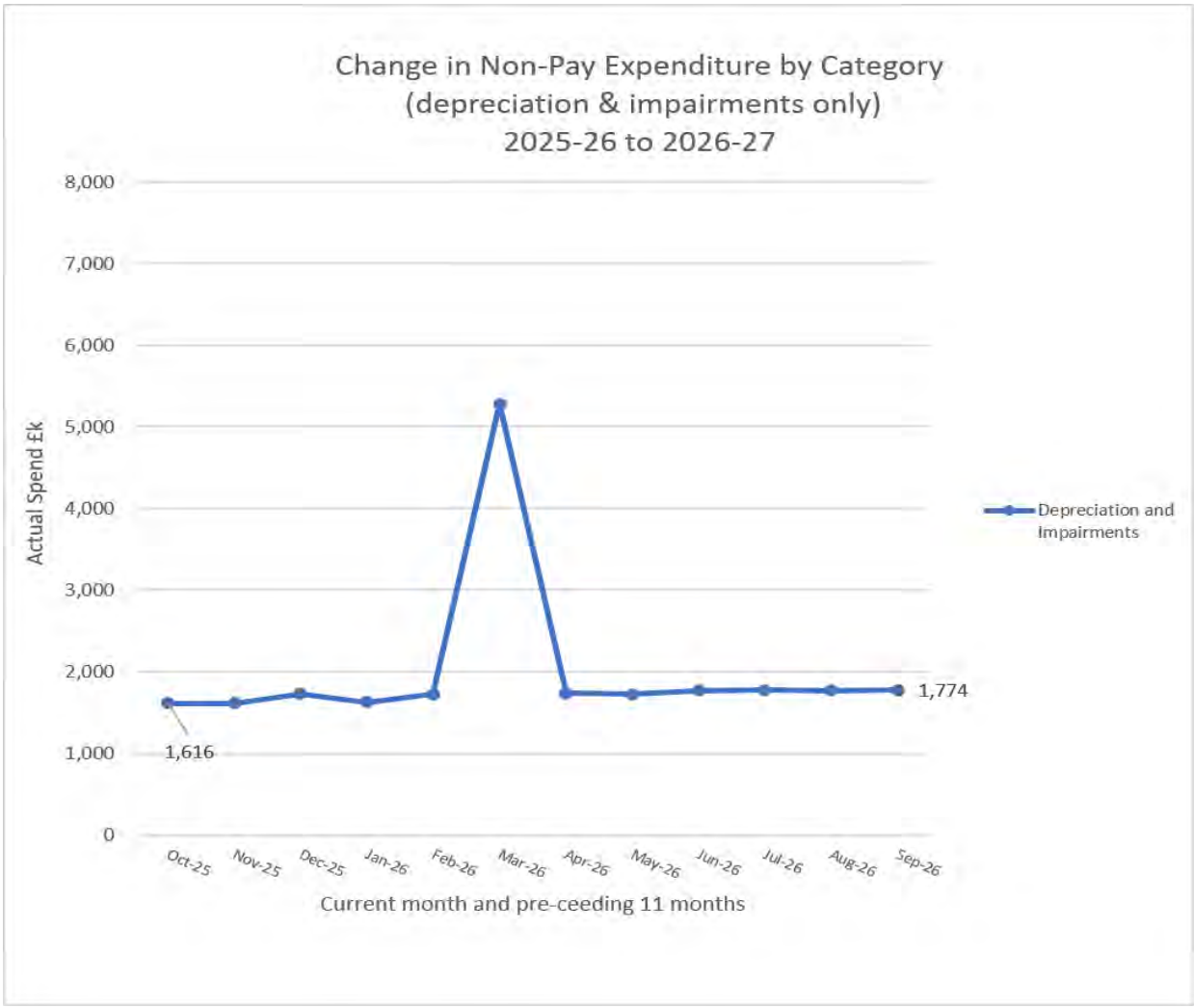
Clinical Services & Supplies saw a sharp decrease in spend from March 2026 to April 2026. Spend was significantly higher in the following divisions & areas in March: Excess Treatment Costs in RD&I of £192k (full 2025-26 year spend reported in one month that will be phased in future); HPC collection costs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

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

Within the other costs category, legal costs paid by the Corporate division in March resulted in the spike seen in the graph. The main reason for the increase in spend in August 2026 was recognition of non pay consultancy spend in relation to the nVCC readiness project

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

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



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

4. Savings

As part of the IMTP Financial Plan, the Trust established a 2026-27 savings requirement of £2.647m. This equates to 2.5% of the Trust's core LTA income and is required to support planned investment and manage cost pressures within the system. (Other savings generated by the Trust that benefit the wider NHS Wales financial position are reported here.)

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

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

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

Performance

The Trust's savings performance at 30 September 2026 is £1.077m against a plan of £1.029m, resulting in a year-to-date overachievement of £0.048m. The annual target is still expected to be achieved, but delivery remains at risk and requires continued divisional grip and control.

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

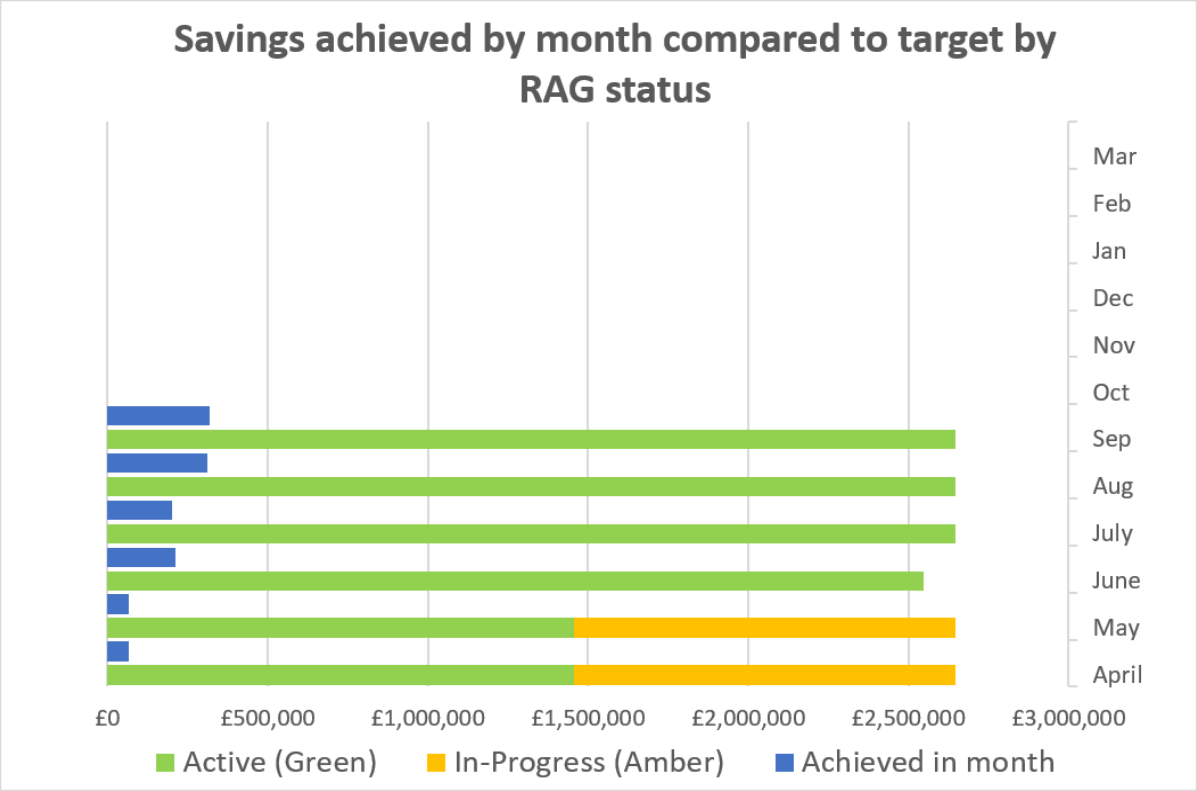
The table below lists all schemes and values planned to deliver the full year target:

ORIGINAL PLAN	TOTAL £000	YTD Planned £000	YTD Actual £000	Variance £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**1,303**	**568**	**565**	**(3)**	**1,303**	**0**
			99%		**100%**	
WBS TOTAL SAVINGS	**879**	**267**	**367**	**100**	**879**	**0**
			137%		**100%**	
CORPORATE TOTAL SAVINGS	**178**	**78**	**78**	**0**	**178**	**0**
			100%		**100%**	
RD&I TOTAL SAVINGS	**287**	**116**	**67**	**(49)**	**287**	**0**
			58%		**100%**	
TRUST TOTAL SAVINGS	**2,647**	**1,029**	**1,077**	**48**	**2,647**	**0**
			105%		**100%**	

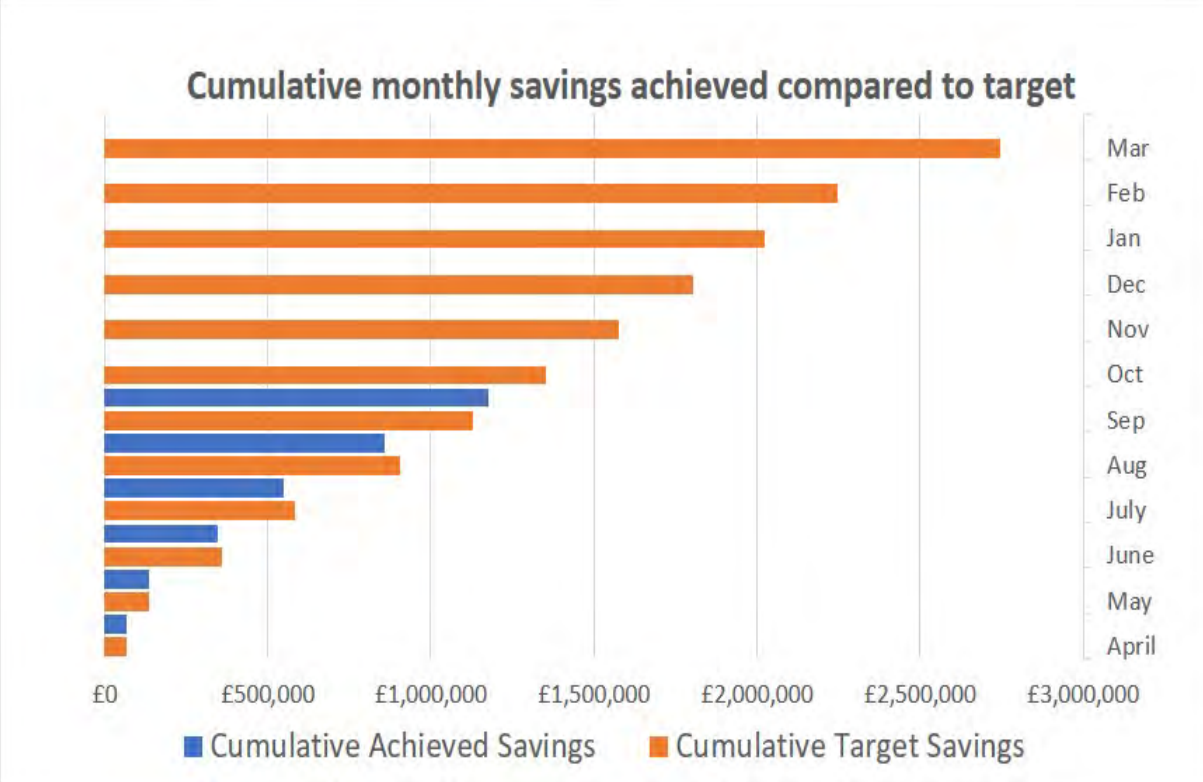
Scheme Type	Division	Recurrent / Non-Recurrent	RAG Rating	TOTAL £000	YTD Planned £000	YTD Actual £000	Variance £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Capacity management - improve efficiency prior to recru	VCS	R	Green	56	20	20	0	56	0
Capacity management - improve efficiency prior to recru	VCS	NR	Green	516	204	204	0	516	0
Reduce spend on postage	VCS	R	Green	10	4	0	(4)	10	0
Procurement supply chain	VCS	R	*Not forecast to deliver*	50	20	0	(20)	0	(50)
WBS Establishment Control	WBS	R	Green	40	20	20	0	40	0
Stock Control - Optimised level of stock retention	WBS	R	Green	100	40	40	0	100	0
Stock Control - Optimised level of stock retention	WBS	NR	Green	150	60	60	0	150	0
Nucleic Acid Testing new managed service contract	WBS	R	Green	127	64	64	0	127	0
Omnichannel contact centre solution	WBS	R	Green	3	1	1	0	3	0
Omnichannel contact centre solution	WBS	NR	Green	28	14	14	0	28	0
WBS Demand Planning - Processing volumes - Transfusio	WBS	R	Green	30	12	12	0	30	0
WBS Demand Planning - Processing volumes - Transfusio	WBS	NR	Green	50	20	20	0	50	0
WBS Demand Planning - Apheresis - Donation Services	WBS	NR	Green	40	16	16	0	40	0
Establishment vacancy control	Corporate	R	Green	80	32	32	0	80	0
Establishment vacancy control	Corporate	NR	Green	20	8	8	0	20	0
Corporate HQ savings	Corporate	R	Green	5	2	2	0	5	0
Capacity management - improve efficiency prior to recru	RD&I	R	Green	50	20	20	0	50	0
Capacity management - improve efficiency prior to recru	RD&I	NR	Green	50	20	15	(5)	50	0
Total Saving Schemes				**1,405**	577	548	(29)	1,355	(50)
Income Generation									
Maximise profit share	VCS	R	Green	100	48	46	(2)	100	0
Maximise profit share	VCS	NR	Green	50	24	24	0	50	0
Private patient income optimisation	VCS	R	Green	200	102	102	0	200	0
Private patient income optimisation	VCS	NR	Green	150	78	84	6	150	0
Contract Income Overperformance	VCS	R	Green	171	68	85	17	221	50
Sales of Plasma	WBS	NR	Green	171	0	0	0	171	0
Ethylenediaminetetraacetic acid (EDTA) Testing Income	WBS	R	Green	40	20	20	0	40	0
Plasma For Medicines (Recovered Plasma)	WBS	R	Green	100	0	100	100	100	0
Bank Interest	Corporate	NR	Green	73	36	36	0	73	0
Commercial Income Generation	RD&I	R	Green	100	40	14	(26)	100	0
Commercial Income Generation	RD&I	NR	Green	87	36	18	(18)	87	0
Total Income Generation				**1,242**	452	529	77	1,292	50
TRUST TOTAL SAVINGS				**2,647**	**1,029**	**1,077**	**48**	**2,647**	**0**
						105%		**100%**	

The above excludes accountancy gains which are reported to Welsh Government in a separate savings table within the Monthly Monitoring Return

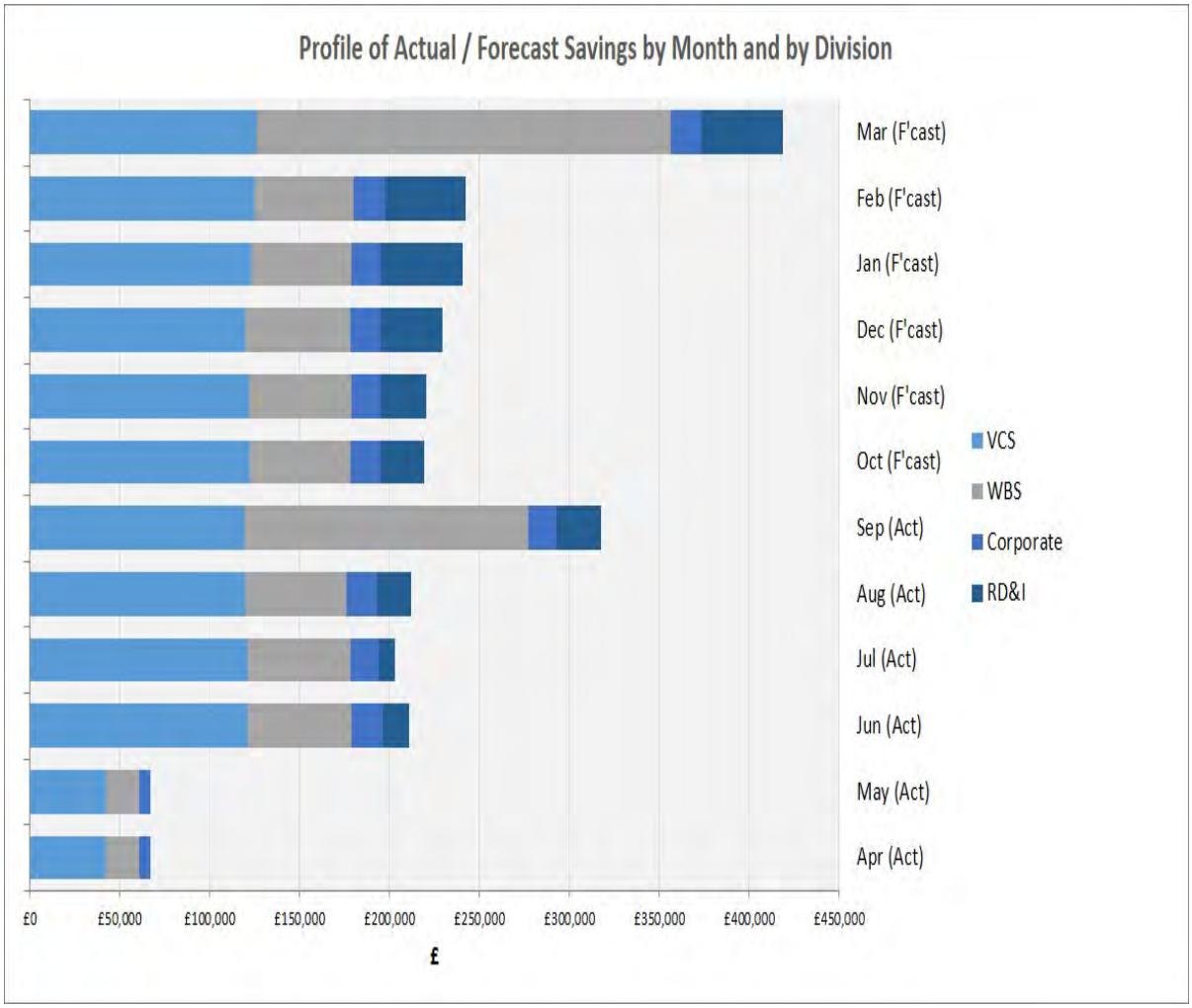
The value of the monthly savings achieved to date can be seen in the graph below, compared with the green / amber status of the schemes. The full value is forecast to be delivered and therefore all current schemes are rated green:



The following graph shows the planned cumulative savings across the year, compared with the actual savings achieved each month so far this year:

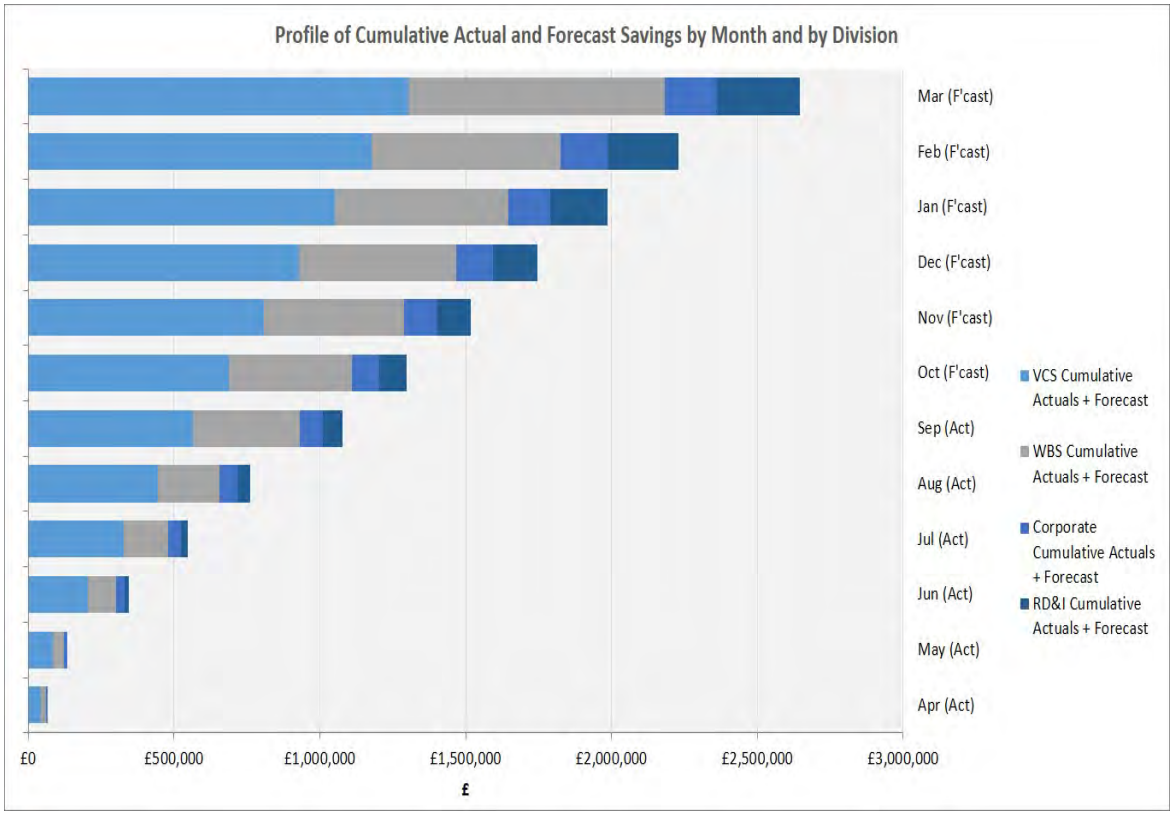


Shown below are the actual and forecast savings per month by division. It is clear that a substantial amount of the required savings value allocated to WBS is scheduled to be delivered in March 2027. This has reduced from previous reports by £0.100m income generation in relation to Plasma for Medicines which was reported as fully achieved in September 2026. The remaining scheme currently forecast to deliver all savings / income generation in March 2027 is sales of plasma at a value of £0.171m. This scheme should be monitored closely so that, if a delivery risk emerges, alternative schemes can be identified and implemented well before March 2027.

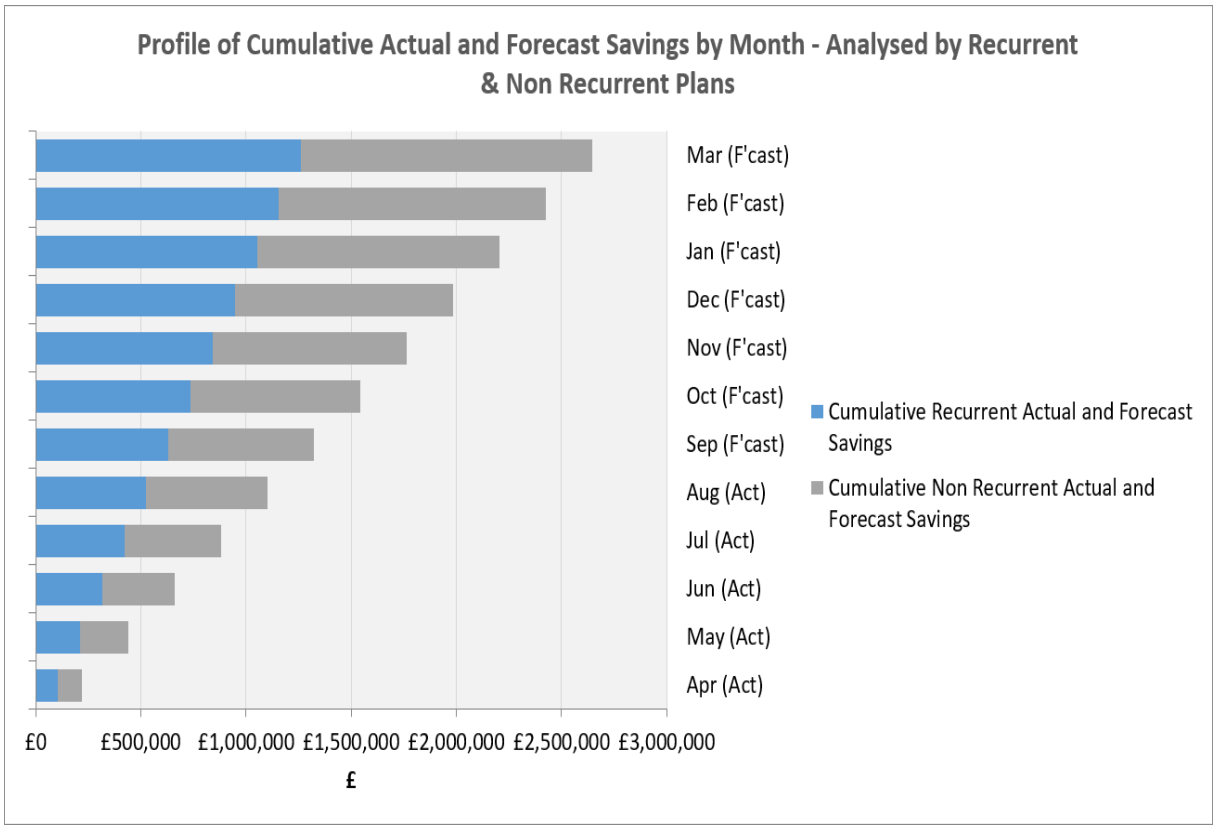


As mentioned above, WBS reported income generation of £0.100m in September which was the full year's anticipated value.

The same data is shown below on a cumulative basis, as opposed to a month by month basis:



Finally, this cumulative data has further been analysed between recurrent and non recurrent schemes:



5. Reserves

The financial strategy for 2025-26 and previous years included an emergency reserve of £0.500m which was accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. As part of the IMTP planning process for 2026-2029 Welsh Government directed the Trust to utilise this reserve to support the underlying position on a recurrent basis and therefore is not available from this financial year onwards.

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

6. Cost Pressures / Investment Decisions

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

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

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

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

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

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

7. End of Year Forecast / Risk & Opportunity Assessment

Although the Trust submitted a balanced plan for 2026-29, delivery remains high risk, particularly because of uncertainty over the income required to fund committed capacity investment in Velindre Cancer Services.

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

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

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

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

For WBS, the investments made to date are being managed through the non-recurrent mitigations described earlier in this commentary. For VCS, the IMTP position is that no service investment will proceed without secured funding. These approaches protect the Trust's 2026-27 financial position but may constrain services and delay potential benefits for commissioners, patients and donors. Some of those benefits may be financial.

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

A risk emerged, and crystallised in part in 2025-26, whereby the forecast activity income in Radiotherapy (in respect of the planned Business Case income for Radiotherapy @ Nevill Hall)

did not match the level of investment in the Workforce. The impact for the full year was £1.000m after mitigations were put in place, such as holding vacancies, non-recurrent funding support, contract performance income for wider services, and non-pay reductions. £0.500m was allocated by holding marginal income growth recurrently, which impacts on the Trust's ability to invest further in cancer services during 2026-27. It is currently anticipated that any shortfall in 2026-27 will be managed via overachievement of wider activity which will be subject to close monitoring.

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

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

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

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

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

Removal of Same Day Emergency Care (SDEC) funding – *(Removed as a risk* *following confirmation from WG to the Trust Chief Executive and Executive Director of Finance that the funding has been approved by the minister)*

The need for SDEC funding to continue on a recurrent basis was raised as a key issue at the Trust's IMTP 2026-29 meeting on 28th November 2025 with WG colleagues, as the Trust would otherwise have been unable to submit a balanced financial plan.

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

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

The Trust included the recurrent funding in its draft IMTP Financial Plan presented to WG colleagues on 3rd February 2026. There was no challenge by WG colleagues to the inclusion of the funding as a key assumption following the issuing of this funding to the Trust via the Allocation letter. The Trust Board approved the IMTP Financial Plan at its March meeting, and the plan was submitted to Welsh Government by the required deadline.

Via a Health Board on 22nd May 2026, the Trust has received a message suggesting that the funding allocated to the Trust was a mistake. If this is the case it will have implications for the Trust financial plans recurrently. The Trust has corresponded with WG on this and both the Trust Chief Executive Officer and the Executive Director of Finance have received confirmation from WG that

the SDEC funding was included in the Allocation letter that which was approved by the Minister. The Trust will now be writing to the one Health Board that raised the issue to inform them of the position.

Signed LTAs containing the relevant SDEC funding are in place with the affected Health Boards, and payments are being made in accordance with those agreements. The Trust therefore does not consider SDEC funding to present a risk to financial balance in 2026-27, and the item has been removed from the MMR tables sent to WG. It will also be removed from future reports on this basis.

Deep dives are planned in upcoming months to provide further insight into these risks for Board & Committee consideration.

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

Opportunities

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

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

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

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

8. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL 2026/27 £m	YTD Spend £m	Budget Remaining @ M7 £000s	Forecast Spend 2026/27 £m	Forecast Year End Variance 2026/27 £m
All Wales Capital Programme					
Integrated Radiotherapy Solution	16.068	0.173	15.895	16.068	0.000
IRS – Next Generation Delivery System (NGDS)	7.000	0.000	7.000	7.000	0.000
WBS HQ Continuity Business Case OBC/FBC Fees	1.142	0.023	1.119	1.142	0.000
nVCC - Project*	37.825	7.146	30.679	38.075	(0.250)
nVCC – Project - Quantified Risk - Public Sector - Drawn down	0.059	0.059	0.000	0.059	0.000
nVCC - Enabling Works	0.393	0.000	0.393	0.393	0.000
Welsh Blood Service Fleet Replacement Programme 2025-26	1.249	0.510	0.739	1.249	0.000
Fees to develop the OBC/FBC for the PET at the nVCC	0.256	0.043	0.213	0.256	0.000
Digital Resource for the nVCC Project	0.550	0.000	0.550	0.550	0.000
Digital Backlog funding 2026-27	0.149	0.000	0.149	0.149	0.000
Estates Backlog funding 2026-27	0.400	0.000	0.400	0.400	0.000
Whitchurch Hospital Fees - Contingency*	0.007	0.021	(0.014)	0.243	(0.236)
DPIF - Medicines and Prescribing: ePMA	0.025	0.000	0.025	0.025	0.000
DPIF - Transforming WBMDR software	0.166	0.026	0.140	0.166	0.000
DPIF - Transforming WBMDR software stage 2	0.167	0.000	0.167	0.167	0.000
Total All Wales Capital Programme	65.456	8.001	57.455	65.942	(0.486)
Discretionary Capital	2.246	1.284	0.962	2.246	0.000
Total	**67.702**	**9.285**	**58.417**	**68.188**	**(0.486)**

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

The approved 2026-27 Capital Expenditure Limit (CEL) for the year ended 31 March 2027 is currently £67.702m (2025-26: £20.603m). This includes All-Wales capital funding of £65.456m and discretionary funding of £2.246m. The forecast spend of £68.188m is higher in anticipation of a release of funding required from the nVCC project QRA and the Whitchurch Hospital contingency held by WG, explained below.

A further £8.644m has been allocated to the unapproved element of the CEL for drawdown from Welsh Government as required by the Trust in relation to nVCC and the sale of the Whitchurch Hospital site. The nVCC project team has requested a £0.250m drawdown against the project contingency fund held by Welsh Government in addition to a separate request to release £0.236m to support the sale of the Whitchurch Hospital site. While approval is awaited, the forecast year-end variance is reported as an overspend.

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

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

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required

to complete the OBC stage of the WBS TGI scheme. WG colleagues have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m: £1.000m of which was awarded and spent in 2025-26, with a further allocation on the 2026-27 CEL. It is currently anticipated that the OBC/FBC will be submitted to WG in May 2027.

A request for c.£1.350m has been sent to Welsh Government in the form of an SBAR to request funding for the development of an OBC/FBC for the decommissioning of the existing Velindre Cancer Centre site. Queries have been received and are being worked through with the service lead following which an updated response will be provided to WG.

In relation to the Blood Establishment Computer System (BECS), a separate case has been provided to Welsh Government for the Implementation and Delivery Capital requirements for 2026/27 & 2027/28. There is a potential further requirement for additional functionality and upgrades, but this will likely form a request into DPIF (c. £2.215m revenue 2028-2033). The costs for BECS are currently being absorbed within the discretionary capital allocation until such a time that funding is confirmed (c. £1.060m has been incurred to date). The Trust has now responded to WG queries on the business case and expectation is that advice with be shortly provided to the minister to secure funding approval.

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

This year the deadline for information to be provided to WG in this respect was brought forward to 16th October. The Trust was required to submit a request to amend any values currently included on the CEL: both in the approved and unapproved sections, and separately a prioritised list of items not currently under consideration for items that could be procured by 31st March 2027 if agreed by WG.

Below shows the request submitted to amend the CEL. (This includes items that were within the unapproved section and therefore the total of the "approved CEL" column differs from the table above.)

Description	Current CEL as at 30-Sep-2026	Allocations from Unapproved Amounts	Handback (No Longer Required)	Rephase (Still Required in Future Year)	New Requests	Requested CEL
nVCC - Project	£37.825	£0.000	£0.000	(£1.655)	£0.000	**£36.170**
nVCC - Project - Quantified Risk - Public Sector - Drawn down	£0.059	£0.250	£0.000	£0.000	£0.000	**£0.309**
nVCC - Enabling Works	£0.393	£0.000	£0.000	(£0.320)	£0.000	**£0.073**
Fees to develop the OBC/FBC for the Positron Emission Tomography (PET) at the new Velindre Cancer Centre	£0.256	£0.000	£0.000	£0.000	£0.000	**£0.256**
Digital Resource for the nVCC Project	£0.550	£0.000	£0.000	£0.000	£0.000	**£0.550**
Integrated Radiotherapy Solution	£16.068	£0.000	£0.000	(£0.237)	£0.000	**£15.831**
IRS - Next Generation Delivery System (NGDS)	£7.000	£0.000	£0.000	£0.000	£0.000	**£7.000**
Welsh Blood Service Fleet Replacement Programme 2025-26	£1.249	£0.000	£0.000	£0.000	£0.000	**£1.249**
WBS HQ Continuity Business Case OBC/FBC Fees	£1.142	£0.000	£0.000	£0.000	£0.000	**£1.142**
Digital Backlog funding 2026-27	£0.149	£0.000	£0.000	£0.000	£0.000	**£0.149**
Estates Backlog funding 2026-27	£0.400	£0.000	£0.000	£0.000	£0.000	**£0.400**
Whitchurch Hospital Fees - Contingency	£0.007	£0.236	£0.000	£0.000	£0.000	**£0.243**
DPIF - Medicines and Prescribing: Electronic Prescribing and Medicines Administration (ePMA)	£0.025	£0.000	£0.000	£0.000	£0.000	**£0.025**
DPIF - Transforming Welsh Bone Marrow Donor Registry (WBMDR) software	£0.166	£0.000	£0.000	£0.000	£0.000	**£0.166**
DPIF - Transforming Welsh Bone Marrow Donor Registry (WBMDR) software stage 2	£0.167	£0.000	£0.000	£0.000	£0.000	**£0.167**
Centrifuges x3	£0.000	£0.000	£0.000	£0.000	£0.076	**£0.076**
Blood Analyser	£0.000	£0.000	£0.000	£0.000	£0.168	**£0.168**
HP Aruba UXI Sensors	£0.000	£0.000	£0.000	£0.000	£0.036	**£0.036**
Mobile Phones	£0.000	£0.000	£0.000	£0.000	£0.126	**£0.126**
Total Approved Funding:	**£65.456**	**£0.486**	**£0.000**	**(£2.212)**	**£0.406**	**£64.136**
nVCC - Project - Quantified Risk - MIM	£3.243	£0.000	£0.000	(£3.243)	£0.000	**£0.000**
nVCC - Project - Quantified Risk - Public Sector	£4.716	(£0.250)	(£1.438)	(£1.421)	£0.000	**£1.607**
nVCC - Enabling works - QRA	£0.449	£0.000	£0.000	(£0.109)	£0.000	**£0.340**
Whitchurch Hospital Fees - Contingency	£0.236	(£0.236)	£0.000	£0.000	£0.000	**£0.000**
Total Unapproved Funding:	**£8.644**	**(£0.486)**	**(£1.438)**	**(£4.773)**	**£0.000**	**£1.947**
Total Discretionary Funding:	**£2.246**	**£0.000**	**£0.000**	**£0.000**	**£0.000**	**£2.246**
CEL Requirement 2026/27:	**£76.346**	**£0.000**	**(£1.438)**	**(£6.985)**	**£0.406**	**£68.329**

The following have been excluded and are dealt with as separate requests into Welsh Government:	£
----- oVCC Decomissioning	£1.350
----- Blood Establishment Computing System (£2.231m)	£2.231

Additional funding was sought for the following items:

Investment proposal description	Location	Category (building / equipment / digital)	Latest date to receive WG approval for 31 March 2027 delivery	Amount £m (including VAT)	Priority
Centrifuges x3	WBS	Medical Equipment	01/12/2026	0.076	1
Blood Analyser	WBS	Medical Equipment	01/12/2026	0.168	2
HP Aruba UXI Sensors	Trust Wide	Infrastructure	31/01/2027	0.036	3
Mobile Phones	Trust Wide	Client devices	31/01/2027	0.126	4
			TOTAL	**0.406**	

Updates on the responses received from Welsh Government will be provided in future reports.

Performance to date

Actual expenditure to 30th September 2026 on All-Wales Capital Programme schemes was £8.001m. This comprises £7.248m on nVCC schemes, £0.173m on the IRS, £0.510m for WBS fleet replacement, £0.021m regarding the Whitchurch Hospital site, £0.026m in respecting of transforming WBMDR software, and £0.023m on WBS HQ business case fees.

Spend on the Discretionary Capital Programme was £1.284m. As schemes have now been approved, they should be progressed as early as possible in the financial year to reduce the risk of later year delivery pressures. **This is particularly important given the expected requirement for Procurement colleagues to support nVCC equipment procurement, which is predominantly scheduled for the final quarter and will require close monitoring to ensure deliveries are received before 31st March 2027. Additional short-term staffing resource may be required to support equipment delivery.**

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme. The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

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

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

All Wales Approved and Unapproved Capital Schemes	2026-27 £m	2027-28 £m	2028-29 £m	2029-30 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC	36.123	3.472	0.000	0.000	0.000	39.595
TCS nVCC (IRS Implementation Phase 3)	1.702	0.579	0.000	0.000	0.000	2.281
TCS nVCC Enabling Works	0.393	0.000	0.000	0.000	0.000	0.393
Integrated Radiotherapy Solution (IRS)	17.155	0.180	0.000	0.000	0.000	17.335
EPMA (DPIF)	0.025	0.000	0.000	0.000	0.000	0.025
Talbot Green Infrastructure (WBS)	1.142	0.000	0.000	0.000	0.000	1.142
Fleet Replacement (WBS)	0.882	1.465	0.000	0.000	0.000	2.347
Positron Emission Tomography	0.256	0.000	0.000	0.000	0.000	0.256
Total Approved Capital Schemes	**57.678**	**5.696**	**0.000**	**0.000**	**0.000**	**63.374**
All Wales Unapproved Schemes						
Whitchurch Hospital Site	0.280	0.000	0.000	0.000	0.000	0.280
nVCC – Project - Quantified Risk - MIM	3.243	0.000	0.000	0.000	0.000	3.243
nVCC – Project - Quantified Risk - Public Sector	4.716	3.085	0.000	0.000	0.000	7.801
nVCC – Enabling works - QRA	0.449	0.000	0.000	0.000	0.000	0.449
nVCC - QRA Public Sector Draw Down	0.059	0.000	0.000	0.000	0.000	0.059
WBS TGI Infrastructure	10.000	14.000	14.000	14.000	8.000	60.000
WBS Plasma for Fractionation	0.000	0.910	0.002	0.000	0.001	0.913
WBS BECS Blood Management System	1.840	1.187	0.000	0.000	0.000	3.027
RISP	TBC	TBC	TBC	0.000	TBC	0.000
Backlog Maintenance (WBS)	0.532	0.215	0.000	0.000	0.000	0.747
Asset Replacement (WBS)	0.250	0.000	0.530	0.000	0.000	0.780
WLIMS 2.0	TBC	TBC	TBC	0.000	TBC	0.000
WHAIS Phase 2	TBC	TBC	TBC	0.000	TBC	0.000
Digital CRM Multi Case Functions (WBMDR, AOS	TBC	TBC	TBC	0.000	TBC	0.000
Digital IT Infrastructure	0.500	0.500	0.500	0.500	0.000	2.000
Other Digital Service Developments	TBC	TBC	TBC	0.000	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	0.000	TBC	0.000
Enhanced Care Unit (VCS)	TBC	TBC	TBC	0.000	TBC	0.000
oVCC Decommissioning	1.000	0.000	0.000	0.000	0.000	1.000
IRS Machine Mix and Hypersight	7.200	0.000	0.000	0.000	0.000	7.200
nVCC Digital Enabling Works	0.737	1.442	0.000	0.000	0.000	2.179
Total Unapproved Capital Schemes	**30.806**	**21.339**	**15.032**	**14.500**	**8.001**	**89.678**
Total All Wales Capital Plans	**88.484**	**27.035**	**15.032**	**14.500**	**8.001**	**153.052**
Discretionary Assumptions	**2.000**	**2.000**	**2.000**	**2.000**	**2.000**	**10.000**
IFRS16 Assumptions	**0.345**	**0.331**	**0.000**	**0.000**	**0.000**	**0.676**
Total Funding Capital IMTP Requirement:	**90.829**	**29.366**	**17.032**	**16.500**	**10.001**	**163.728**

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

9. BALANCE SHEET (Including Hosted Organisations)

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

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

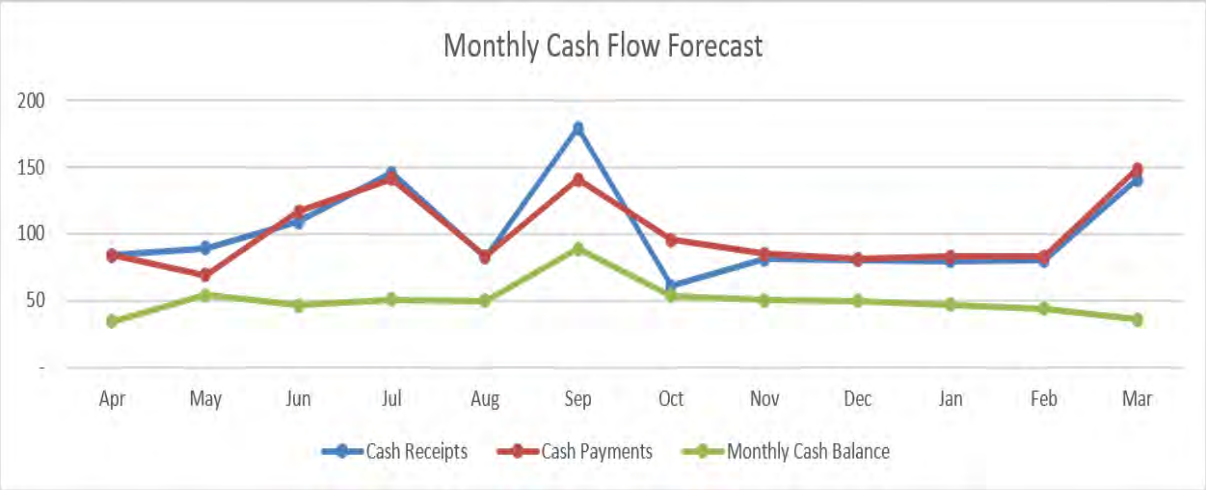
	Opening Balance Beginning of Apr-2026	Closing Balance End of Sep-26	Movement from 1st April Sep-26	Forecast Closing Balance End of Mar 27
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	437.115	345.758	(91.357)	345.758
Intangible assets	10.585	10.588	0.003	10.588
Trade and other receivables	1,530.778	1,530.710	(0.068)	1,530.710
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,978.478	1,887.056	(91.422)	1,887.056
Current Assets				
Inventories	33.680	32.467	(1.213)	32.467
Trade and other receivables	678.791	890.033	211.242	890.033
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	34.330	88.393	54.063	35.792
Non-current assets classified as held for sale	0.009	0.009	0.000	0.009
Current Assets sub total	746.810	1,010.902	264.092	958.301
TOTAL ASSETS	2,725.288	2,897.958	172.670	2,845.357
Current Liabilities				
Trade and other payables	(289.098)	(462.686)	(173.588)	(410.085)
Borrowings	(1.637)	(1.637)	0.000	(1.637)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(445.825)	(444.681)	1.144	(444.681)
Current Liabilities sub total	(736.560)	(909.004)	(172.444)	(856.403)
NET ASSETS LESS CURRENT LIABILITIES	1,988.728	1,988.954	0.226	1,988.954
Non-Current Liabilities				
Trade and other payables	(3.555)	(3.555)	0.000	(3.555)
Borrowings	(228.064)	(228.064)	0.000	(228.064)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,532.537)	(1,532.536)	0.001	(1,532.536)
Non-Current Liabilities sub total	(1,764.156)	(1,764.155)	0.001	(1,764.155)
TOTAL ASSETS EMPLOYED	224.572	224.799	0.227	224.799
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	39.789	39.789	0.00	39.789
PDC	164.484	164.699	0.215	164.699
Retained earnings	20.299	20.311	0.012	20.311
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	224.572	224.799	0.227	224.799

10. CASH FLOW (Includes Hosted Organisations)

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

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

	Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
RECEIPTS													
Income from other Welsh NHS Organisations	71.087	55.921	84.089	55.758	51.909	54.559	55.899	54.589	54.589	54.089	54.089	51.589	698.164
WG Revenue Funding	3.983	26.209	9.079	80.625	22.791	106.474	-5.967	17.973	17.533	17.133	17.573	17.133	330.536
Short Term Loans													0.000
PDC												63.515	63.515
Interest Receivable	0.186	0.182	0.212	0.250	0.207	0.191	0.140	0.140	0.140	0.140	0.140	0.140	2.067
Sale of Assets													0.000
Other	8.246	6.592	15.307	8.854	7.482	18.153	10.527	8.250	8.250	8.250	8.000	8.000	115.911
TOTAL RECEIPTS	**83.502**	**88.903**	**108.687**	**145.487**	**82.389**	**179.377**	**60.599**	**80.951**	**80.511**	**79.611**	**79.801**	**140.376**	**1,210.194**
PAYMENTS													
Salaries and Wages	31.491	45.082	45.972	46.845	47.454	44.947	44.918	44.892	44.892	44.892	44.892	44.892	531.168
Non pay items	50.257	22.744	70.002	90.844	34.244	94.561	48.743	36.924	21.160	24.366	31.190	77.387	602.421
Short Term Loan Repayment													0.000
PDC Repayment	0.000											0.000	0.000
Capital Payment	2.208	1.214	0.650	3.517	1.293	1.169	1.771	2.806	14.621	13.335	6.511	26.263	75.357
Other items													0.000
TOTAL PAYMENTS	**83.957**	**69.039**	**116.624**	**141.207**	**82.992**	**140.677**	**95.431**	**84.622**	**80.672**	**82.592**	**82.592**	**148.542**	**1,208.946**
Net cash inflow/outflow	(0.455)	19.863	(7.938)	4.280	(0.603)	38.700	(34.833)	(3.671)	(0.161)	(2.981)	(2.791)	(8.166)	
Balance b/f	34.330	33.875	53.739	45.801	50.081	49.478	88.179	53.346	49.675	49.515	46.534	43.744	
Balance c/f	33.875	53.739	45.801	50.081	49.478	88.179	53.346	49.675	49.515	46.534	43.744	35.578	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCS	(26.200)	(26.184)	0.016	(52.510)	(52.510)	0.000
RD&I	0.070	0.070	0.000	0.350	0.350	0.000
WBS	(12.263)	(12.263)	0.000	(24.431)	(24.431)	0.000
Sub-Total Divisions	**(38.393)**	**(38.377)**	**0.016**	**(76.591)**	**(76.591)**	**0.000**
Corporate Services Directorates	(9.393)	(9.397)	(0.004)	(18.884)	(18.884)	0.000
Delegated Budget Position	**(47.787)**	**(47.775)**	**0.012**	**(95.475)**	**(95.475)**	**0.000**
nVCC	(0.098)	(0.098)	0.000	(0.193)	(0.193)	0.000
Health Technology Wales	(0.136)	(0.136)	0.000	(0.272)	(0.272)	0.000
Trust Income / Reserves	48.021	48.021	0.000	95.940	95.940	0.000
Trust Position	**0.000**	**0.012**	**0.012**	**0.000**	**0.000**	**0.000**

The position at close of month 6 is an **underspend of £0.012m.**

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

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**54.883**	**54.670**	**(0.213)**	**113.022**	**113.022**	**0.000**
Expenditure						
Staff	34.541	33.945	0.596	68.887	67.890	0.998
Non Staff	46.543	46.910	(0.367)	96.644	97.642	(0.998)
Sub Total	**81.084**	**80.854**	**0.229**	**165.531**	**165.531**	**0.000**
Total	**(26.200)**	**(26.184)**	**0.016**	**(52.510)**	**(52.510)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services at the end of September 2026 was an **underspend of £0.016m**. The expected outturn position at this stage is **breakeven**, although some associated risk remains.

Income at month 6 was an **underachievement of £0.213m**. This was due to largely due to radiotherapy activity income underperformance of £0.280m, planning for catering services £0.032m and under-recovery of income from WRP for legal provisions £0.231m, offset by an overachievement of Private Patient drugs income of £0.357m.

The pay position is **underspent by £0.596m** at the close of month 6. This reflects the impact of the previously described high number vacancies within the division, offset by unfunded roles. There is also a divisional CIP required to address the net impact of the VCS restructure.

Non-staff expenditure at month 5 was **overspent by £0.367m**. This is predominantly due to an overspend on general drugs that are not rechargeable to HBs (non NICE / HCD) of £0.305m, in addition to postage and carriage £0.135m, and £0.064m in respect of the C&V SLA, offset by provisions for recovery of legal costs of £0.210m.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**18.760**	**19.199**	**0.439**	**38.663**	**39.541**	**0.878**
Expenditure						
Staff	10.610	10.985	(0.375)	21.415	22.164	(0.750)
Non Staff	20.413	20.477	(0.064)	41.679	41.807	(0.128)
Sub Total	**31.023**	**31.462**	**(0.439)**	**63.094**	**63.972**	**(0.878)**
Total	**(12.263)**	**(12.263)**	**0.000**	**(24.431)**	**(24.431)**	**0.000**

Key Highlights/ Issues:

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

WBS reports a **£0.439m overachievement** of income to date. This is mainly due to additional non-recurrent plasma income of £0.458m offset by an income underachievement of £0.093m in relation to the resolution of year end 2025-26 commercial products invoices impacted by the BECS outage in March 2026. These were offset by underachievement of WBMDR income of £0.010m in month.

The staff **overspend of £0.375m** is a result of an increased CIP savings target and unfunded posts appointed at risk, largely offset by pay vacancies across the service. The unfunded posts will be reviewed with a view to securing part funding that is ringfenced in the Trust IMTP.

The WBS non-staff position was **overspent by £0.064m** in month 6. Non-recurring activity and volume-related benefits from performance below demand planning targets continue to offset some supply chain cost pressures. The service is recovering from the eProgressa outage at the end of March and has also seen fluctuations in activity-driven spend due to excessive temperatures over the summer months.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**2.516**	**2.922**	**0.406**	**5.203**	**5.608**	**0.406**
Expenditure						
Staff	9.530	8.977	0.553	18.963	18.410	0.553
Non Staff	2.379	3.342	(0.963)	5.124	6.082	(0.959)
Sub Total	**11.910**	**12.319**	**(0.410)**	**24.087**	**24.492**	**(0.406)**
Total	**(9.393)**	**(9.397)**	**(0.004)**	**(18.884)**	**(18.884)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of September 2026 was a **minor overspend of £0.004m**, with the current expected outturn position forecast as **breakeven**.

The Trust is continuing to benefit from receiving high levels of bank interest as a result of interest rate rises over the last couple of years, however with interest rates decreasing we can expect to see this benefit reduce as the year progresses. In addition, an increased income generation target within the divisional savings plan for 2026-27 will reduce the opportunity for additional gains above those planned.

Several vacancies within the division result in the year to date underspend, particularly within the Data & Insights, Corporate Quality & Safety and Finance teams. These underspends offset overspends in the Estates team, as well as the use of agency staff and the divisional savings target.

Non-pay overspend largely relates to divisional CIP target, the increased running costs associated with the hospital estate and corporate management costs including those relating to the governance review and other consultancy costs. Additional non recurrent legal costs of c£0.600m are now forecast within the year, offset by the additional, unbudgeted, bank interest referred to above.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**3.018**	**2.777**	**(0.241)**	**6.164**	**5.922**	**(0.241)**
Expenditure						
Staff	2.569	2.402	0.167	5.091	4.925	0.167
Non Staff	0.380	0.305	0.075	0.723	0.648	0.075
Sub Total	**2.949**	**2.707**	**0.241**	**5.814**	**5.572**	**0.241**
Total	**0.070**	**0.070**	**0.000**	**0.350**	**0.350**	**0.000**

RD&I Key Highlights / Issues

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

The **£0.241m year-to-date underachievement** in income is mainly due to lower-than-budgeted endowment income of £0.116m, reflecting staff vacancies and reduced activity within the Small Awards Scheme. Welsh Government income is £0.042m below budget due to lower levels of RICH activity and an income coding issue. Other income is £0.083m below budget, largely as a result of vacant posts not attracting the expected corresponding VPAG funding.

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

The staff **underspend** to date is due to several vacancies that have not yet been recruited to, which is also contributing to lower than budgeted income relating to those posts being received.

The non-staff **underspend** to date is caused by release of an accrual made in 2025-26 no longer deemed appropriate, lower than anticipated spends within the Innovation team, offset by overspends on training and travel costs. Some costs relating to 2025-26 that were not accounted for in that year have also had an impact on the position.

nVCC – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.024**	**0.064**	**0.040**	**0.048**	**0.088**	**0.040**
Expenditure						
Staff	0.110	0.150	(0.040)	0.221	0.261	(0.040)
Non Staff	0.011	0.011	0.000	0.020	0.020	0.000
Sub Total	**0.122**	**0.162**	**(0.040)**	**0.241**	**0.281**	**(0.040)**
Total	**(0.098)**	**(0.098)**	**0.000**	**(0.193)**	**(0.193)**	**0.000**

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of September 2026 is **breakeven.**

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

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.909**	**0.842**	**(0.067)**	**1.817**	**1.750**	**(0.067)**
Expenditure						
Staff	0.958	0.876	0.082	1.916	1.834	0.082
Non Staff	0.087	0.102	(0.015)	0.173	0.189	(0.015)
Sub Total	**1.045**	**0.978**	**0.067**	**2.089**	**2.022**	**0.067**
Total	**(0.136)**	**(0.136)**	**0.000**	**(0.272)**	**(0.272)**	**0.000**

HTW Key Highlights / Issues

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

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

Trust Board		
Integrated Operational and Strategic Risk Report		
DATE OF MEETING	26 November 2026	
STATUS	Public	
REPORT AUTHOR	Mel Findlay, Risk and Assurance Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	Non Gwilym, Interim Director of Corporate Governance	
SCRUTINY ROUTE TO DATE		
	26/10/2026	Executive Management Board
	Executive Management Board (EMB) reviewed the current Board Assurance Framework and noted that the framework is developing positively and becoming easier to read and more accessible, while further work is required to improve consistency as an assurance tool. EMB noted the change to the new committee structure, with each BAF assigned to a lead committee and associated operational risks aligned for scrutiny.	
ONWARD SCRUTINY ROUTE	Further scrutiny will be undertaken by the Audit and Risk Assurance committee at its December meeting.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 3 - AMBER (Some measurable impact evident from actions initially taken and an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement)	
EXECUTIVE SUMMARY	This report presents an integrated view of strategic and operational risk, drawing together the Board Assurance Framework (BAF), Trust Risk Register and the outcomes of Executive Management Board (EMB) and committee scrutiny to support Trust Board oversight. Risk management and BAF reporting are improving, supported by increased Executive scrutiny and strengthened review arrangements. However, further work is needed to align operational and strategic risks, identify control and assurance gaps explicitly, and demonstrate the effectiveness of mitigating actions, particularly where risk scores remain unchanged. This will be strengthened by the establishment of the Trust Risk Management Group on 4 December. The main findings are:	

	• The Trust Risk Register contains 28 risks: five for VCS, 19 for WBS and four for corporate services, including digital. Each BAF strategic risk is assigned to a lead committee, with associated operational risks being aligned for scrutiny. • Committee scrutiny covered finance, sustainability, research, development and innovation, people, quality, safety, patient and donor experience, and digital resilience. Key concerns included workforce wellbeing and capacity, clinical service pressures, out-of-hours arrangements and the impact of major organisational change. • Committees requested clearer evidence of control effectiveness, action ownership, target dates and escalation routes. Further work includes a digital resilience and cyber risk deep dive and a comprehensive review of BAF 06 through the January 2027 committee workshop. • No specific matters were identified for immediate Board escalation by the committees. This does not remove the need for the further assurance and improvements requested through committee scrutiny. Work on the Risk Policy, Risk Strategy and Appetite Statement will inform an updated Risk Management Framework for Board presentation in January.
ACTION / DECISION	The Trust Board is asked to: • **NOTE** the current strategic and operational risk position • **NOTE** the outcomes of Executive Management Board and committee scrutiny and the progress made in strengthening risk management arrangements. No specific matters were identified for immediate escalation by the Performance and Finance or Quality, Safety and Experience Committees; further work requested by committees to strengthen risk reporting and assurance remains set out in this paper. • **REVIEW** the adequacy of the controls, assurances and mitigating actions described in the paper, particularly the evidence of effectiveness where risk scores remain unchanged and the alignment between operational risks and the Board Assurance Framework. • **AGREE** any further assurance or follow-up reporting required.
ADDITIONAL RESOURCES	Appendices noted below.
RELEVANT TRUST STRATEGIC GOALS • Outstanding for quality, safety, and experience	

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

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Trust Risk Register
	Appendix 2	Board Assurance Framework

1. SITUATION

This report provides Trust Board with an update on the Board Assurance Framework and Trust Risk Register since the previous reporting cycle. It brings together the strategic and operational risk position and the outcomes of committee scrutiny, highlighting the key assurance gaps, progress in strengthening risk management arrangements and any matters requiring the Board's consideration.

2. BACKGROUND

From July 2026, each BAF strategic risk has been assigned to a lead committee under the new committee structure. The Trust Risk update considered by Executive Management Board on 26 October 2026 supported committee scrutiny during the reporting period.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT – EMB review

EMB welcomed progress in developing the BAF but called for consistent risk scoring, clearer controls and assurances, and stronger links between strategic and operational risks, performance reporting and committee oversight. It asked for existing issues to be managed separately from prospective risks and for risk information to be accurate and up to date. SACT

and brachytherapy pressures remained a focus, including demand, capacity, improvement activity and digital opportunities.

Following EMB, the Risk Register and BAF were reviewed further ahead of committee scrutiny. At VCS, an in-depth review produced a revised register and a strengthened monthly process covering risk descriptions, scores, actions and progress. Reviews with departmental heads will feed into divisional leadership scrutiny and the VCS Integrated Quality, Safety and Risk Group in November, with outcomes reported to EMB that month.

The position as it stands reads as follows:
There are currently 28 risks on the Risk Register.
- There are 5 risks for VCS.
- There are 19 risks for WBS.
- There are 4 risks for corporate services including digital.

Committee consideration of the operational and strategic risk position
The following summaries outline committee consideration of the operational and strategic risk position, including scrutiny of the Board Assurance Framework (BAF) and aligned risks, to inform the Board's oversight. They highlight the assurance received, the principal areas of challenge and the further work requested to strengthen risk reporting. Common themes include greater assurance regarding the alignment between operational and strategic risks, more explicit identification of control and assurance gaps, and stronger evidence of the effectiveness of mitigating actions, supported by clear ownership, timescales and escalation arrangements.

Performance and Finance Committee Risk and BAF discussion
The Committee considered BAF 04: Finance and BAF 05 — Sustainability, whose risk scores remained unchanged at 12 and 9 respectively. For Finance, the Committee heard that the internal audit of financial controls was nearing completion, with findings expected at the next Audit and Risk Assurance Committee meeting, and that work on the contract register was progressing. The investment-appraisal action required more time because it covers revenue, capital and charity processes. For Sustainability, it was explained that the strategic approach had been broadened; external conditions remained challenging, but internal assurance was strong. Further work was needed to involve staff and communities in sustainability. Members were asked to review the controls, assurances, gaps and planned actions for both risks. The Chair confirmed that no specific matters had been identified for escalation to the Board.

Quality, Safety and Experience Committee – Risk and BAF discussion
The Committee reviewed the strategic and operational risk position within its remit, including BAF 1, BAF 2 and BAF 3. Members welcomed the significant work undertaken since the previous meeting to strengthen the BAFs and noted increased Executive scrutiny of both strategic and operational risk.

The Committee's discussion focused on whether the current reporting provided sufficient evidence of effective controls, assurance gaps, mitigating actions, ownership and timescales. Members emphasised that where risks remained static over successive reporting periods, clearer target dates and evidence of the impact of mitigating actions were needed to demonstrate whether progress towards target risk was reasonable.

Further development of the operational risk register was identified as necessary. In particular, the Committee sought clearer alignment between operational risks and the BAF, together with visibility of the controls and actions against individual operational risks and appropriate management of overdue actions. The Committee noted the planned re-establishment of the Operational Risk Management Group and the work underway to strengthen risk management arrangements.

Specific challenge was provided regarding assurance gaps associated with overnight senior clinical decision-making and out-of-hours arrangements. Members received further information on existing mitigations and planned workforce developments but reinforced the need for actions addressing identified gaps to be explicit within the risk reporting.

The Committee also considered digital resilience and cyber risk, recognising that the inherent impact of cyber incidents may remain high even where improvement is demonstrated across other aspects of digital resilience. A future deep dive was requested to enable more detailed scrutiny of the component risks, controls and assurance.

Overall, the Committee recognised the significant improvement in risk and BAF reporting, while concluding that further work was required to strengthen the relationship between operational and strategic risk and provide clearer evidence of the effectiveness and impact of controls and mitigating actions. No specific matter was identified for immediate escalation to Trust Board, although the Committee noted the importance of considering the risk position against the Board's agreed risk appetite as the arrangements mature.

Research, Development and Innovation Committee – Risk and BAF discussion
The Committee noted the Board Assurance Framework (BAF) and supported its overall direction, while recognising that further development was required to ensure it fully reflects the RD&I risk landscape. Members sought greater visibility of operational and emerging risks, clearer articulation of controls, mitigating actions and assurance gaps, and explicit escalation routes from operational groups to the Committee.

It was suggested that consideration be given to alignment with the Board's reporting threshold for risks scored 12 and above, to ensure that significant and emerging risks are appropriately visible to the Committee.

Areas identified for further review included radiotherapy capacity, biopsy provision and collaborative working with Cardiff and Vale UHB. Members also requested that the statement on operational risks be reviewed to ensure it accurately reflects the current position.

The BAF will continue to be refined through subsequent Committee reporting cycles.

People, Culture and Engagement Committee – Risk and BAF discussion
The People, Culture & Engagement Committee noted that the strategic risk rating remained unchanged since March 2026, with continuing concerns regarding staff wellbeing and burnout, sickness absence, service demand and resource constraints among other issues. Members emphasised that engagement, employee voice, autonomy and belonging were organisational risk factors with implications for performance, productivity and patient and donor safety, rather than solely workforce matters.

The Committee sought clearer alignment between the strategic risk, associated operational risks and evidence considered across its wider agenda during the meeting. Members challenged the absence of reported gaps in assurance and requested a review to ensure that gaps in control and assurance were explicitly identified and supported by clear evidence of control effectiveness. Existing and emerging controls, including business-partner support, sickness absence analysis and divisional deep dives and improvements in Executive communications, should be accurately reflected. The wording and scoring of the risk relating to work-related stress and safety also required clarification ahead of Board reporting.

The Committee welcomed confirmation of funding for the Staff Wellbeing Service until March 2028, but questioned whether reliance on charitable funding and longer-term sustainability should be explicitly recognised within the risk framework.

Significant organisational change, particularly the new Velindre Cancer Centre transition and Talbot Green infrastructure developments, was recognised as both a potential source of additional workforce pressure and an opportunity to embed preventative wellbeing support before, during and after change. The Committee agreed that a comprehensive review of BAF 06 be undertaken in light of the full discussion, ensuring that strategic and operational risks, controls and assurance gaps were accurately captured and risks clearly articulated and appropriately. It was agreed that this review would form part of a committee workshop scheduled for January 2027.

Risk Policy update
The Executive Management Board considered the draft Risk Policy at its October meeting. The latest iteration will return to EMB in November for further review and discussion of the proposed approach before the policy is finalised. The draft Risk Policy will be considered by the Audit and Risk Assurance Committee in December, before the Board considers its Risk Strategy and Appetite Statement that month. All documents will then be brought together in an updated Risk Management Framework for presentation to the Board in January.

Risk Management Group
The inaugural meeting of the Risk Management Group will take place on 4 December 2026.

The Trust Board is asked to:

- **NOTE** the current strategic and operational risk position
- **NOTE** the outcomes of Executive Management Board and committee scrutiny and the progress made in strengthening risk management arrangements. No specific matters were identified for immediate escalation by the Performance and Finance or Quality, Safety and Experience Committees; further work requested by committees to strengthen risk reporting and assurance remains set out in this paper.
- **REVIEW** the adequacy of the controls, assurances and mitigating actions described in the paper, particularly the evidence of effectiveness where risk scores remain unchanged and the alignment between operational risks and the Board Assurance Framework.
- **AGREE** any further assurance or follow-up reporting required.

FINANCIAL IMPLICATIONS

No additional funding is sought through this report. Financial implications associated with the risks covered by this integrated report are outlined in the relevant BAF risks, including those relating to quality, safety and experience.

3.2 LEGAL IMPLICATIONS
No specific legal implications arise directly from this assurance report.

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

3.4 WELSH LANGUAGE IMPLICATIONS
No direct Welsh language implications arise from this assurance report.

3.5 RISKS / REPUTATIONAL IMPLICATIONS
3.5.1 Relevant Strategic Risk - Board Assurance Framework (BAF)

BAF 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.

Trust Risk Register – Quality, Safety and Experience Committee - November 2026

Risk scores are calculated by multiplying impact (first number in brackets) by likelihood (second number in brackets).

No	ID	DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER	RISK TITLE & DESCRIPTION	INHERENT RATING	CURRENT RATING	TARGET RATING	RISK RATING EXPECTED DATE	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS	PROGRESS SINCE LAST REPORTING PERIOD
Velindre Cancer Service													
12+ Risks in the Quality and Safety domains													
1	3969		VCS	Safety	Head of Nursing	There is a risk that patients may not be escalated appropriately to senior decision makers due to unclear escalation pathways, staff uncertainty, scope of practice or availability of on call team due to other workload pressures, resulting in delayed decision making, inappropriate management and increased risk of harm.	20 5x4	12 4x3	8 4x2	18.12.26	↓ Decreased	- Clarify and map escalation pathways and produce quick reference guides for staff within resource folder - Define role and responsibilities - Clarify when escalation to senior decision maker is mandatory - Review of on call workload patterns and use of AOS consultant/ consultant on call - Review of helpline data to determine wider workforce planning is required - Undertake monthly audit of calls on AMaT to assess compliance with escalation. - Benchmark with other providers to assess their protocols for escalation - Workforce – consider additional member of staff covering helpline – ACP or Medical (Clinical fellow level)	Review our interim clinical pathways for patients contacting the helpline indicated by their triage scores. Business case presented to Execs by 5th October 2026.Review has been undertaken and has supported development of business case. Recruitment timelines being confirmed.
2	4053	24.8.26	VCS	Safety	Technical Support Manager and Health and Safety Lead	If individuals use the grass mound adjacent to the CTU car park as a pedestrian access route, then they may be exposed to slipping or tripping hazards associated with the ground surface and environmental conditions, resulting in falls, injury, patient or staff harm, complaints, claims and reputational damage.	16 4x4	12 4x3	8 4x2	18.12.26	→ No change	- To plant hedges and shrubbery around the grass mound to deter access for pedestrians	07/10/26 - Awaiting quotes for remedial work related to action.
3	3832	12/02/2025	VCS	Safety	Head of Nursing	There is a risk to staff safety as a result of 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	30.10.26	→ No change	- Education and training development for CSTDs for rapid role out	Business case approved by EMB. Procurement complete - phased system from 10 November 2026.
4	4019	20.7.26	VCS	Multiple Risk Domains: Performance and Service Sustainability and Reputational	Director of Velindre Cancer Service	There is a risk to performance and reputation as a result of inaccurate data being produced relating to SCP leading to incorrect performance information being included within public Board papers.	15 3x5	15 3x5	6 3x2	09/01/2027	→ No change	- An action plan needs to be developed	Following TRI meeting it was discussed that there is no change and work is continuing with digital.
5	4049	14.8.26	VCS	Quality	General Manager	There is a risk to patient safety, quality of care and delivery of the acute oncology pathway as a result of insufficient resident senior clinical decision-making and escalation support overnight, leading to delays in the assessment, escalation and treatment of deteriorating patients, an increased likelihood of clinical incidents and patient harm, and reduced resilience of the acute oncology service.	20 5x4	15 5x3	6 3x2	26.4.27	→ No change	- Secure approval and implementation of an overnight ACP/ANP model to provide resident senior clinical decision-making and escalation support for deteriorating patients and acute oncology pathways overnight.	Currently have acute physician as cost pressure, awaiting business case outcome for approval.
Welsh Blood Service													
12+ Risks in the Quality and Safety domains													
6	3418	03.7.25	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	30.11.26	→ No change	- Implementation of LIMS 2 in Transfusion Laboratories, ensuring all relevant workflows are transitioned and staff are trained, to reduce the likelihood of reporting errors, as evidenced by a measurable reduction in incident reports or data discrepancies related to reporting errors within 6 months post-implementation.	implement the NHS Wales LIMS 2 Programme within Transfusion Services, ensuring all relevant workflows are transitioned and staff are trained, to reduce the likelihood of reporting errors, as evidenced by a measurable reduction in incident reports or data discrepancies related to reporting errors within 6 months post-implementation. *Note - Target date has changed to Feb 2027 due to delays in project timelines
7	3716	24.06.25	WBS	Quality	Director of Welsh Blood Service	There is a risk to patient safety as a result of reusing sample numbers leading to incorrect patient results reported.	12 4x3	12 4x3	8 4x2	30.09.27	→ No change	- Ensure that Immulink information sent manually contains only current sample results. - Update LAB-066, Printing and Reporting of Results from NEO Iris; the SOP is in draft and awaiting review. - Update the middleware so that it no longer supports the reuse of sample numbers; this will be completed through the change management process.	No change to risk- managing manually and no further incidents. Action will be measurable by the implementation of TCLE system. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of the TCLE LIMS system will directly address this risk; the estimated completion date is September 2027.
8	3388	05/07/2024	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	31.12.26	→ No change	- Update LAB-066, Printing and Reporting of Results from NEO Iris; the SOP is in draft and awaiting review.	Go live now expected to be delayed to at least mid-December 2026. An Exception Report will be prepared for CPG approval to document the impact of the delay on project milestones, resource requirements and forecast delivery dates. Patient and service impacts remain unchanged. Fetal RhD results continue to have limited accessibility to service users until completion of the reporting integration.
9	3643	04/11/2025	WBS	Quality/ Safety	Director of Welsh Blood Service	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16 4x4	16 4x4	4 4x1	08.02.27	→ No change	- Update the middleware so that it no longer supports the reuse of sample numbers; this will be completed through the change management process.	Action outstanding to implement new LIMS system. TCLE National Project has an estimated completion of February 2027. National resources have been allocated to the LIMS TCLE project to ensure delivery. Implementation of TCLE LIMS system will directly address this risk - implementation date delayed to 08/02/2027
10	3837	5.12.25	WBS	Quality	Head of Transfusion Services	There is a risk to quality as a result of unknown risks from LIMS2.0 TCLE going live with known defects, leading to patient harm.	16 4x4	12 4x3	8 4x2	30.11,26	→ No change	- Review risk regarding severity 1 and 2 defects. Although listed as significant and requiring review in 6 months, this will be reviewed at 3 months in line with current timelines for cutover testing and go-live.	Risk scoring to remain the same until user acceptance testing (UAT) is completed. Exact date to be confirmed pending Intersystems resource to support T5.
15+ Risks in other domains													

11	3801	14.10.25	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	There is a risk to Performance and Service Sustainability of cell free fetal DNA screening as a result of FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase, leading to uncertainty over confirmation from DHCW on definitive validation and go-live dates. Timelines could shift at short notice if issues arise.	16 4x4	16 4x4	8 4x2	30.11.26	→ No change	- Management of FEDIS Phase 2 Delays and DHCW Dependency - Continue to escalate FEDIS Phase 2 delivery delays and risks to the WBS Futures Delivery Board to obtain indicative timelines from DHCW. - Maintain active monitoring of project progress through weekly touchpoint meetings with DHCW and updated project plan. Identify and implementing feasible efficiencies to reduce the duration of UAT and validation where possible.	DHCW have confirmed date of 21/09/2026 to commence SIT for the FEDIS reporting interface. This follows completion of SIT for another higher-priority workstream for a different Trust. During our weekly project meeting on 09/09/2026, DHCW advised that the preceding project remains on track to complete on schedule and therefore the FEDIS SIT is currently expected to start on time. However, commencement of SIT remains dependent on DHCW and cannot yet be formally guaranteed - therefore risk is stabilising but not yet reduced. Project planning activities have continued in parallel to minimise further delays once SIT is completed. A workshop with DHCW was held on 14/08/2026 to clarify the approach to UAT, validation and cutover activities, including confirmation of the planned test environments, support arrangements and escalation routes. Requests for access to the UAT Welsh Clinical Portal environment have been submitted and validation documentation is in development, including plans for cutover testing, risk mitigation and ongoing support arrangements. As a consequence of this further delay to SIT of approximately 3 weeks, go live is now expected to be delayed to at least mid-December 2026. An Exception Report will be prepared for CPG approval to document the impact of the delay on project milestones, resource requirements and forecast delivery dates.
12	4003	23/6/26	WBS	Performance and Service Sustainability	Director of Welsh Blood Service	There is a risk to reputation, performance and service sustainability as a result of the ongoing use of end of life FoxPro and DOS based systems in respect of interfacing requirements with laboratory systems and databases, leading to IT system failures and inability to provide one or more WBMDR services.	15 5x3	15 5x3	5 5x1	31.12.27	→ No change	- Recruit and onboard WBMDR project resources - Review, update and obtain approval for the User Requirements Specification (URS) - Confirm procurement strategy and prepare procurement documentation - Establish governance arrangements for project delivery - Confirm project board membership and reporting arrangements	Process mapping and URS development is ongoing with 'As is' mapping completed by end of October and 'To Be' mapping by middle of November. Alongside that The procurement specification is being developed and work on the Full business case is starting.
13	4004	23.6.26	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk to reputation, performance and service sustainability as a result of the ongoing use of end of life FoxPro and DOS based systems in respect of the global communication with external registries, leading to IT system failures and inability to provide one or more WBMDR services.	16 4x4	16 4x4	4 4x1	31.12.27	→ No change	- Recruit and onboard WBMDR project resources - Review, update and obtain approval for the User Requirements Specification (URS) - Confirm procurement strategy and prepare procurement documentation - Establish governance arrangements for project delivery - Confirm project board membership and reporting arrangements - By 30 September 2026, the following will be completed: - Full multi-disciplinary project team recruited and onboarded. - User Requirements Specification reviewed, updated and formally approved. - Procurement strategy agreed with NWSSP Procurement. - Procurement documentation completed and approved. - Project governance framework established and operational. - Project Board membership confirmed with agreed Terms of Reference and reporting arrangements. - Dependencies - Availability and engagement of WBMDR subject matter experts. - Timely support from NWSSP Procurement and relevant procurement governance groups. - Stakeholder agreement on system requirements and project scope. - Availability of organisational recruitment support and approval processes. - Engagement of Project Board members and senior stakeholders. - Project Board meetings scheduled and reporting arrangements implemented.	PROGRESS NOTES: Process mapping and URS development is ongoing with 'As is' mapping completed by end of October and 'To Be' mapping by middle of November. Alongside that The procurement specification is being developed and work on the Full business case is starting.
14	3306	15/01/26	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	01.12.26	→ No change	- Incoming electrical supply to be upgraded to dual supplies, this will be actioned with TGI planned works. 01/12/2026	No change to risk. Continue to manage PPM programmes in place across site.
15	4054	28.8.26	WBS	Performance and Sustainability	Head of Transplantation Services	There is risk to performance and service sustainability as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
16	4055	28.8.26	WBS	Reputational	Head of Transplantation Services	There is risk to reputational damage as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
17	4056	28.8.26	WBS	Quality	Head of Transplantation Services	There is risk to quality as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.

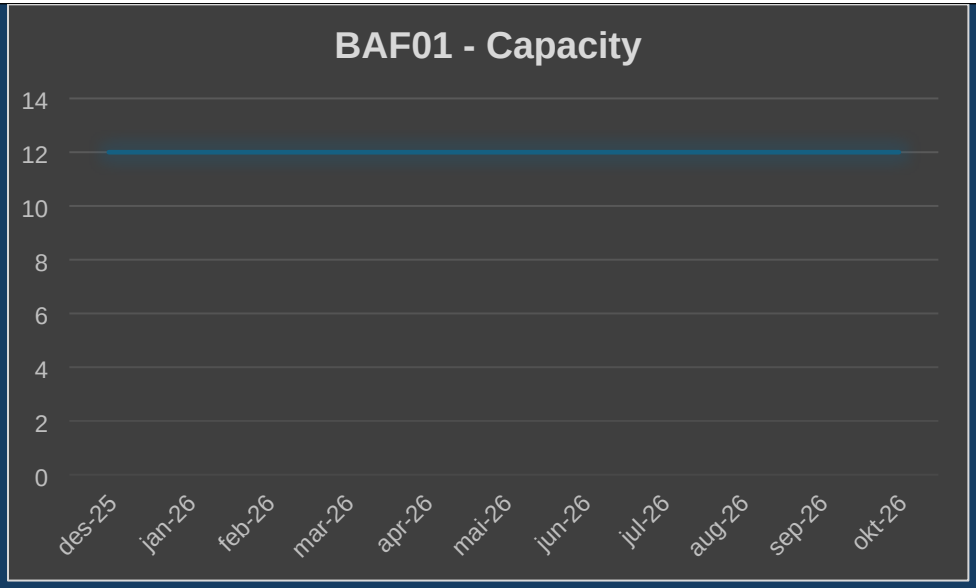
18	4057	28.8.26	WBS	Quality	Head of Transplantation Services	There is risk to quality as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
19	4058	28.8.26	WBS	Safety	Head of Transplantation Services	There is risk to safety as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
20	4059	28.8.26	WBS	Safety	Head of Transplantation Services	There is risk to safety as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
21	4060	28.8.26	WBS	Financial Sustainability	Head of Transplantation Services	There is risk to financial sustainability as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
22	4061	28.8.26	WBS	Financial Sustainability	Head of Transplantation Services	There is risk to financial sustainability as a result of not securing or a delay in securing stem cell apheresis rooms at the nVCC, leading to a break in service, probable reliance on third party suppliers, increased operational costs, reduced or no cell collection capacity, reduced resilience of transplant services in Wales, delays to UK and global transplant programmes, loss of JACIE and WMDA accreditation, loss of Human Tissue Authority Licence, and impact on patient safety, VUNHST reputation and income generation.	15 5x3	15 5x3	5 5x1	01.04.27	→ No change	- Secure Confirmation of Apheresis Provision at the New VCC - Develop a Fully Costed Contingency Model for Alternative Delivery - Establish Decision Escalation Threshold - Maintain Regulatory and Accreditation Compliance - Protect Collection Capacity and Service Resilience	PROGRESS NOTES: A space for the apheresis to take place at the nVCC has been identified. This does not include the working area for the nurses to manage the confidential paperwork and the product; however, assurance has been given that this will be managed. A discussion with Jason and the architect is awaited to design the interior of the room, expected before the end of October.
23	4067 *new to TRR		WBS	Performance and Service Sustainability	Head of Transfusion Services	There is a risk to performance and service sustainability due to WLIMS delivery exceeding national programme time line leading to the reallocation of staff resource at short notice.	12 3x4	15 3x5	3 3x1		• New	- Review actions and include action plan	This risk is being reviewed as part of the overarching risk assessment (FMEA 3837) for WBS deployment of LIMS2.0. The main risk assessment can be found on the record for 3837, and has also been set as a linked record.
24	4069 *new to TRR		WBS	Performance and Service Sustainability	Head of Transfusion Services	There is a risk as a result of the constraint timeline for the implementation of Tranche 5 leading to overall insufficient project resourcing for preparation and delivery requirements.	12 4x3	16 4x4	4 4x1	1.4.27	• New	Close monitoring of national timelines for delivery. Engaement with WBS PMO to ensure that project support has been identified.	This risk is being reviewed as part of the overarching risk assessment (FMEA 3837) for WBS deployment of LIMS2.0. The main risk assessment can be found on the record for 3837, and has also been set as a linked record.
Corporate													
15+ Risks in other domains													
25	3646	15.04.2025	Corporate	Performance and Service Sustainability	Chief Digital Officer	There is a risk that the WLIMS 2.0 go-live date will be delayed due to delays in the national programme timeline, affecting the realisation of project outcomes and creating additional demand for further development of existing legacy systems.	20 4x5	20 4x5	4 2x2	30.11.26	→ No change	- CEO of DHCW took a paper to DDAT Board regarding congestion in digital planning quarter 4. - Participating in national planning for LIMS across NHS Wales. Local plans are ready to test on LIMS 2.0. - Agree the new launch date with WBS Futures Programme. - Mitigation plan in place with existing SERIF system.	Internal work for WLIMS is largely complete and low risk. The national programme continues to be challenged. September is still the official go live Tranche five, however it is expected to shift to October 2026. WLIMS has been escalated to the CEO management team. There is no change to the current risk rating.
26	3656	24.04.25	Corporate	Multiple Risk Domains	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	30.11.26	→ No change	Assurance mapping to be reviewed and completed by September 2026 Implementation of NWSSP Review Recommendations to be completed by end of September 2026.	EMB considered revised paper work 26 October 2026. Final implementation group meeting to take place beore end of November 2026. Target date amended to end of November 2026, with amendments to Standing Orders as evidence of conclusion.
27	3633	15.04.25	Corporate	Multiple Risk Domains	Chief Digital Officer	There is a risk to Quality and Performance and Service Stability as a result of the lack of capacity of Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis leading to delays in the Trust's ability to introduce new digital systems to support its strategic objectives. In particular integration for the IRS, WHAIS, FEDIS projects has had to be escalated to the DHCW Executive for resolution. 7c	15 3x5	12 3x4	6 3x2	30.10.26	→ No change	- Agree with DHCW a prioritised integration plan for IRS, WHAIS and FEDIS, including named leads, dependencies and delivery milestones. - Maintain regular programme-level engagement with DHCW to monitor SIT, UAT, assurance and go-live readiness, escalating unresolved constraints through the agreed governance routes. - Develop and maintain risk-managed contingency arrangements for delayed national integration, with progress reported through Trust and DHCW digital governance.	FEDIS is progressing, due for go live in October and monitoring until November 2026. WHAIS is proceeding to plan. Risk review, rating unchanged.
28	3001 *risk reopened		Corporate	Safety	Interim Director for People and OD	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16 4x4	12 4x3	9 3x3	31.12.26	• New	- The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. - Plans in those areas of work already in place need to be aligned to this risk or new plans developed.	Risk reopened during reporting period.

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

Executive Summary	WBS - WBS continues to meet clinical demand, supported by established operational resilience and escalation arrangements. However, blood supply resilience remains under sustained pressure, with 2026 demonstrating the impact of collection capacity, workforce availability, demand variation and environmental factors on stock levels. The Blood Supply Chain Planning Group is strengthening end-to-end oversight of capacity, demand and supply, supported by development of improved data and insight, an operational assurance framework and longer-term changes to the collection model. Delivery of sustainable capacity across WBS also remains dependent on infrastructure investment, digital modernisation and commissioner/funding decisions. VCS – Rising demand and clinical complexity continue to challenge service capacity. The ongoing IRS rollout supports a more sustainable and flexible Radiotherapy service. SACT remains under pressure as systemic therapies advances, cancer incidence rises and increasing number of patients live with cancer. Sustained improvement work is progressing new ways of working, service delivery options and better business intelligence to strengthen capacity planning and support consistent delivery across current and future hub-and-spoke services. The Cancer PTL now enables real-time patient-level pathway tracking, improving visibility of bottlenecks and supporting active pathway management. Risk score trend: The risk score has remained static since the last period.

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

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	2	4	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	3747 V	Insufficient capacity within the SACT day case service leading to delays in patients receiving SACT treatment.	12
	4049 V	Overnight Acute Oncology capacity	
	3714 V	Increased demand on the SACT booking team leading to delay in scheduling SACT treatments and potential breaches.	15
	4054-4061 W	Stem cell apheresis accommodation and service continuity	15
	2518 V	insufficient capacity to meet demand fluctuations in numbers of brachytherapy patients	16
	4049 V	Insufficient resident senior clinical decision-making and escalation support overnight, leading to delays in the assessment, escalation and treatment of deteriorating patients, an increased likelihood of clinical incidents and patient harm, and reduced resilience of the acute oncology service.	15
	3969 V	Treatment Helpline escalation and timely decision-making risk, incorporating access, triage and escalation arrangements.	12

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	01.02	Support implementation of the Infected Blood Inquiry recommendations and the National Blood Health Plan to strengthen prudent use of blood, demand management and blood supply sustainability across Wales.	Work continues at UK and Welsh level to support implementation of the Infected Blood Inquiry recommendations, with digital connectivity and transfusion laboratory workforce identified as key priorities. WBS is working with HEIW to map transfusion laboratory workforce requirements and progressing an Outline Business Case to define the digital requirements needed to strengthen connectivity, reporting and understanding of patient	WBS Director	April 2027 ~~December 2026~~

			outcomes. Delivery remains dependent on appropriate resource and system support across NHS Wales.		
	01.03	Progress the business cases and commissioning arrangements required to secure sustainable funding for WBS service developments and capacity requirements. ~~Develop and progress capacity and demand business cases across key operational areas within WBS, and engage with commissioners (JCC) to secure agreement and funding to support sustainable service delivery.~~ These include: • Red Cell Immuno-haematology workforce due to increases in demand • Collection team resilience to support demand fluctuations and prevent service going into supply shortages • Introduction of West Nile Virus testing • Increasing recruitment of Welsh Bone Marrow Donor Register Volunteers • Recurrent funding to support our Component Development Laboratory Staffing infrastructure to support mandated changes upstream.	Business cases continue to be progressed through the relevant commissioning and Welsh Government governance routes. Funding and commissioning dependencies continue to be monitored as part of WBS strategic and portfolio oversight.	WBS Director	March 2027
	01.04	Strengthen blood supply chain resilience to ensure collection capacity and capability can sustainably meet forecast demand.	The Blood Supply Chain Planning Group (BSCPG) continues to oversee end-to-end capacity, demand and supply. Work is progressing to strengthen the data and insight available to support decision-making, including development of the BSCPG dashboard and wider Operational Assurance Framework, alongside longer-term development of a more resilient collection model. Daily resilience arrangements continue to		April 2027

			provide short-term operational oversight and escalation.		
	~~01.04~~ 01.05	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	Data and Modelling have been updated to sense check that the Outpatients demand forecast for nVCC, has not outstripped capacity between design and build. Currently there is capacity within nVCC. Further, more detailed modelling required at SST level to include service interdependencies, including the increasing trend in virtual in services such as VAP.	**VCS Director**	**April 2027**
	~~01.05~~ 01.06	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	Service-level demand and capacity planning has been constrained by limited data. The Cancer PTL and 'go paperless' initiative are improving the information available to strengthen planning and productivity. The SACT business case uses the updated GE model to assess demand, capacity and service requirements. Data & Insights owns this action. The COO is leading commissioning of a more granular World SACT model, with a proposed target of Q4 2027. Radiotherapy has sufficient linac capacity; no additional demand and capacity modelling was undertaken.	**VCS Director**	**~~February 2026~~ Jan 2027**
	~~01.06~~ 01.07	Strengthen WBS service resilience and infrastructure assurance.	Existing business continuity and supply resilience arrangements are in place, with ongoing monitoring through operational and escalation routes. The BJC and OBC for the Talbot Green Infrastructure Programme have been submitted to Welsh Government. Responses to Welsh Government clarification questions were submitted in October 2026, and the proposals were presented to the Infrastructure Investment Board on 6 November 2026. The programme remains strategically important to addressing WBS's long-term infrastructure resilience, capacity and sustainability risks.	WBS Director	December 2026

			~~The Business Justification Case and Outline Business Case for the Talbot Green Infrastructure Programme have been submitted to Welsh Government to support infrastructure upgrades, service sustainability and future capacity requirements. Work is ongoing to develop to Full Business case stage.~~		
	~~01.07~~ 01.08	Strengthen oversight of digital dependencies affecting WBS capacity and sustainability.	Digital dependencies continue to present a material capacity and sustainability risk. WLIMS 2.0 Blood Transfusion is progressing towards a revised February 2027 go-live, while BECS delivery remains subject to data migration, workforce and funding dependencies. WBS continues to manage and escalate these dependencies through WBS Futures, Trust Digital and national governance arrangements.	Chief Digital Officer / WBS Director	December 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Blood Supply Chain Planning Group (BSCPG) oversight of end-to-end capacity, demand and supply, supported by daily operational resilience arrangements.	WBS does not yet have a sufficiently integrated, automated view of collection capacity, demand, stock, production and operational constraints to support strategic decision-making.	Routine monitoring of stock, collections and demand through daily resilience arrangements and BSCPG, with escalation through WBS governance.	The BSCPG dashboard and wider Operational Assurance Framework are still in development, limiting the ability to provide integrated evidence of medium and longer-term capacity and resilience.
Established collection planning and operational resilience arrangements, with work underway to develop a more resilient hybrid collection model.	The current predominantly community-based collection model remains vulnerable to workforce availability, venue constraints, extreme weather and fluctuations in donor availability.	Collection performance, capacity and stock resilience are routinely monitored, with operational escalation and contingency arrangements used where required.	There is not yet sufficient assurance that the current collection model can consistently deliver the required collection capacity over the medium to longer term without short-term operational intervention.
Joint blood stock planning with Health Boards (SLAs, Blood Health Plan, regular reviews) Routine stock resilience planning and UK mutual aid coordination Business continuity arrangements for core services	No real-time “vein-to-vein” data / business intelligence to link Health Board activity changes, blood issuing patterns, demand, and patient outcomes **(**dependent on external digital systems outside WBS control; being progressed via	SLA reviews with Health Boards; BHNOG KPI monitoring; operational escalation routes and local operational planning groups (e.g., SE Wales demand modelling; service area operational planning).	Limited assurance on demand-related decision-making: WBS cannot validate alignment between issuing patterns, Health Board activity changes and patient outcomes due to lack of real-time “vein-to-vein” data Limited independent assurance on standardisation of utilisation: insufficient independent assurance that variation in blood utilisation across Health Boards/clinical teams is being effectively addressed and sustained

(BIAs, contingencies, BCPs, shortage plans) Governance to balance BAU delivery with strategic programmes (WBS Futures/CPG) Blood Supply Chain Planning Group and developing Operational Assurance Framework to strengthen oversight of demand forecasting, collection activity, component production, supply chain resilience and capacity planning. Digital dependency management for WBS critical systems and programmes, including escalation of national and supplier-related risks through appropriate WBS, Trust and national governance routes. Commissioning and investment planning controls, including development and resubmission of capacity and demand business cases to support sustainable service delivery. Infrastructure resilience and capacity planning are managed through the Talbot Green Infrastructure (TGI) Programme, including development and submission of the Business Justification Case (BJC) and Outline Business Case (OBC) to support infrastructure upgrades, service sustainability and future capacity requirements.	Infected Blood Inquiry-related programmes). Variation in demand management / blood utilisation across Health Boards and within clinical teams (inconsistent practice drives inappropriate use and affects demand). Limited organisational control over national and supplier-led digital programme timelines, including WLIMS2.0, FEDIS and BECS dependencies, which creates uncertainty for WBS capacity and sustainability planning. Delivery of infrastructure improvements remains dependent on approval and funding of the TGI Business Case, limiting current organisational control over timing and implementation of required upgrades. Capacity and demand business cases have been developed and submitted to JCC , but delivery of some mitigations remains dependent on commissioner support and investment decisions.	Reporting through WBS SLT / VCS Divisional Team to EMB; oversight via COO/EMB, QSP Committee and Board; Trust-wide Clinical & Scientific Board. Welsh Government Quality, Planning & Delivery Reviews; regulatory inspections (e.g., MHRA, HTA); escalation via EPRR/Local Resilience Forum where needed; UK Blood Services MoU/mutual aid; Internal Audit, Wales Audit Office and regulator audits. Blood Supply Chain Planning Group reporting and development of the Operational Assurance Framework, including oversight of demand forecasting, collection activity, component production and supply chain resilience. Programme reporting through WBS Futures and relevant digital governance routes, including monitoring of delivery risks, national dependencies and supplier-related risks affecting WBS sustainability. Commissioner engagement and JCC	Limited assurance on delivery confidence for national and supplier-led digital programmes that affect WBS capacity and sustainability, including WLIMS2.0 and FEDIS. Limited assurance that capacity and demand business cases will secure the investment required to mitigate known demand and sustainability pressures.

		review of WBS capacity and demand business cases to support scrutiny of service sustainability requirements.	
SACT Steering Group provides strategic oversight of SACT risks, improvement milestones, capacity/demand, workforce and nVCC readiness. Capacity and demand modelling, the SACT PTL, outreach provision and current improvement programme provide operational controls	Demand continues to exceed capacity across parts of the pathway, including booking/scheduling, pharmacy, treatment delivery, ACP capacity and pre-SACT assessment. Current modelling does not yet fully incorporate treatment-time standards or all pathway dependencies	SACT Steering Group reporting; performance/QPI reporting; SACT PTL; workforce and chair-capacity modelling; oversight through VCS and executive governance. The business case provides a defined capacity and workforce response. Opportunity for increased digital working being understood.	Limited assurance that the current model can sustainably accommodate continuing demand growth while delivering national SACT standards. Further assurance is required on whole-pathway capacity, chair capacity and productivity, pharmacy/aseptic capacity, workforce recruitment and the final nVCC/trials chair configuration required as a sustainable baseline.
IRS rollout, LINAC replacement/renewal programme and routine Radiotherapy performance and capacity management provide the core controls. Current assessment is that sufficient LINAC capacity exists.	Capacity is dependent on the successful delivery of IRS, equipment commissioning, workforce availability and the transition/move sequence. Complexity of treatment also creates pressure beyond machine capacity alone.	Radiotherapy performance reporting; IRS programme governance; Service Preparedness/readiness reporting; equipment and commissioning plans; executive and Board oversight. RT PTL is being developed.	Assurance is stronger on physical LINAC capacity than on the end-to-end pathway. Further assurance is required that workforce, planning, digital, physics and transition dependencies will collectively support sustainable capacity through the nVCC move.
Treatment Helpline, assessment/SDEC arrangements, inpatient provision, escalation processes and business continuity arrangements provide a baseline acute oncology response. VCS has also undertaken winter/EPRR stress testing and developed surge arrangements	There remains insufficient consistent resident senior clinical decision-making and escalation support overnight. The current model does not yet provide a standardised 24/7 response, and Treatment Helpline/escalation	Acute Oncology business-case governance; operational incident/escalation reporting; EPRR and winter stress testing; VCS governance and Service Preparedness oversight. The proposed phased model directly addresses	Until the future Acute Oncology model is implemented and tested, limited assurance remains over consistent out-of-hours senior decision-making, escalation and service resilience. Recruitment, commissioning and regional pathway dependencies remain material.

	arrangements remain recognised risks.	the unresolved senior clinical oversight, Helpline and overnight-cover risks.	
Cancer PTL now provides patient-level pathway visibility and active management of bottlenecks. Access governance provides oversight of pathway standards, breaches, long waits, patients without next events and recovery actions	PTL/data maturity is improving but does not yet provide a complete end-to-end regional view. Interfaces with Health Board pathways remain important dependencies.	Cancer PTL reporting; Access Board/directorate review; performance reporting; breach/root-cause review; escalation through VCS, EMB and QSP governance.	Evidence of improved visibility is stronger than evidence of sustained outcome improvement. Further assurance is required that PTL intelligence consistently drives earlier intervention, reduced variation and measurable improvement in access.
Service-level planning is undertaken for SACT and Radiotherapy. Cancer PTL and go-paperless work are improving the underlying data; the updated GE model supports SACT planning and further granular modelling is being commissioned.	There is not yet a sufficiently granular, integrated VCS demand-and-capacity model covering demand, workforce, treatment complexity, pharmacy, diagnostics, physical capacity and network interdependencies.	Data & Insights reporting; Cancer PTL; service-level capacity modelling; SACT business-case modelling; routine VCS performance and executive review. Cancer Dashboard in development with East Kent Hospitals.	Limited assurance over medium and longer-term capacity requirements across the whole VCS system. Existing models provide useful planning evidence but do not yet provide one integrated forward view against which capacity decisions and benefits can be tested.
Service Preparedness governance, Readiness Board arrangements, integrated programme/risk management, individual service readiness workstreams and emerging regional operational governance provide controls over transition.	A number of service interdependencies remain live, including SACT/trials chair capacity, pharmacy/aseptics, digital dependencies, Acute Oncology, workforce, equipment commissioning and elements of the move sequence. The October Service Preparedness review explicitly identified several of these as unresolved readiness dependencies.	Service Preparedness Group and Readiness Board reporting; live risk register; workstream dashboards; P6 programme; executive scrutiny and nVCC governance.	Assurance remains dependent on successful closure and testing of interdependent readiness actions rather than individual workstream completion alone**.** A consolidated demonstration that the operating model works safely end-to-end through transition is still required.

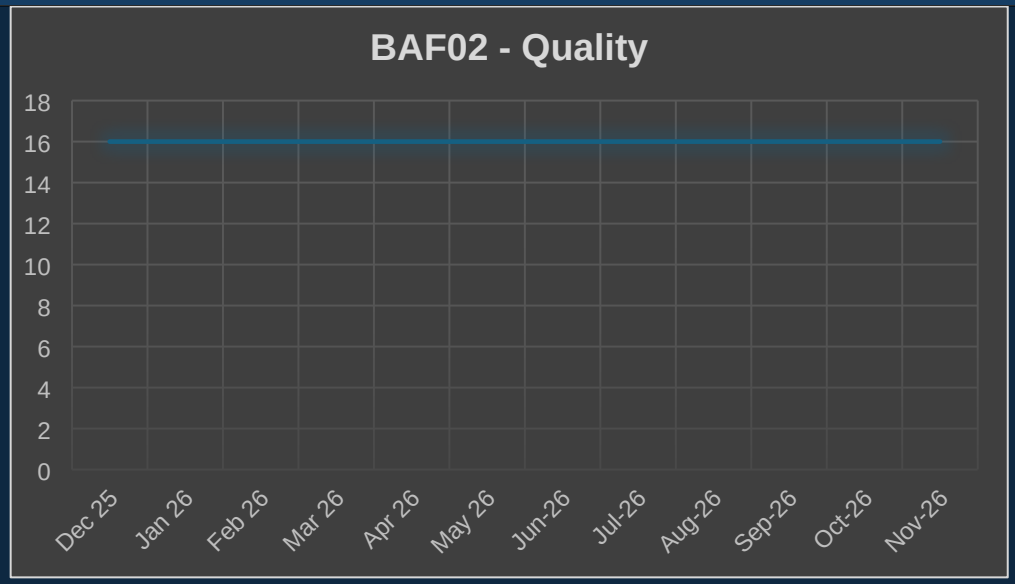
Risk 02	There is a strategic risk that the quality, safety and experience outcomes the Trust seeks to achieve for patients, donors and populations may be adversely impacted if the organisation is unable to effectively deliver, embed and sustain the improvements, transformation, leadership and governance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

Executive Summary	The Trust continues to manage a significant quality, safety and experience risk profile across Cancer and Blood Services while delivering major service, workforce and digital change. Current intelligence provides reasonable assurance overall: Q2 patient and donor satisfaction remained high at 96% for VCS and 99% for WBS, VCS incident activity and overdue investigations reduced, and external assurance has identified areas of good practice. However, the position is not yet sufficiently mature to reduce the BAF score. Key areas requiring continued oversight include treatment-process and medicines safety, falls and pressure damage, timeliness of complaint and incident management, overdue redress cases, WBS laboratory and distribution errors, and resilience of critical clinical and digital systems. Recent incident learning reinforces the importance of timely recognition and escalation, clear pathway ownership, standardised processes, trained and competent staff, and resilient systems. Quality intelligence is improving, but PROMs, mortality and outcome measures, the Trust quality dashboard and systematic use of patient and donor voice are not yet fully embedded. The current score of 16 (Major x Likely) therefore remains appropriate. Reduction towards the target score of 9 should be considered when the principal control and assurance gaps have demonstrably closed and improvement is sustained across services. A cluster of interdependent WBS laboratory digital risks remains, relating to legacy-system resilience, implementation quality, programme capacity and resource availability. These are being reviewed to ensure the underlying strategic exposure is clearly represented without duplication. The current Trust Risk Register continues to support the BAF 02 assessment, with material risks relating to clinical escalation and senior decision-making, laboratory and digital system resilience, national programme dependencies, hosted-service governance, workforce capacity and nVCC service readiness. While some individual risks are improving, the overall profile does not yet demonstrate sufficient and sustained reduction in strategic exposure to support a change to the current BAF score 16.

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

- Maintain exemplary standards of quality, safety and governance that meet or exceed organisational**,** regulatory, professional and accreditation requirements.
- Be recognised nationally and internationally as a leading organisation for quality, safety, experience and clinical outcomes.

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	of L	Score	I	L	Score
	4	5	20	4	4	16	4	4	16	4	4	16	4	4	16	3	3	9



Associated Risks	Risk ID	Risk Title	Current Risk Score
	4049 V	Insufficient resident senior clinical decision-making and escalation support overnight, leading to delays in the assessment, escalation and treatment of deteriorating patients, an increased likelihood of clinical incidents and patient harm, and reduced resilience of the acute oncology service.	15
	4054-4061 W	Stem cell apheresis accommodation and service continuity	15
	4019 V	Inaccurate data being produced relating to SCP leading to incorrect performance information being included within public Board papers.	15
	3969 V	Treatment Helpline escalation and timely decision-making risk, incorporating access, triage and escalation arrangements.	12

	3418 V	Pre- and post-examination process risk for tests yielding patient results, with potential adverse impact on patient care.	12
	3388 W	FEDIS interface limitations affecting accessibility of reports and potentially impacting antenatal care.	16
	3643 W	Aged Laboratory Information System risk affecting RCI and Automated Testing ability to operate a safe service.	16
	3801 W	FEDIS Phase 2 schedule slippage and DHCW dependency affecting fetal DNA screening sustainability and go-live certainty.	16
	3633 C	DHCW capacity to integrate VUNHST digital systems into national architecture, affecting delivery of digital systems supporting strategic objectives.	12
	3656 C	Quality of clinical and corporate governance assurance and reporting arrangements for hosted services.	15
	3306 W	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.	15
	3832 V	Administering SACT without the use of closed drug transfer system devices, leading to potential impact on health from repeated cytotoxic exposure	15
	3716 W	There is a risk to patient safety as a result of reusing sample numbers leading to incorrect patient results reported.	12

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	02.01	Implement the digitisation of a robust set of service level to Board quality, safety outcome and experience metrics including mortality, aligned with the Performance Management Framework.	PMF enhancements continue. WBS routinely reports quality, safety and donor experience indicators, while further work is needed on mortality, PROMs and VCS experience intelligence. The Integrated Performance Framework Task and Finish Group established in July 2026 is bringing quality and activity measures together, with a final draft product targeted for December 2026. The Q2 Quality and Safety report also identifies Trust risk 3902 relating to the absence of a	Director of Strategy, Planning & Performance	Dec 2026

			Trust-wide Quality Management Dashboard. The Integrated Performance Framework review for WBS is progressing, including development of a revised KPI suite that separates core assurance measures from improvement measures and strengthens alignment from service-level oversight through SLT, EMB and Board. Implementation is being aligned to the 2027/28 reporting cycle.		
	02.02	Deliver *** and monitor impact of programme of quality and safety investigation training for all potential investigation leads.	Investigation training is established and incorporates human factors, systems thinking and a Treat Me Fairly approach. The Trust has increased its pool of trained investigators over 40 and a recent Welsh Risk Pool assessment commended the quality of Part 5 investigation reports. Continued focus is required on timely closure, consistency of investigations and evidence that learning is sustained. Propose close.	Director of Nursing, AHP and Health Science	Nov 2026

	02.03	Implement the digital PROMS system for patients and establish a mechanism for regular analysis and identification of areas for learning and improvement.	Digital PROMs are live in four pathways, with further roll-out planned across VCS. Work continues to make data accessible for direct care and meaningful analysis. Data flow has been approved for integration with the National Data Resource/Welsh Clinical Portal and NHS App, with WCP integration due December 2026. Routine Board-level PROMs assurance remains a gap.	Executive Director Finance	March 2028
	02.04	Fully implement Electronic Prescribing and Medicines Administration across Velindre cancer Service.	Implementation has progressed. General medicines is moving through user acceptance testing with go-live targeted for November 2026. Medicines and treatment-process incidents in Q2 reinforce the need to strengthen prescribing, administration and verification safeguards and demonstrate the effectiveness of the new controls.	Chief Digital Officer	Nov 2026

	02.05	Support implementation of the Infected Blood Inquiry recommendations and the National Blood Health Plan to strengthen prudent use of blood, demand management and blood supply sustainability across Wales.	Work continues at UK and Welsh level to support implementation of the Infected Blood Inquiry recommendations, with digital connectivity and transfusion laboratory workforce identified as key priorities. WBS is working with HEIW to map transfusion laboratory workforce requirements and progressing an Outline Business Case to define the digital requirements needed to strengthen connectivity, reporting and understanding of patient outcomes. Delivery remains dependent on appropriate resource and system support across NHS Wales.	Chief Operating Officer	Nov 2026
	02.06	Implement the revised Putting things Right regulations: Listening to People.	Listening to People has been implemented across the Trust. Q2 compliance with complaint response timescales was 82.5%, so implementation now needs to focus on timeliness, quality of response, learning and sustained compliance, alongside any further national guidance.	Director of Nursing, AHP and Health Science	Nov 2026

			Propose close as implemented		
	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	Patient and donor satisfaction remains high, 96% for VCS and 99% for WBS in Q2. Feedback coverage and systematic use remain areas for improvement. WBS reported a 3.6% response rate in Q2 following introduction of the national People Experience Survey. A Trust review of experience, co-production and engagement is being used to reassess arrangements against the national framework and strengthen floor-to-Board patient and donor voice.	Executive Director of Nursing, AHP and Health Science Director of Corporate Governance	April 2027
	02.08	Strengthen the quality and safety assurance and oversight mechanisms for hosted services.	Strengthening of hosted-services quality and safety oversight is underway, with further work required through the governance review to clarify accountability, reporting, escalation and assurance for services hosted by the Trust.	Chief Operating Officer, Executive medical director and Executive Director of Nursing, AHP and Health Science	Nov 2026
	02.09	Embed and enhanced learning framework across the Trust, including learning from external organisations.	The Trust learning framework is in place and was reviewed in September 2026. Q2 incident, complaints,	Chief Operating Officer and Executive Director of Nursing, AHP and Health Science	April 2027

			claims and redress intelligence demonstrates examples of learning and improvement, but repeated themes remain around communication, treatment processes, escalation and pathway ownership. The priority is now to demonstrate that learning is consistently implemented, shared and sustained, with clear service-to-Executive accountability.		
	02.10	Align Trust quality and safety arrangements with the National Patient Safety Plan 2026–31 and National Clinical Governance Framework (draft), embedding patient safety through the QMS and strengthening proactive risk management, learning and Board assurance.	Existing QMS, incident management, learning, risk and assurance arrangements provide a strong foundation and are being mapped against the new national requirements. Initial assessment indicates good alignment, with further work required around proactive safety, integrated safety intelligence, organisational learning and clearer service-to-Board assurance.	Director of Nursing, AHP and Health Science	October 2026
	02.11	Implement a Quality Dashboard and balanced score card	A Trust-wide Quality Dashboard and service balanced scorecards are not yet in place. Digital resource has initially focused on the	Chief Digital Officer	April 2027

			PMF/integrated performance framework. Trust risk 3902 specifically identifies the quality and assurance implications of the absence of a Trust-wide Quality Management Dashboard. A defined implementation plan, ownership and delivery timescale remain required.		
	02.13	Implement capacity and demand planning for transformation delivery at WBS	Review of the WBS Change Management Process is progressing through an iterative approach, avoiding wholesale redesign where existing arrangements remain effective. A revised Change Proposal Form has been developed, the closure process simplified, and further work is progressing on implementation planning, capacity/resource assessment and supporting system changes.	Chief Operating Officer / WBS Director	December 2026
	02.14	Strengthen governance and assurance of WBS transformation delivery	Governance arrangements continue to mature through WBS Futures. Current work includes strengthening Executive Lead responsibilities, refining	Chief Operating Officer / WBS Director	December 2026

			Delivery Board governance and improving benefits reporting and monitoring to provide clearer assurance that programmes are delivering their intended outcomes.		
	02.15	Develop and implement an Advanced Clinical Practitioner (ACP/ANP) service model to provide resident senior clinical decision-making, deteriorating patient response and escalation support across acute oncology and enhanced care services.	Workforce model developed and agreed in principle. Clinical requirement recognised as a key enabler for safe delivery of the acute oncology and enhanced care model within the New Velindre Cancer Centre. Implementation planning underway.	Executive Director of Nursing, AHP, HCS / Exec medical Director	March 2027
	02.15	Complete workforce, activity and financial modelling to determine the sustainable establishment required to support overnight ACP provision within current and future service demand.	A resident senior clinical decision-making model remains a key patient-safety and service-resilience requirement. Workforce, activity and financial modelling and the ACP/ANP service model should be progressed together, with clear interim mitigations, future nVCC requirements, decision points and assurance on the timeliness of deterioration recognition and escalation. Activity, acuity and pathway requirements being reviewed to inform	Divisional Director / Workforce director	December 2026

			establishment and business case development. Business case discussed at a number of forums, decision expected Oct 2026. OCP required once officially agreed.		
	Close Actions since the last meeting				
	02.12	Strengthen WBS portfolio prioritisation and sequencing	WBS Futures governance continues to strengthen portfolio-level prioritisation, sequencing and oversight of interdependencies. Further work is progressing to strengthen the role of Executive Leads, align portfolio decisions with organisational capacity and clarify benefits oversight and accountability.	Chief Operating Officer / WBS Director	September 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Capacity & demand management: routinely assessed as part of IMTP. Quality & safety oversight: routine monitoring through performance/quality frameworks (e.g., PMF and AMaT tracker). Patient/donor experience feedback: mechanisms to	• PROMs, mortality and other outcome measures are not yet fully embedded within routine Trust performance reporting. • Trust-wide Quality Management Dashboard and service balanced scorecards are not yet implemented.	• Q2 Integrated Quality and Safety Report provides reasonable assurance, with VCS patient satisfaction at 96% and WBS donor satisfaction at 99%. • VCS incidents reduced in Q2 and incidents open for more than 30 days reduced to 87 by	• Board assurance remains incomplete because PROMs, mortality/outcomes reporting and a comprehensive Quality Management Dashboard are not yet fully established. • Further evidence is required that improvements from incidents, concerns, claims and redress are sustained and have reduced recurrence. • Q2 complaint response compliance was 82.5%; 16 redress cases remained open beyond 12 months, requiring continued oversight of timeliness. • WBS manual transcription/laboratory errors and distribution errors require continued trend monitoring and evidence that

capture experience and feed learning into improvement. Clinical outcomes review: structured mortality review and the Medical Examiner Service to identify issues and learning. Workforce capability & learning: Velindre Oncology Academy to support training and development. Clinical audit**:** audit systems and processes to check compliance and drive improvement.	• Patient and donor voice is not yet systematically embedded from service to Board decision-making. • Learning is not yet consistently evidenced as implemented and sustained; recurring themes remain in communication, treatment processes, escalation and pathway ownership. • Timeliness of complaint, incident and redress processes remains variable. • Legacy digital/laboratory systems and dependencies on national digital delivery continue to create vulnerability. • Hosted-services quality governance and assurance arrangements require further strengthening. • Overnight senior clinical decision-making and future workforce resilience require further development for current demand and nVCC. • Capacity and specialist workforce constraints may affect the pace and safe delivery of concurrent	September 2026; WBS late incident reports remain substantially improved compared with earlier periods. • No Q2 incidents triggered national reporting; two VCS incidents triggered Duty of Candour. • Pressure-ulcer performance improved, with one avoidable case in Q2; a Tissue Viability Nurse commenced in October 2026. • External scrutiny includes HIW, Welsh Risk Pool and relevant regulatory/accreditation bodies. Welsh Risk Pool Q2 concerns assessment reported an improved position and commended the quality of Part 5 investigation reports. • Mortality review, clinical audit, patient/donor experience, incident, complaints, claims/redress and regulatory intelligence are reviewed through established governance routes. • WBS regulatory reporting and QMS arrangements provide additional assurance	preventive actions are effective; legacy LIMS replacement remains an important dependency. • Limited assurance remains regarding systematic use of patient and donor voice, particularly where feedback response rates are low. • Further assurance is needed on hosted-services governance and on delivery dependencies outside direct Trust control. • Limited assurance remains on the resilience of overnight senior clinical decision-making and its fitness for future nVCC operating requirements. • Integrated evidence across quality, workforce, operational resilience and transformation risks is not yet sufficiently mature to support reduction of the BAF score.

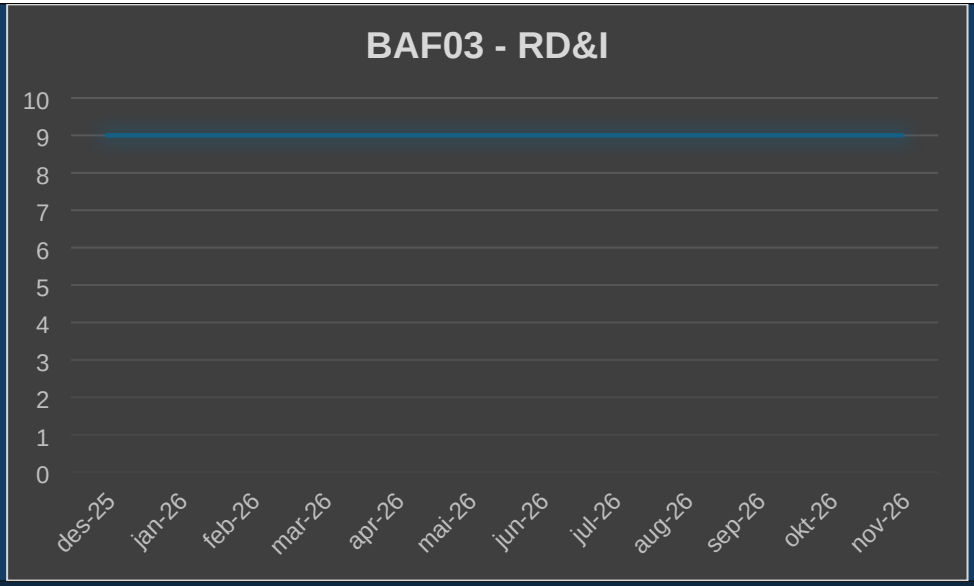
	transformation programmes.	over blood and laboratory services. • Programme governance provides visibility of transformation risks, dependencies and delivery status.	

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

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

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

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	3	12	3	3	9	-	-	-	-	-	-	3	3	9	3	2	6



Associated Risks	Risk ID	Risk Title	Current Risk Score
	Nil return		

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	03.01	Develop and implement a structured benchmarking programme with UK peer cancer centres to review optimal Research Service infrastructure, workforce, and delivery models. Align benchmarking outputs with OECI Designation criteria and partnership theme.	A benchmarking visit to The Clatterbridge Cancer Centre NHS Foundation Trust was completed on 26 November 2025. This provided valuable, first-hand insight into a mature, disease-site-based approach to research study set-up, delivery, ongoing management, and governance oversight, including the alignment of workforce models, training, and operational accountability. Following the visit, a structured set of clarification and follow-up questions has been submitted to Clatterbridge colleagues to enable deeper understanding of specific operational, workforce, and financial arrangements and to support meaningful comparison with Velindre's current and future-state models. Key learning themes from the benchmarking activity are now being synthesised into a structured paper, with accompanying recommendations to inform a phased programme of improvement and enhancement for the Velindre Research Service. This includes	• Associate Medical Director for RD&I • Cancer R&D Strategy Lead • Head of R&D • Research Delivery Manager	Dec 2026

			explicit consideration of how benchmarking outputs align with OECI Designation requirements, particularly in relation to integrated research delivery, workforce capability, governance maturity, and partnership working. Ongoing peer-to-peer dialogue between the two organisations will continue to support this work.		
	03.02	Commission a programme of internal and independent audits of Research Service processes, including study set-up, delivery, and governance. Scope to cover compliance with UK Clinical Trials Regulation and ICH GCP E6(R3), coming into force in April 2026, linked to workforce development/training theme.	Work is underway to establish a structured programme of internal and independent assurance across Research Service processes, including study set-up, delivery, and governance, aligned to the forthcoming implementation of the UK Medicines for Human Use (Clinical Trials) Regulations 2024 and ICH GCP E6(R3) in April 2026. As a foundational step, a comprehensive refresh of the Research Service Standard Operating Procedure (SOP) suite is in progress. This is being delivered through a phased and risk-based approach, including finalisation of the overarching SOP framework, prioritisation of procedures linked to high-risk and high-impact activities, and allocation of authorship across the Research Service and relevant supporting functions. This work is deliberately sequenced to provide a clear, controlled baseline against which internal audits can be commissioned, ensuring that audit scope, criteria, and findings are directly aligned to current regulatory requirements and inspection expectations. The SOP refresh is being coordinated with wider implementation activity, including inspection readiness planning, workforce training, and the introduction of new digital systems, to ensure consistency between documented processes, operational practice, and assurance mechanisms. This alignment will enable future internal audits to test not only procedural compliance, but also real-world application and governance effectiveness across the study lifecycle. 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	• Head of R&D • Research Delivery Manager	Mar 2027

			UK Clinical Trials Regulations 2024 and ICH GCP E6(R3), alongside consolidation of existing internal provision and identification of priority external training routes, including Health and Care Research Wales and specialist non-commercial and commercial providers.		
	03.03	Develop and implement a sustainable funding model for RD&I, reducing dependency on charitable and short-term funding streams. Link to financial sustainability theme and VPAG/charitable investment planning.	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP Project Board where relevant). External oversight and review including Health and Care Research Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits and Welsh Government oversight.	To be advised	Apr 2027

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Research strategies defining Trust ambitions for research & innovation in line with national priorities (Trust Cancer Research Ambition, WBS Strategy, WG Innovation Framework) Delivery plans for research governance/delivery are monitored to assure progress on delivery Benchmarking research activity (via OECI accreditation membership and UK peer cancer centre comparisons) Engagement with UK / National bodies Cardiff Cancer Research Partnership (CCRP)	Opportunities remain to further external benchmarking and system comparison with peer organisations to support continuous improvement. Additional internal review and audit would provide confidence in the effectiveness and consistency of processes. Ongoing work continues to complete alignment of procedures and training materials with evolving regulatory requirements. Continued work is underway to maximise sustainability / resilience of RD&I funding in a changing external funding environment.	RD&I performance reporting and internal oversight via the RD&I Integrated Performance Report, self-assurance, and RD&I core/operational management groups. Oversight through Trust governance routes—Executive Management Board, RD&I Sub-Committee, Quality, Safety & Performance Committee (and Charitable Funds Committee / CCRP Project Board where relevant).	Opportunities exist to strengthen assurance through the ongoing programme of benchmarking, internal review and audit activity. Assurance relating to the implementation of regulatory changes will continue to mature as procedure updating, training, and compliance is embedded and monitored. Assurance related to the RD&I operational model sustainability will be developed through implementation of emerging funding and workforce plans.

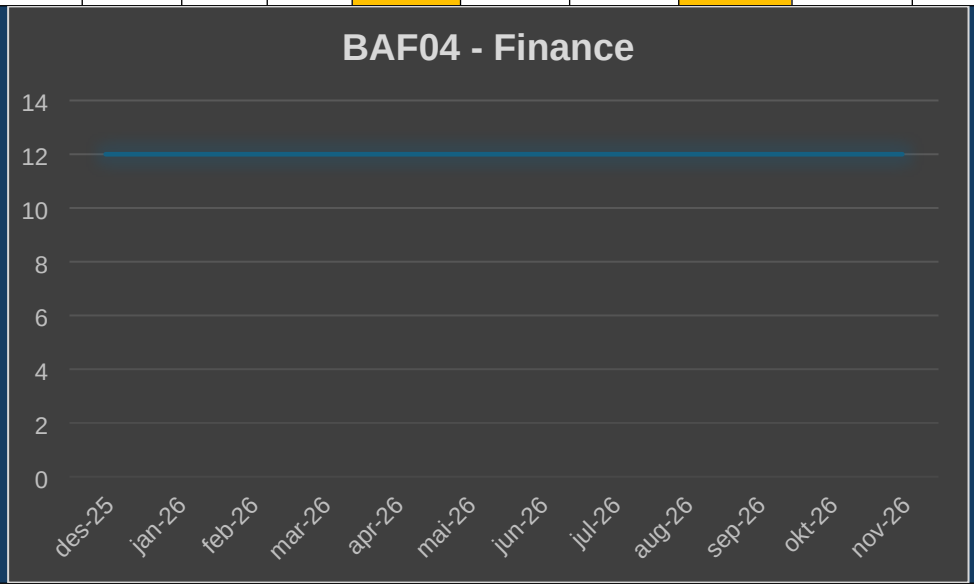
Welsh Blood Service research governance		External oversight and review including Health and Care Research Wales reporting/meetings/returns, Welsh Government joint executive meetings, OECI peer review/accreditation, MHRA inspection findings, annual research performance review, and (for WBS) MHRA/HTA audits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

Risk 04	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	Date of Risk	Current Risk Score
		1 April 2026	12
		Last Review Date	
		October 2026	

Executive Summary	There are a range of factors that impact on the finance sustainability and long term value risk. We prevent, mitigate or detect impact on this risk through a number of key financial controls. Where these controls are partially effective or not effective actions are being taken to improve the effectiveness of the control and where this achieves the anticipated improvement in control the assurance from that control is increased. Risk score trend: The risk score has remained static since the last period, and has been considered in line with the development of the IMTP.

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

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	Nil		

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	09.02	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	IMTP savings created using SMART actions to strengthen identification, monitor progress and delivery. Finance workshop with Executive team took place in 2025/26 to present the current financial position and discuss disinvestment options and financial recovery. A Finance and Planning Committee to be established during 2026/27 which will focus on the financial position and performance.	EDoF / EDoSTP&D / DDoF / DDoP	Ongoing
	09.04	Development of Investment Appraisal process and prioritisation framework	The investment appraisal will be developed in conjunction with shaping the soon to be created Planning & Finance Committee which have overall control and oversight over Trust investment decisions. Aim to present at next Planning and Finance Committee on the 12th November	EDoF / EDoSTP&D / DDoF / DDoP	Extension to 12th November per Finance & Planning Committee meeting (from October 2026)
	09.05	Identification of business development and external funding opportunities	Cardiff Cancer Research Hub financial plan review has identified that in 2025-26 costs are covered by funding but there is a risk of shortfall in 2026-27 between anticipated trial & other income and forecast costs. Further work taking place with Cardiff & Vale to model additional trial activity and impact on cost and income. A tri-party risk share proposal for the Programme Hub element of the service has been	EDof / EDirector of Planning / COO / VCS Director	March 27

			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 to support the Trust in completion of remaining financial / commercial actions in improvement plan 1) negotiate new contracts with insurance companies & revisions to tariffs 2) additional activity charging separately for pathology 3) negotiation around payment of old debts. Work to also include EDoF / EDoSTP&D / COO negotiation with the Trust CAG sharing of the financial risk around PP credit loss (bad debts) and agreeing consistent charges for PP support to consultant private practice. CAG has endorsed a revised policy which addresses the sharing of bad debts and wider consistency of consultant private practice. Work is concluding with Liaison Financial external consultants whereby the extensive review of tariffs for all private patient activity has been undertaken and validated by VUNHST and Liaison Financial. Contract negotiations with insurance providers has concluded with a consistent tariff applied for all services from Sept 2026 and involves pathology charging as well as payment of old debts.		
	09.06	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correctly. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for.	Review of contract currency is currently underway in VCS to understand the true cost of service. However, given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2027-28 (see next item).	EDof / EDirector of Planning / COO / VCS Director	March 27

			VCS is currently reported a LTA activity over performance for 2026-27 which was used to mitigate the financial risks and provided investment into services.		
	09.07	LTA contract with Commissioners and re-basing exercise	To ensure Commissioners fund the total cost of Velindre running cancer services from 2026-27 there needs to be agreement from all Commissioners to change the commissioning principles for Velindre from 'historic shares' based on activity and NICE consumption in 2004-05 to a 'current activity' baseline and NICE consumption Hywel Dda UHB unilaterally forced the Trust to move to an LTA based on actual activity in 2025/26. This resulted in a £0.825m loss in income recurrently from Hywel Dda UHB on NICE & HCD. A Deputy Director of finance task and finish group for Commissioning has been established with the first meeting having taken place on the 27.02.2026 to review contract re-basing exercises and agree a standardised approach. As at Sept 2-26 the Group continues to meet and discuss an approach. Given the status of agreeing the contract base a change in contract currency is not expected to be initiated until at least 2027-28. Re-basing exercise nonetheless will continue with completion date targeted for Qtr 4 which will then be presented to Commissioners.		June 27

	09.08	Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.	Ongoing work with initial review captured as part of the 2026 IMTP process, with a particular focus on reviewing non-pay expenditure during qtr 1 following year end. This has been shifted to qtr 2 due to capacity gaps in the team. Work progressing – Aim for completion by end of October	DDof/ Head of VBHC / Divisional Directors	October 2026 (revised from July 26)
	29.06.2026	Procurement contract register	The need to create a robust contract management process, with a live maintained contract register held locally and aligned to all Wales registers. In progress, (extension request to 10th December which aligns with the AMAT audit actions extension request) Procurement are currently updating the list following the transition between the teams for WBS and also need to add in the national contracts that Velindre area part of including DHCW (Risp/EPMA etc). Once complete will be shared on a team's channel visible to all who require access. The Trust will need to assign contract managers for every contract over £100k to align with audit recommendations and new AW policy.	Deputy Director of Finance / Head of Contracts	December 2026 (Revised from October 2026 in line with request from Head of Contracts against the AMAT audit actions)

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

FSLTV2 – Quarterly Finance Reviews (Detective) FSLTV3 – Divisional Performance Review (Detective) FSLTV4 – Executive and Trust Board Reporting (Detective) FSLTV5 – Statutory and Mandatory Financial Reporting (incl. Annual Accounts) (Detective) FSLTV6 – Monthly Finance and Performance Meetings (Mitigating) FSLTV7 – Collective Commissioners Review (Preventative) FSLTV8 – Investment Appraisal (Preventative)	Directorate Level Budget holders, reports and training, Touch point meetings Directorate Level Budget holders, reports and training, Touch point meetings Executive budget holders / Programme SROs Executive budget holders / Programme SROs Executive budget holders / Programme SROs Directorate Level Budget holders, reports and training, Collective Commissioners Group, LTA Reporting Executive budget holders / Programme SROs, Capital Planning Group	introduced (partly mitigating issues), a residual weakness remains, particularly relating to Radiotherapy IRS implementation, which is being addressed with Service and Business Intelligence.	

FSLTV9 – Financial Strategy / Medium Term Financial Plan / Budget Setting (Preventative)	Executive budget holders / Programme SROs		
FSLTV10 – Scheme of Delegation and Delegated Financial Authority (Preventative)	Oracle financial system controls, budget holders, Delegated Financial Limits		
FSLTV11 – Value Based Healthcare programme (Detective)	Value Based Healthcare project leads; VBH programme SROs, VBHC Steering Group		
FSLTV12 – Procure to Pay monitoring (Detective)	Requisitioners / budget holders, PSPP Group.		
FSLTV13 – Debtors / Cash monitoring (Detective)	(P2P), Private Patients lead (debtors), etc. Debtors Reporting		
FSLTV14 – Discretionary Capital Financial Planning and Reporting (Mitigating)	Budget Holders / Capital leads, Capital Planning and Delivery Group, Fixed Asset Register		

FSLTV15 – Major Capital Programmes monitoring (Detective) FSLTV16 – Counter Fraud (Preventative) FSLTV17 – Tax management (Detective) FSLTV18 – Procurement (Preventative) FDLTV18 – Procurement - Contract Management	Programme SROs, Scheme of delegation, governance framework CP&D Group Budget Holders, training Counter Fraud Reports Budget Holders, requisitioners, buyers, FA team, VAT Working Group, EY, HMRC Budget Holders, reporting, training, Procurement compliance reporting *Additional assurance is provided by* Divisional Finance Reports, Trust Board finance reporting (incl. MMRs, Welsh costing returns) Committees and groups: QSP Committee, Audit Committee, PSPP Group, Capital Planning & Delivery Group, Executive Management Board, Strategic Development Committee, VBHC		

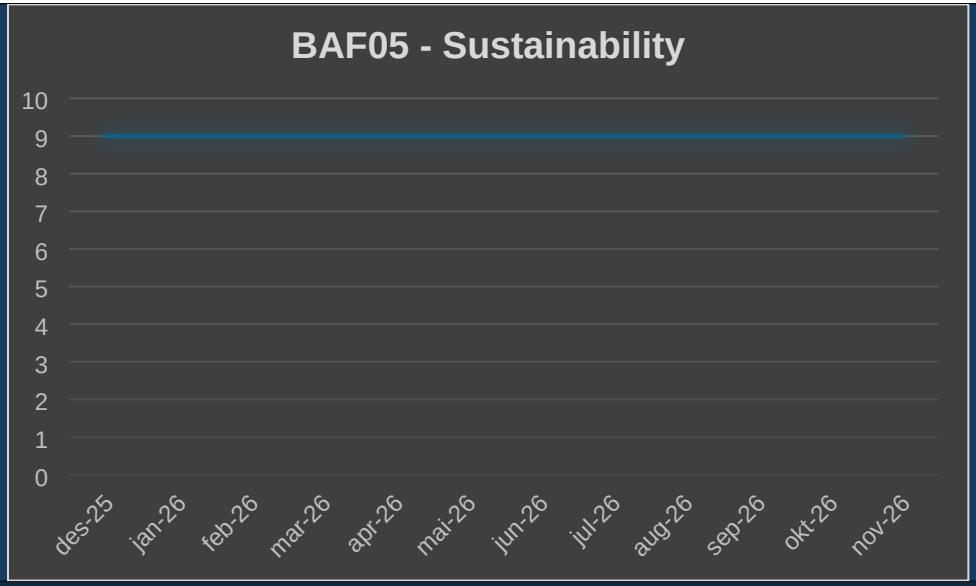
	steering committee, VAT working group, etc. Internal Audit External Audit External oversight/advisory bodies incl NHS Exec (P&I) / WG / LHB Commissioners / HMRC		

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

Executive Summary	The Trust has strong operational environmental controls and assurance through governance groups, ISO 14001, and audits. Key gaps in capital decision-making, clinical pathways, and job descriptions are being addressed through targeted actions to achieve full integration and reduce strategic risk

Associated Strategic Objectives	Sustainability • Deliver the Trust strategic goal on sustainability: *"A sustainable organisation that plays its part in creating a better future for people across the globe."* • Embed sustainability into corporate governance and decision-making, specifically: o integrate sustainability into all governance routes and o ensure capital decisions/business cases consistently include environmental/sustainability considerations • Embed sustainability into clinical care delivery, by integrating sustainability into clinical pathways/models of care • Embed sustainability into organisational culture and responsibilities, by including sustainability .	Exec Lead	Director of Place, Portfolio and Partnerships
		Assurance Level	4
		Risk Appetite	Open

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	3	9	3	3	9	3	3	9	3	3	9	2	2	4



Associated Risks	Risk ID	Risk Title	Current Risk Score
	Nil		

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

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Governance & organisational approach: “Creating Wider Value” approach, performance reporting/highlight reports, alignment to Well-being Objectives in governance/board papers, oversight via Climate Action Board.	Sustainability is not yet fully integrated into all governance routes and capital decision-making (i.e., not consistently embedded in how decisions are made). Sustainability is not yet embedded in clinical pathways (the new	Performance reporting / highlight reports Site Sustainability Implementation Plans (SIPs), including site-level energy and waste monitoring Trust Travel Plan (2022–2027), Cycle to Work scheme, annual travel survey	Capital projects may be approved without consistent consideration of environmental impacts. Embedding sustainability in clinical pathways is under development and not yet integrated into standard practice (Clinical MDT not yet fully operational).

Clinical sustainability: Sustainable Care Models supported by review through the Clinical Sustainability MDT, environmental policy/divisional environmental statements, and ISO 14001 internal audits. Carbon & energy: “Carbon Zero” delivered through site Sustainability Implementation Plans (SIPs), site-level energy monitoring, and building management/energy optimisation, with supporting governance groups. Sustainable estates/capital projects: “Sustainable Infrastructure” built into capital programmes (e.g., nVCC/TGI), project risk registers, design review processes and specialist sustainability input; aiming for BREEAM standards. Waste & resources: Waste management policy, segregation/recycling at source, single-use plastic phase-out, waste monitoring, and contractor compliance audits. Renewables transition: Controls supporting move to renewable/low-carbon energy, embedded in capital projects and SIPs. Nature & biodiversity: Green social prescribing partnerships and biodiversity enhancement plans (within SIPs), supported by engagement activity and external biodiversity audits. Travel & transport: Trust Travel Plan (2022–2027), cycle-to-work scheme, annual travel survey, and related	Clinical Sustainability MDT is under development and not yet part of standard practice). Sustainability is not included in all job descriptions/recruitment materials (so it isn’t consistently built into roles/responsibilities, including Well-being of Future Generations duties).	Waste Management Policy, segregation/recycling at source, single-use plastic phase-out Climate risk assessments and site emergency preparedness plans Sustainability induction/training, staff engagement programmes and awards Environment Policy, divisional Environmental Statements, Environmental Manual Capital project delivery controls (e.g., nVCC/TGI activity, project risk registers) Climate Action Board (regular oversight) ISO 14001:2015 Management Group FRESH Group (Fire, Risk, Estates, Sustainability & Health and Safety) Committees/oversight fora: Quality, Safety & Performance Committee, Strategic Development Committee, EMB/SLT Capital governance and specialist challenge: Capital Project Board / nVCC Project Board, Reviewable Design Data process, specialist engineering/sustainability consultants Clinical governance route: Clinical Sustainability MDT (review function ISO 14001:2015 External Audit (including surveillance audit passed October 2025) NWSSP Internal Audit Audit Wales Other independent checks noted: waste contractor compliance audits, external biodiversity audits	Sustainability is not currently part of standard recruitment materials or role profiles, with an opportunity to align to Well-being of Future Generations requirements.

monitoring through ISO 14001 structures. Climate adaptation & resilience: Climate risk assessments, emergency preparedness plans, and inclusion of adaptation measures in major projects, reviewed through governance routes. People & culture: Sustainability induction/training, staff engagement programmes and sustainability staff awards (“people as agents for change”).			

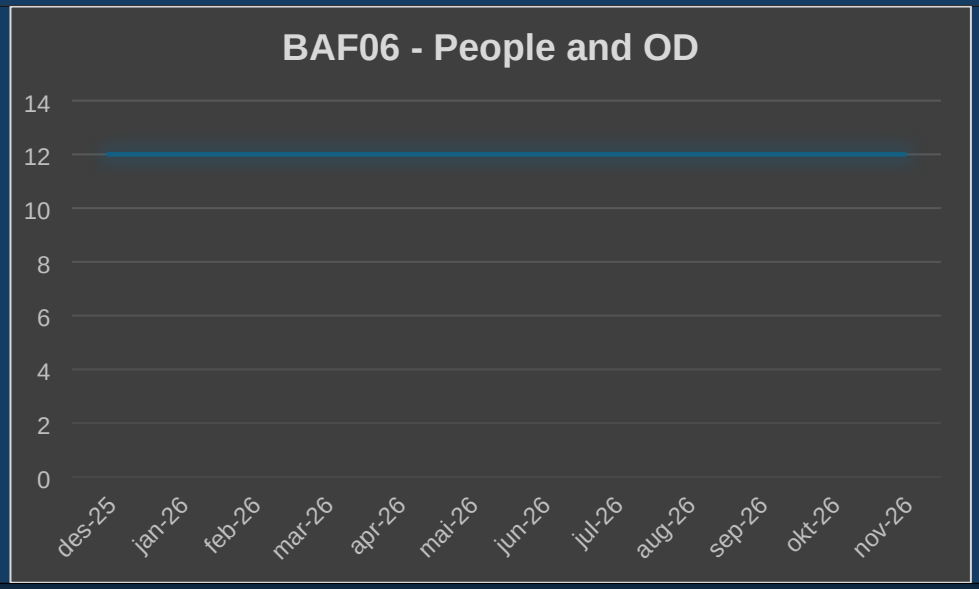
Risk 06	There is a strategic risk that our people will not feel a sense of belonging, not feel valued in their roles, not understand how they contribute to organisational success, and will be unable to speak up in confidence, resulting in a negative impact on staff experience if we do not foster a cohesive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

Executive Summary	This strategic risk brings together the cultural factors that enable the Trust to deliver its core purpose (including values and behaviours, systems and processes) and the external and internal factors that affect the supply, shape and capacity of the workforce at organisational and multi-disciplinary team level. A People Strategy is in place with work programmes focused on enabling us to become an employer of choice, with the Healthy and Engaged and People Development and Education steering groups, as set out below. Work programmes are underway to address feedback and mitigate the risk through development, support, wellbeing and other interventions, including effective strategic and operational workforce planning focused on recruitment, retention and people development. In addition, the Trust is seeking to maximise workforce capacity through a reduction in absence levels, supported by wellbeing interventions and the application of workforce policies in a way that minimises harm to staff and teams. In April 2026 EMB reviewed the Trust Staff Survey result alongside the feedback from Line of Sight and agreed to adjust the Cultural Milestone Plan, agreed on 26th March 2026, to focus on the following areas: • Executive recruitment • Leadership • Psychological safety • Supporting VCS to move to the new hospital There is a risk of a negative impact to staff wellbeing due to the psychological and physical impact of the sustained pressure of work, continued transformation of services and the challenge in reconciling continued high levels of clinical and non-clinical demand with available resources. This could lead to high levels of sickness absence, reduced organisational and individual effectiveness, higher staff turnover and staff burnout. This is exacerbated at times of industrial action which remains a risk in 2025/26. 1. Staff wellbeing & organisation performance 2. Leadership & Management 3. Culture, Values & behaviours

Associated		**Exec Lead**	Director of People and OD

Strategic Objectives		Assurance Level	Level 5
	Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations. **Planned and Sustained People:** having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence-based care and support patient and donor wellbeing. **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.	Risk Appetite	Open

Scoring	Inherent Risk			March 2026			May 2026			July 2026			September 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	4	12	3	4	12	3	4	12	3	4	12	3	3	9



Associated Risks	Risk ID	Risk Title	Current Risk Score
	3001 C	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	12

Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	6.1	Culture, Values & behaviour Implement the actions of the Trust Strategic Equality Plan, including embedding the Anti-Racist Wales Action Plan in the Trust	The Trust received the WES report and Welsh Government feedback on the SEP maturity matrix giving scores of 1 for Workforce and Access and Experience and 2 for Overall. The feedback from both reports will be taken forward in the SEP actions for the remainder of 2026-27.	OD Specialist	March 2027
	6.2	Staff wellbeing & organisation performance Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	The Staff Wellbeing service met increased demand in Q4 and provided support and sessions across all levels of the stepped care model. The business case for the Staff Psychology and Wellbeing Service has now been approved and funded until March 2028.	OD Specialist	December 2026
	6.3	Culture, Values & behaviours Embed positive values and behaviours across the Trust to create positive culture. Cultural Baseline Review	This work is being progressed through the existing priorities of 1. Our Governance and Leadership work with Line of Sight 2. Executive team recruitment 3. Supporting Velindre Cancer Service to move 4. Staff Survey engagement and action planning (include learning from other sources, for example WRES/WES) 5. Wider leadership development. A programme of work for supporting nVCC and for embedding positive behaviours has been outlined with an external provider. The resources to enable this work to take place are in place.	Executive Director of Workforce and OD	December 26

Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Strategy and organisational alignment: Trust strategies and enabling strategies (including the People Strategy) to set direction and align priorities. Leadership, behaviours and culture: values/behaviours framework and leadership development grounded in compassionate leadership.	Control development required: further work is required to fully develop Communication and employee voice: communication infrastructure needs to be in place to support leadership messages and staff engagement, including employee voice	People Development & Education Steering Group Culture, Wellbeing and Equality Steering Group. Workforce Planning Oversight Group Routine monitoring through Senior Leadership Teams (SLTs) using workforce dashboards	

Workforce planning capability and governance: workforce planning methodology, training, dedicated infrastructure, and embedded reporting/oversight arrangements. Recruitment, attraction and employer brand: consistent recruitment and selection processes and employer brand activity supported by recruitment metrics. Education and skills pipelines: education implementation planning and pathways to support new skills, new roles and development. Wellbeing and harm reduction: health and wellbeing infrastructure and embedding avoidable employee harm principles. Performance management and assurance: performance management frameworks and routine monitoring through governance forums. Service models and role clarity: clear service models and operational workforce plans aligned to service delivery. Inclusion and language standards: monitoring and improvement plans for Welsh Language Standards. Health and wellbeing service funded to support staff wellbeing	Behavioural Framework is basic and not sufficient to drive cohesive culture.	Recruitment metrics reporting (incl. NWSSP recruitment metrics) and divisional/strategic monitoring groups. Reporting to EMB, People, Culture and Engagement Committee and the Trust Board. Following Trust wide governance review. Internal Audit reports Internal and External Audit Welsh Government reporting via JET and IMTP	
Strategy progress reports monitored through EMB	Strategy progress reports assured through People Committee		
Plan developed through Staff Health & Wellbeing Group	Plan approved through EMB	Plan assured through People Committee	
Adherence to policy monitored through monthly performance meetings	Adherence to policy assured through Management Group	Adherence to policy assured through People COmmittee	

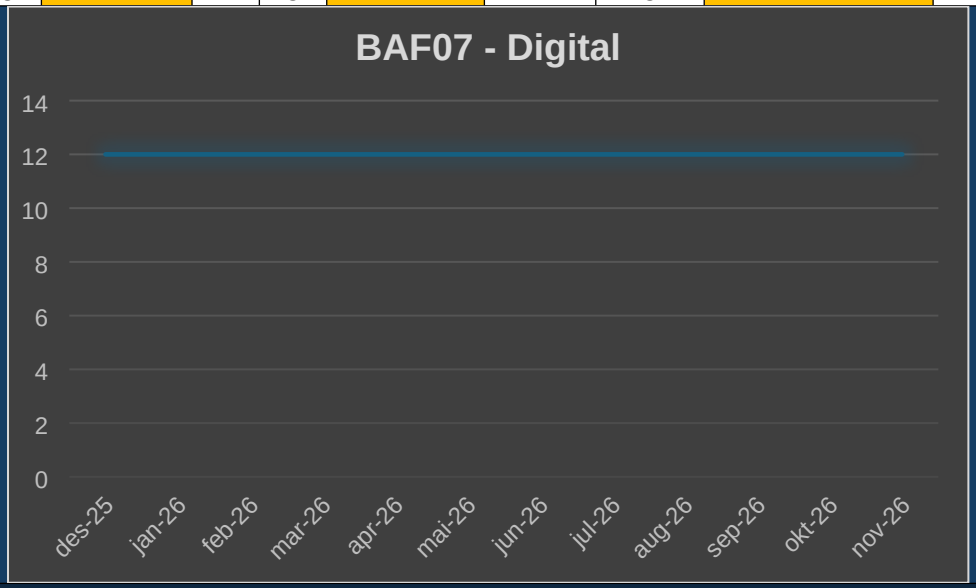
Trend data included in Integrated Performance Report for review by EMB	Trend data included in Integrated Performance Report assured through People Committee	Integrated Performance Report assured through Board	

Risk 07	There is a strategic risk that insufficient investment, capacity and capability to maintain, replace and effectively utilise digital systems and infrastructure will result in system failures, cyber security vulnerabilities and limited digital transformation, leading to disruption to clinical services, reduced quality and efficiency of care constrained decision-making, systems the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security.	**Date Risk Raised** 1 April 2026 **Last Review Date** October 2026	**Current Risk Score** 12

Executive Summary	Work is ongoing on the key controls - no movement to overall current risk scoring due to overall digital risk position and that system wide Cyber threat level remains high for Healthcare. The aggregate risk for National Programmes for RISP/EPMA/LIMS has been reduced as RISP is now live (April 26) and has now reached stable operations, EPMA is now scheduled for Feb '27 go-live. There continues to be high-risk with the go-live date for WLIMS Tranche 5 (Blood Transfusion) nationally, although the Trust continues to be well placed with its internal preparations for LIMS and is providing additional support to the National Programme. The Tranche 5 date has now been moved to Feb '27 (was Nov '26) with data migration agreement the key remaining component. Work on agreeing overall digital plans has made progress, with the Digital plan for nVCC Readiness now approved by the Executive. Additional capacity is required for this and additional funding has been made available, good progress has been made with the recruitment. Digital plan is now being managed as part of the overall nVCC Readiness plan. The delivery of National Programmes through DHCW continues in escalation Level 4: Targeted Intervention (was previously 3) in April 26. The Level 4 escalation now also includes aspects of systems leadership. Welsh Government have engaged Tara Donnelly to write a new Digital and Data Strategy for NHS Wales for Nov 26, the Trust were included in the interviewees for the work. NHS Wales Digital Transformation will be the subject of a PAPAC inquiry following the Audit Wales digital transformation audit. The Trust has been invited to provide evidence to the inquiry in Nov '26. Key controls have been reviewed, gaps identified and action plan updated. Risk score trend: The risk score has remained static since the last period.

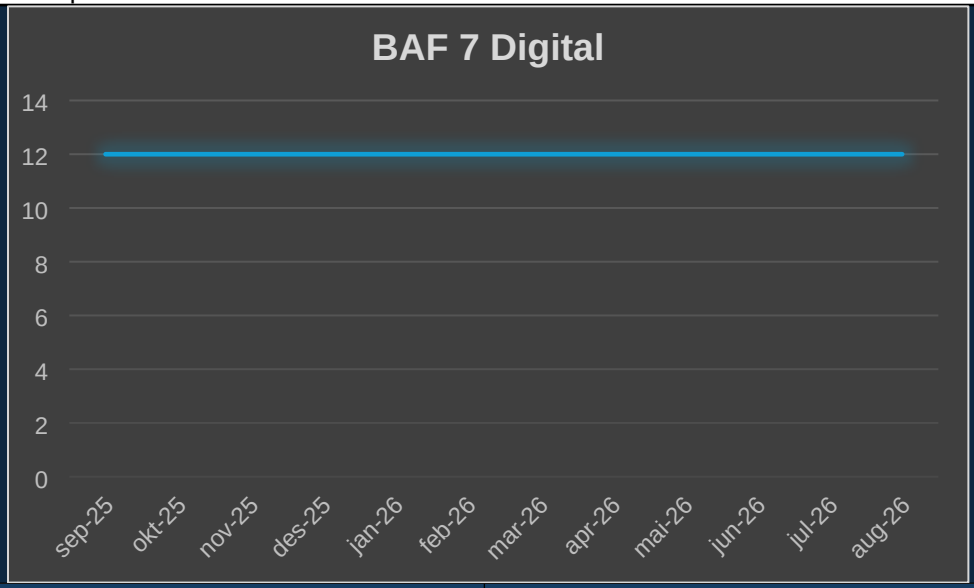
Associated Strategic Objectives	• Quality, safety and experience - the risk explicitly impacts patient/donor care quality and service disruption • Service delivery / clinical effectiveness - system failures and limited digital transformation affect continuity and efficiency of clinical services • Innovation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

Scoring	Inherent Risk			Mar 2026			May 2026			July 2026			Oct 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	4	3	12	4	3	12	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
		THIS SECTION WILL BE UPDATED FOLLOWING FINALISATION OF THE TRR	
	3646 W	WLIMS 2.0 go-live date delayed due to national programme timeline delays, impacting delivery of project outcomes and increasing demand on existing legacy systems.	20
	3633 C	Limited capacity within Digital Health and Care Wales to integrate VUNHST digital systems into the National Architecture on a timely basis, affecting IRS, WHAIS and FEDIS delivery.	12
	3837 W	Risks from LIMS2.0 TCLE going live with known defects, leading to patient harm.	
	4003 / 4004	Ongoing use of end-of-life FoxPro and DOS-based WBMDR systems, creating risks to reputation, performance and service sustainability through potential IT system failure and inability to provide one or more WBMDR services.	15 / 16
	3801 W	FEDIS phase 2 schedule slippage against timescales due to unexpected issues identified during the testing phase,	16
	4067 W	WLIMS delivery exceeding national programme time line leading to the reallocation of staff resource at short notice.	15
	3388	There is a risk to Quality and Performance as a result of reporting errors and limited accessibility of reports due to no interfaces between the Fetal D IT System (FEDIS) and NHS Wales Digital Applications, leading to suboptimal antenatal care.	16

	3643	There is a risk to patient safety as a result of an aged Laboratory Information System (SERIF) leading to RCI and Automated Testing being unable to operate a safe service.	16



Action to Address Gaps	Action ID	Action Detail	Progress Notes	Action Lead	Target Date
	07.01	Complete the Digital Reference Architecture impact assessment, confirming alignment between the NHS Wales National Target Architecture / Digital Blueprint and the Trust's local digital architecture, including implications for WLIMS, BECS, FEDIS, WHAIS, EPMA, IRS, cyber resilience and nVCC readiness.	National Target Architecture and the Digital Blueprint have progressed and are now sufficiently developed to enable local impact assessment. The Trust is well placed on several national programmes, with RISP live and stable, EPMA on track for November 2026, and internal WLIMS preparations largely complete; however, WLIMS Tranche 5 remains high risk nationally, with the proposed go-live now November 2026 and precursor activities running late. FEDIS and WHAIS continue to progress, with FEDIS planned for October go-live and monitoring to November 2026. This action should now focus on documenting local implications, dependencies and any residual gaps arising from the national architecture.	Chief Digital Officer	October 2026
	07.02	Establish and implement a Trust-wide prioritisation framework for Data, Insight and Digital service requests, ensuring clear escalation, decision-making and alignment with digital capacity, national programme dependencies, nVCC readiness and operational risk priorities.	Limited digital capacity remains a recurring theme across the Trust risk profile, with pressures linked to national programme delivery, digital integration dependencies, WBS Futures, nVCC readiness and cyber resilience. Current prioritisation continues to be managed locally within teams rather than	Director of Place, Portfolio and Partnership	30 September 2026

			through a consistent Trust-wide framework. The action remains overdue and should be reset with a defined implementation route, including Portfolio Team input, reporting arrangements and criteria for prioritising high-risk digital work.		
	07.03	Confirm the Trust's representation and escalation route within the revised NHS Wales digital governance arrangements, including Digital Blueprint implementation, Digital Advisory Group engagement, DDAT escalation arrangements and senior routes for national programme risks.	The previous action to participate in Digital Data and Technology Leadership arrangements is complete. However, the risk remains because national digital governance has changed and the DDAT Leadership Board has not met for over 6 months, with DHCW delivery in Level 4 targeted intervention and the Digital Blueprint / Digital Advisory Group becoming increasingly important. The Trust does not currently have a declared IM for Digital, which creates a gap in representation at key national groups, including the Digital IM Peer Group and national strategy development. This action has therefore been reframed to ensure representation, escalation and influence are formally confirmed. The position will be reviewed again in Nov '26	Chief Digital Officer	~~30 September 2026~~ 30 Nov 2026
	07.04	Complete the digital diagnostic and develop the investment case for future digital service capacity, explicitly addressing resilience, cyber security, national programme support, legacy system reduction, data and insight prioritisation, and nVCC readiness requirements.	The initial diagnostic has been completed and reported through Digital Programme Board and EMB. Work has been delayed while the digital workstream for nVCC readiness was established; this workstream is now approved by the Executive, integrated into the wider nVCC readiness plan and supported by additional funding, with recruitment progressing. The updated investment case should now incorporate the current TRR themes: cyber security actions, WLIMS / LIMS national programme risk, BECS transition and testing dependencies, FEDIS / WHAIS integration, and the continuing gap against the 4% digital investment benchmark.	Chief Digital Officer and Director of Finance	October 2026

Key Controls Established	Key Gaps in Controls	Assurance	Key Gaps in Assurance
Trust Digital Strategy (published Oct '23). This will need to be reviewed when the new WG Digital and Data Strategy is available (target Nov '26). Digital governance reporting into Trust committees and programme boards.	Limited ability to minimise the impact of national programme delays (LIMS and RISP) on the Trust. Digital investment is below the 4% benchmark and there is no current plan to reach the required level.	Digital governance and delivery forums (e.g., Digital Programme Board; WBS/Velindre Futures, nVCC Readiness Board), outcome/benefits tracking, staff/patient/donor feedback (incl. KLAS), mandatory training metrics, Digital IMTP and capital programme oversight, Digital Inclusion Plan	The Trust does not have a declared IM for Digital which means we are not represented at key groups – such as the Digital IM Peer Group – or National Digital Strategy Development.

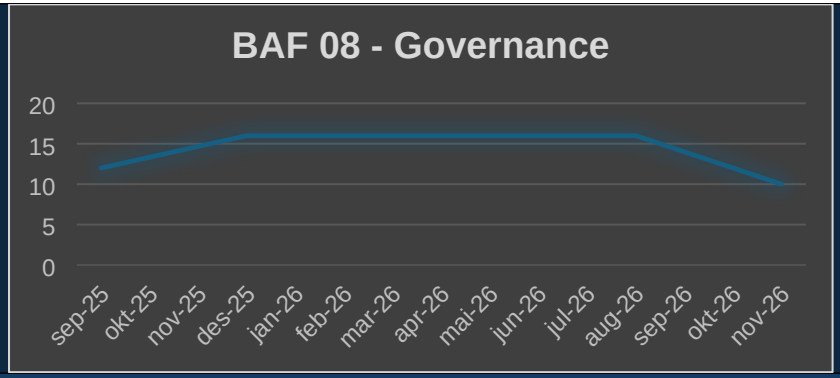
Active delivery/leveraging of key technologies (e.g., LIMS, IRS, BECS, EPMA). Training and education packages to build internal digital capability (Exec and Board included). A new Digital Capabilities Framework is available from HEIW. Training and education packages for donors and patients. Ring-fenced digital investment in Trust budget (benchmark 4%). Build digital resource capacity and capability. Digital inclusion in the wider community. Prioritisation and change framework for managing service requests. Reduce/monitor unsupported applications and legacy systems. Trust digital governance. Lead/lag indicator reporting integrated into the wider performance framework. Cyber assurance controls in place. Digital transformation guided by an agreed digital architecture (Design Authority being established). AI strategy, policies and guidance for implementation and maintenance. Trust Information Governance arrangements.	Impact assessment is needed for the national target architecture and blueprint and how it aligns with local Velindre architecture. As the National Target Architecture has now been agreed this work can commence. Architecture deep dives for the next 12 months have been agreed and the Trust are actively contributing.	activity/accreditation, and Divisional SMT/SLT reviews. Executive and committee reporting/oversight (EMB; SIRO reports; Strategic Development Committee; QSP/Quality, Safety & Performance; Audit/Performance Committee), cyber action plan reporting, and specialist governance bodies (e.g., IQSG; Caldicott Guardian/SIRO/DPO; Clinical & Scientific Strategy Board). Internal Audit (recurring across controls), plus external/independent oversight where applicable (e.g., Cyber Resilience Unit/WG IQPD as competent authority for NIS, Digital Communities Wales accreditation, External Audit of accounts, ICO/Welsh Government, national programme governance/DDaT leadership boards).	

Risk 08	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Date Risk Raised	Current Risk Score
		February 2025	10
		Last Review Date	
		November 2026	

Executive Summary	The Trust continues to work with Welsh Government and NWSSP to implement the recommendations of the review of NWSSP Accountability and Governance Arrangements. Risk 3656 "There is a risk to the quality of clinical and corporate governance due to the current assurance and reporting arrangements of hosted services" has been reduced to 12 on this basis. Change to the Trust's Model Standing Orders, reflecting the changes to the Board committee structure is due for approval in November. These changes will include the new Terms of Reference for the Charitable Funds Committee. Robust forward look programmes capturing *ad-hoc* agenda items remain in development. A new manual supporting wider organisational awareness of Board and committee ways of working has been developed and will be presented to EMB in November for consideration. Consideration of the new accountability framework for the Trust is ongoing and on schedule as part of the Board development and governance improvement plan to be completed by March 2027. The new Risk Policy was considered by EMB in October. ARAC will receive a draft at its December meeting, prior to Trust Board consideration alongside a new Risk Strategy and Risk Appetite Statement in January 2027. Risk score trend: The overall risk score has reduced to 10 since the last reporting period. The evidence for this is progress made by the NWSSP implementation group, the clear route for governing the Trust's refreshed Risk Management Framework over the coming months alongside the establishment of the Risk Management Group.

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

Scoring	Inherent Risk			January 2026			March 2026			May 2026			July 2026			Target Risk		
	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score	I	L	Score
	4	4	16	3	5	12	4	5	20	4	3	12	4	3	12	4	2	8



Associated Risks	Risk ID	Risk Title	Current Risk Score
	n/a		16

		Action Detail	Progress Notes	Action Lead	Target Date
	08.03	Review Trust Risk Policy	New policy, appetite statement and supporting procedures drafted and under review in partnership with external partner. Second EMB review due November 2026 as part of Governance Improvement Plan and prior to Assurance and Risk Assurance Committee December 2026 and Trust Board consideration January 2027.	Director of Corporate Governance	January - 2027
	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	• New Corporate Governance Manual to be considered by EMB in November 2026.	Director of Corporate Governance	March 2027
	08.07	Participate in WG implementation group re: NWSSP review of accountability and governance and implement recommendations in line with December 2025 statement.	Completion due November 2026.	Director of Corporate Governance	Nov.26
	08.09	New Board Development Programme delivered	12 month Board development programme approved by Trust Board in July 2026.	Director of Corporate Governance	March 2027
	08.10	New Governance Improvement Plan delivered	Newly adopted Governance Improvement plan for completion by March 2027.	Director of Corporate Governance	March 2027

			New Corporate Governance team service plan developed in line with GIP.		
Closed Actions					
	08.01	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work.	Benchmarking integral to the development of the Board Development and Governance Improvement Plan. New Risk Management Framework and System Development informed by NHS Wales benchmarking. Supplier demonstration days held over May-June period to inform system replacement.	Director of Corporate Governance	April 2026
	08.02	Develop new plan for phase 2 GAR programme.	GAR programme stood down and amalgamated into governance improvement programme since March 2026.	Director of Corporate Governance	December 2025
	08.05	Training programme to support Duty of Quality reporting, Quality Impact Assessment completion and Assurance Level awareness.	Ongoing programme of training in place and to be considered as part of Governance Improvement Plan. Key briefing documents shared with Trust Board members and available for staff.	Director of Corporate Governance/Executive Director Nursing, Allied Health Professionals and Health Scientists	Nov-25
	08.06	Coordinate policy review process and update Policy on Policies as standard operating procedure to support organisational development, compliance and awareness of policies.	Policy on Policies developed and approved by QSP Committee in November 2025. Policy review report considered by WSP Committee twice a year.	Director of Corporate Governance	Nov-25
Key Controls Established		**Key Gaps in Controls**	**Assurance**	**Key Gaps in Assurance**	

Trust Risk Register framework, policy, procedures and Risk Appetite Statement. Annual Assessment of Board Effectiveness Board Committee Effectiveness Arrangements Board Development Programme and Governance Improvement Programme approved by Trust Board July 2026 Quality of assurance provided to the Board External benchmarking on governance, assurance and risk to confirm best practice Cross-reference of Integrated Medium Term Plan objectives to strategic objective in the Board Assurance Framework	Risk Policy under review with aim of seeking Board approval in September 2026 Governance improvement Plan for Trust Board approval July 2026 - *completed* Implementation of NWSSP Accountability and Governance review implemented by September 2026. Refreshed Trust Clinical Governance Framework	Independent assurance through Internal Audit and Audit Wales work External oversight/escalation via Welsh Government Escalation & Intervention Arrangements, including Public Accountability meetings. Governance oversight and monitoring through internal forums Specialist external advice and audit when required Revised assurance mapping on core and hosted governance via new committee structure and refreshed arrangements for hosting assurances Approval of 2026-27 IMTP	Approval by Audit Committee and Board regarding the new Risk Framework (due January 2027) Third line of defence in respect of C4 – Board Development Programme underway (for completion March 2027). Structured Assessment and Annual Audit Plan for 2026/27 underway. Focus on IMTP leaves a gap regarding external assurance regarding wider governance delivery.

TRUST BOARD		
STRATEGIC PARTNERSHIPS UPDATE		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	LAUREN FEAR. DIRECTOR OF PLACE, PORTFOLIO & PARTNERSHIPS	
PRESENTED BY	LAUREN FEAR. DIRECTOR OF PLACE, PORTFOLIO & PARTNERSHIPS & DR JACINTA ABRAHAM, EXECUTIVE MEDICAL DIRECTOR	
REPORT SPONSOR	I, **Lauren Fear, Director of Place, Portfolio and Partnerships**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	20/10/2026	Research, Development and Innovation Committee
	Velindre Collaborative and Cardiff Health Partners update for discussion	
ONWARD SCRUTINY ROUTE	n/a	
PURPOSE OF THE REPORT	FOR NOTING / FOR INFORMATION	
EXECUTIVE SUMMARY	This strategic partnerships update will focus on the following recent developments in: • Cardiff Health Partners • Velindre Collaborative • Cardiff and Vale University Health Board - Velindre University NHS Trust Strategic Partnership *It is important to note that in the execution of all Trust Board portfolios, each Board Member and their teams rely on strategic partnerships to effectively fulfil accountabilities. This update contains those the Directorate of PPP has had a leadership role in over the last period.*	

ACTION / DECISION	The Board is asked to note this report.
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:	
• 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	
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):	
• A Prosperous Wales • A Healthier Wales • A More Equal Wales • A Wales of more Cohesive Communities	
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.	
Status: QIA not required - not a strategic decision	
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)	
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report	

1. UPDATE ON RECENT DEVELOPMENTS

1.1 Cardiff Health Partners

1.1.1 In the September 2026 Trust Board meeting, the Board considered the Partnership Agreements for both Cardiff Cancer Research Partnership and Cardiff Health Partners. Both were supported by the Board, subject to confirming final details on the Cardiff Health Partners agreement.

1.1.2 Cardiff Health Partners has successfully completed its establishment phase and the focus is now on accelerating into delivery. The next phase is to focus on: delivering the existing leader

programmes; addressing shared strategic challenges where partnership working adds value; and securing the core infrastructure required to support delivery.

1.1.3 Over the next 24 months, Cardiff Health Partners will focus on three areas:

- Define, resource and deliver the first tranche of leader programmes (Next Generation Cancer Care, Brain Therapies and Precision Medicine) to define the programme's outputs, intended impacts, measures of success and resource requirements. These will form the basis of the 24-month delivery and resourcing plans and give partners a basis for confirming their contributions moving into delivery.

- Identify future Cardiff Health Partners work through missions, shared gaps and challenges. These include (but are not confined to):
  - Long-term data vision and population prevention/ health
  - Metabolic health
  - Babies, children and young people's health
  - Fast Track Cardiff
  - 'CHP Crack It' challenge-led development and review approach.

- Secure the core operations needed to support delivery. Formalise Cardiff Health Partner's core operating and governance arrangements, including the Joint Research Office (JRO), with clear partner responsibilities and contributions.

1.1.4 Cardiff Health Partners Launch Event is 13th January 2027.

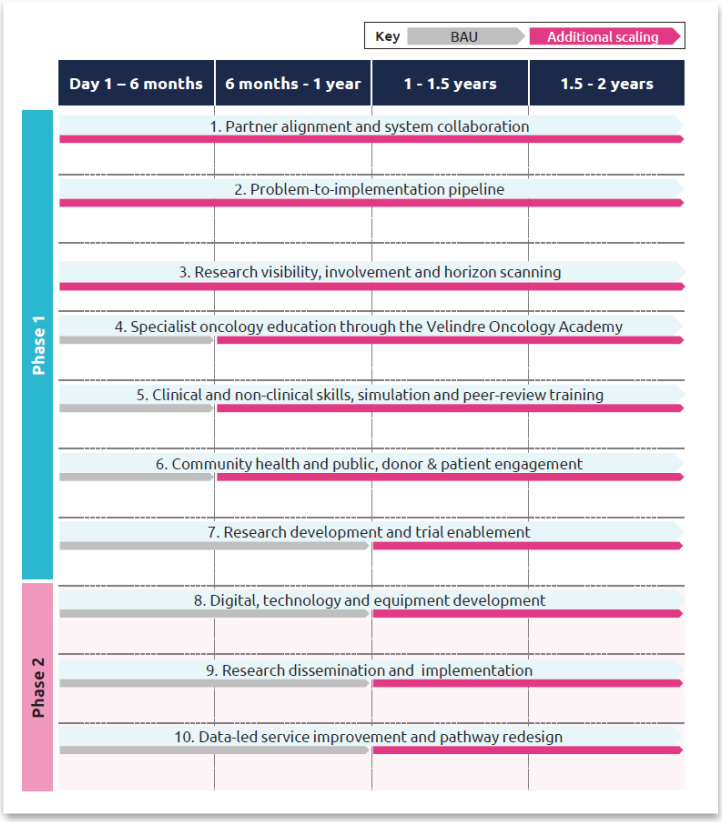
1.2 Velindre Collaborative

1.2.1 Plans are progressing well for the set up of the Velindre Collaborative, as part of the Support workstream of the new Velindre Cancer Centre Readiness Programme.

1.2.2 In addition, there is further engagement with the wider systems and partners on developing and shaping the model to deliver the purpose of the Velindre Collaborative: 'The gateway for Wales cancer-focused collaboration and implementation, translating research, innovation and learning into real, sustainable improvements in cancer care and outcomes for everyone.'

1.2.3 The following service offerings have been developed and are forming the basis for the planning:

1.2.4 The phasing and development is mapped across the first two years operational plan:



1.2.5 The Research, Development and Innovation Committee will continue to oversee the on-going development of the Velindre Collaborative. As part of the January Committee, updates will be provided on:

- Commercial and Finance Plan
- Benefits Plan
- Leadership, Governance and Ways of Working Model

1.3 Cardiff and Vale University Health Board - Velindre University NHS Trust Strategic Partnership

1.3.1 Progress has been made across all partnership priorities during the first year of the refreshed partnership. The partnership has provided a mechanism for coordinated planning of specialist, regional and highly specialised services.

1.3.2 Joint working arrangements have strengthened strategic alignment between organisations and supported the development of shared vision for future service models. Delivery has highlighted the importance of dedicated programme capacity, clearly defined ownership and prioritisation of resources.

1.3.3 Progress against agreed delivery commitments for 2026/27:

- **Joint Clinical Model**

Strategic direction established through development of the Complex Oncology Joint Provider Plan and supporting workstreams. Progress made in exploring priority service developments, including lower-acuity haemato-oncology and acute oncology transformation, with further agreement required on implementation priorities and delivery arrangements.

- **PET-CT (Positron Emission Tomography)**

Partnership oversight has supported development of the fourth PET-CT scanner business case, transition planning for PETIC services and coordination of future PET-CT provision across South East Wales. Further work is required to agree sustainable service, workforce and governance arrangements.

- **Therapeutic Apheresis**

National service model development has progressed well, with agreement reached on the preferred future service model and implementation planning is now underway.

- **Transforming Access to Medicine (TrAMS) - Aseptic Trials/Advanced Therapy Medicinal Product (ATMP) Preparation**

The future approach to ATMP preparation outside of TrAMs has been agreed by partner organisations, with further service mapping underway and established clinical and operational arrangements in place.

2. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **NOTE** the update.

VELINDRE UNIVERSITY NHS TRUST BOARD	
PERFORMANCE & FINANCE COMMITTEE ESCALATION REPORT	
DATE OF MEETING	26th November 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Niké Hooper-Collins
PRESENTED BY	John Union, Independent Member and Chair of Performance & Finance Committee
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR DISCUSSION / NOTING

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Performance & Finance Committee at its meeting held on 12th November. Key highlights from the meeting are reported in paragraph 2.The Board is requested to **NOTE** the contents of the report and actions being taken.

2. ESCALATION REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Performance & Finance Committee held on 12th November:

ALERT / ESCALATE	**Recognising WBS as critical national infrastructure** The Committee considered that greater awareness was required across Welsh Government and the wider system of the essential role of the Blood Service, alongside the need for sustainable commissioning and funding arrangements to support service resilience. It was proposed that relevant Welsh Government colleagues be invited to visit the Welsh Blood Service to strengthen understanding of the breadth and complexity of its services and the importance of both infrastructure investment and sustainable revenue funding.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD		
Charitable Funds Committee Terms of Reference		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	JOLENE DALTON HEAD OF CORPORATE GOVERNANCE (INTERIM)	
PRESENTED BY	Non Gwilym, Director of Corporate Governance (Interim)	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	
	DD/MM/YYYY	
	Not Applicable	
ONWARD SCRUTINY ROUTE	Not Applicable	
PURPOSE OF THE REPORT	FOR APPROVAL	
	The purpose of this report is to seek Board approval of revised Terms of Reference for the Charitable Funds Committee, as part of the implementation of the Board's wider governance review and committee restructuring programme.	
EXECUTIVE SUMMARY	This report seeks Trust Board approval of the revised Terms of Reference for the Charitable Funds Committee. The revised Terms of Reference are part the wider programme of governance reform approved by the Board in March and July 2026 and are intended to strengthen governance arrangements, provide greater clarity of responsibilities and delegated authority and ensure alignment with the revised Board committee structure. The proposed changes do not create additional resource requirements and support the Trust's commitment to effective governance and oversight.	

ACTION / DECISION	The Board is asked to: Approve the Terms of Reference for the Charitable Funds Committee
ADDITIONAL RESOURCES	**None**

RELEVANT TRUST STRATEGIC GOALS

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

- Outstanding for quality, safety, and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations
- A beacon for research, development, and innovation in our stated areas of priority
- An established 'University' Trust which provides highly valued knowledge for learning for all

RELEVANT TRUST WELLBEING GOALS

This report addresses the following wellbeing goal(s):

- A Prosperous Wales
- A Healthier Wales
- A More Equal Wales

QUALITY AND SAFETY IMPLICATIONS

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

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

QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.		
Status: QIA not required - not a strategic decision		
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Terms of Reference for the CFC
	Appendix 2	Appendix 1 of the Board Committee Terms of Reference (previously agreed, but included for completeness)

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

1.1 This report is presented to Trust Board for their approval of the proposed Terms of Reference for the Charitable Funds Committee (CFC).

1.2 As noted in previous Trust Board papers, the changes are intended to strengthen governance arrangements and provide greater clarity regarding committee responsibilities.

2. BACKGROUND

2.1 The Trust has undertaken a review and restructure of its committee arrangements to ensure that they remain fit for purpose, proportionate and aligned to the organisation's current strategic priorities, assurance requirements and operating context. The new Terms of Reference have considered the need to reduce duplication, clarify the flow of assurance to the Board and ensure that each committee has a clear and distinct remit.

2.2 The Trust Board approved revised Terms of Reference for the rest of its Board Committees at its meeting on 30 July 2026 as part of the wider review of the Governance arrangements. At that time the CFC Terms of Reference were not available for approval and remained outstanding as part of the on-going suite of changes

2.3 In line with other Board Committees a comprehensive overhaul of the Terms of Reference are presented for consideration

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 Approval of the revised Terms of Reference will complete implementation of the Board's revised committee structure and provide a consistent governance framework across all Board committees. This will support improved accountability, assurance and transparency within the Trust's governance arrangements.

3.1.2 Alongside the other Committee Terms of Reference, the CFC Terms will improve alignment between committee work programmes and demonstrate the Board's commitment to continuous improvement in governance and effective oversight

3.2 FINANCIAL IMPLICATIONS

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

3.3 LEGAL IMPLICATIONS

3.3.1 There is no direct impact as a result of activity outlined in this report, however the Terms of Reference form part of the Board's governance framework, therefore it is important that they remain accurate, current and aligned with Board-approved governance arrangements and committee structures

3.4 PEOPLE IMPLICATIONS

3.4.1 There are no implications as a result of activity outlined in this report.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 There are no implications as a result of activity outlined in this report.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

08 - Governance

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Board is asked to: approve the proposed amendments to the Charitable Funds Committee Terms of Reference.

Charitable Funds Committee

Draft Terms of Reference

1. Introduction

In line with the Trust's Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the **Charitable Funds Committee** ("the Committee").

Velindre University NHS Trust is the Corporate Trustee of the **Velindre University NHS Trust Charity** ("the Charity"). The Board acts collectively in exercising the Trust's responsibilities as Corporate Trustee. The Committee supports the Board by exercising the responsibilities and authority delegated to it for the governance, management and application of the Charity's funds. These Terms of Reference set out the Committee's responsibilities, delegated authority and operating arrangements.

The Committee shall conduct its business in accordance with Trust values, and the principles of openness and transparency that apply to the work of the Board, subject to the need to maintain confidentiality where appropriate.

2. Constitution

Velindre University NHS Trust was appointed as Corporate Trustee of the Charity by virtue of the Velindre National Health Service Trust (Establishment) Order 1993 (No. 2838), which came into effect on 1 December 1993.

The Board acts collectively in exercising the Trust's responsibilities as Corporate Trustee and is ultimately responsible for ensuring that the Charity's funds are administered and applied in accordance with its governing documents, charitable purposes and applicable charity law.

The Committee has been established by the Board to provide detailed oversight and assurance in relation to the strategy, governance, management, fundraising and the use and investment of the Charity's funds. It shall exercise the responsibilities and authority delegated to it through these Terms of Reference, the Scheme of Delegation and the Standing Financial Instructions.

The Committee incorporates the responsibilities of the former Investment Sub-Committee, bringing oversight of the Charity's investments within its remit.

3. Purpose

The purpose of the Committee is to support the Board, in exercising the Trust's responsibilities as Corporate Trustee, in ensuring the effective stewardship, governance and management of the Charity.

The Committee shall oversee and receive assurance on the arrangements for the control, management and application of the Charity's funds, within the priorities and spending criteria determined by the Board and in accordance with the Charity's governing documents and applicable legal and regulatory requirements.

The Committee shall oversee the development and delivery of the Charity Strategy and receive assurance that appropriate arrangements are in place for:

- fundraising and the receipt of donations, legacies and other income;

- the management and investment of charitable funds;
- grant-making and decisions concerning charitable expenditure; and
- demonstrating the benefits and impact achieved through the use of the Charity's funds.

4. Responsibilities

In carrying out its purpose, the Committee shall have the following responsibilities.

4.1. Strategy and governance

- Oversee the development of the Charity's strategy and objectives for approval by the Board and receive assurance on their implementation and delivery.
- Seek assurance that the Charity is governed and administered in accordance with its governing documents, charitable purposes and applicable legal and regulatory requirements.
- Seek assurance that appropriate policies, procedures, systems and controls are in place for the effective governance and operation of the Charity, including fundraising, grant-making, financial management, investment and the administration of charitable funds.
- Consider relevant guidance and requirements issued by the Charity Commission and other regulatory or advisory bodies and oversee any action required in response.

4.2. Application of charitable funds

- Within the priorities and spending criteria determined by the Board, and in accordance with the Charities Act 2011, as amended by the Charities Act 2022, oversee the application of the Charity's funds exclusively in furtherance of its charitable purposes and for the public benefit.
- Seek assurance that funds are used in accordance with the Charity's governing documents and any restrictions, instructions or wishes attached to the relevant donation, legacy, grant or fund.
- Seek assurance that decisions concerning charitable expenditure are made through a clear, robust and transparent process and are reasonable, clinically and ethically appropriate and consistent with the Charity's objectives.
- Seek assurance that, before charitable funds are applied in support of service delivery, there is clear consideration of the relationship between the proposed expenditure and expenditure that would ordinarily be met from NHS funds.
- Scrutinise and approve, reject or recommend requests for charitable expenditure in accordance with the financial limits and responsibilities set out in the Scheme of Delegation and Standing Financial Instructions.
- Monitor and review the scheme of delegation for charitable expenditure and recommend any changes to the Board.

4.3. Fundraising, donations and income

- Oversee the Charity's approach to fundraising and receive assurance that fundraising activities are lawful, ethical, appropriately controlled and aligned with the Charity's strategy and objectives.
- Monitor fundraising performance, including income, costs, return on investment and delivery against agreed plans and targets.

- Monitor the level and use of donations, legacies, grants and other charitable income, including the progress of any material fundraising appeals.
- Receive assurance that appropriate arrangements are in place for the acceptance, recording and administration of donations, legacies, bequests and grants, including compliance with any conditions or restrictions attached to them.
- Consider opportunities to develop appropriate sources of charitable income and partnerships that support the Charity's objectives.

4.4. Investment and financial stewardship

- Seek assurance that the Charity's investment policies and procedures are followed and that charitable funds are invested prudently in accordance with the Trustee Act 2000, the Charities Act 2011, as amended by the Charities Act 2022, the Charity's governing documents and the approved investment policy.
- Oversee the management and performance of the Charity's investments, including the performance of any appointed investment manager or adviser, to ensure that funds are appropriately protected and generate a suitable return having regard to the Charity's objectives, expenditure commitments and agreed approach to risk.
- Receive reports at least twice each year on investment performance, investment decisions and actions taken under delegated authority.
- Regularly review the Charity's investment arrangements and consider whether alternative investment opportunities or services may better meet its objectives.
- Receive assurance that the Charity's banking arrangements and funds are maintained separately from the Trust's NHS funds and that appropriate liquidity is available to meet current and planned expenditure commitments.
- Approve the establishment and operation of any investment pool where appropriate and recommend to the Board the basis on which income and gains should be allocated between individual funds.

4.5. Reserves and financial management

- Monitor the Charity's financial position, including income, expenditure, commitments, cash flow and individual fund balances.
- Oversee the Charity's Reserves Policy and receive assurance that reserves are maintained at an appropriate level, having regard to planned expenditure, material commitments and the needs of the Charity.
- Monitor restricted, designated, dormant or significantly underused funds and receive assurance that appropriate action is taken to ensure their effective and timely use.
- Receive assurance that the principles of financial regularity, prudence, propriety and value for money are applied in the management and use of charitable funds.

4.6. Annual report, accounts and regulatory reporting

- Review the Charity's annual report and accounts and recommend them to the Board for approval, ensuring that they comply with applicable legislation, Charity Commission requirements and the relevant Charities Statement of Recommended Practice.
- Receive assurance that all required statutory returns and regulatory submissions are accurate, complete and submitted within the required timescales.
- Ensure that the annual report provides a clear account of the Charity's activities, achievements, financial performance and the benefits and impact delivered for its beneficiaries.

4.7. Risk assurance and impact

- Oversee the identification and management of the principal risks relating to the Charity and receive assurance on the effectiveness of the associated controls and actions.
- Report to the Board any significant concerns, gaps in assurance or risks that cannot be managed effectively within the Committee's delegated authority.
- Receive assurance that charitable grants and expenditure are used for their approved purposes and deliver the intended benefits and outcomes.
- Monitor the overall effectiveness and impact of the Charity's activities and the contribution they make to the Charity's objectives and public benefit.
- Receive assurance from the Executive Director of Finance on financial administration and stewardship,
- Receive assurance from the Lead Executive on the Charity's strategy, fundraising, charitable activities and impact, in accordance with their respective responsibilities.
- Receive assurance from relevant programme boards or governance groups on significant charity-funded programmes, including delivery, expenditure, risk and benefits realisation.

5. Responsibilities of the Executive Lead for the Charity Committee and the Executive Director of Finance

5.1. Responsibilities of the Executive Lead for the Charity Committee

- The Board shall designate an Executive Lead for the Charity. The Lead Executive shall oversee the Charity's strategic and operational activities beyond financial administration and provide the Committee with assurance on their delivery. This includes:
    - leading the development and delivery of the Charity's strategy and associated operational plans for consideration by the Committee and approval by the Board where required;
    - overseeing fundraising strategy, appeals, partnerships and supporter engagement, coordinating with the Executive Director of Finance on income and financial controls;
    - overseeing the development and delivery of grant programmes and other charitable activities, including evidence of their benefits and impact;
    - ensuring that proposals seeking charitable support align with the Charity's objectives and receive appropriate specialist scrutiny, including through the RD&I Committee where relevant; and
    - reporting to the Committee on strategic delivery, fundraising performance, charitable activities, risks and impact.
- The Lead Executive shall work with the Executive Director of Finance where activities have both operational and financial implications. The role does not alter financial delegations or the Board's ultimate responsibility for the Charity in exercising the Trust's responsibilities as Corporate Trustee.

5.2. Responsibilities of the Executive Director of Finance

- The Executive Director of Finance is responsible for the financial administration of the Charity, as defined in the Trust's Standing Financial Instructions and Scheme of Delegation and responsibilities include:

- administering the Charity's existing funds and maintaining appropriate accounting records and financial controls;
- identifying any new charity or charitable fund that may be created for which the Trust would act as Corporate Trustee and ensuring that the necessary legal and governance requirements are addressed;
- providing financial and procedural guidance on the receipt and administration of donations, legacies, bequests, grants, fundraising and trading income;
- managing the investment of funds held by the Charity in accordance with the approved investment policy and any authority delegated by the Committee or Board;
- ensuring that appropriate banking arrangements are maintained and that the Charity's funds are kept separate from the Trust's NHS funds;
- ensuring that sufficient funds are available to meet current and planned expenditure commitments;
- preparing the Charity's annual accounts and required financial and statutory returns, and contributing financial information to the annual report, for consideration by the Committee and approval by the Board;
- providing the Committee with timely and accurate financial, investment and performance information; and
- providing assurance on compliance with the Standing Financial Instructions, Scheme of Delegation and relevant financial policies and procedures.

- The Executive Director of Finance may exercise only those powers delegated through the Standing Financial Instructions, Scheme of Delegation or specific decisions of the Board or Committee. The Trust remains the Corporate Trustee and the Board retains ultimate responsibility for the Charity and its funds.

6. Authority and Delegated Decision Making

6.1. Responsibilities of the Board and Committee

- In exercising the Trust's responsibilities as Corporate Trustee, the Board retains ultimate responsibility and legal accountability for the Charity. The respective responsibilities of the Board and Committee are set out below.

- The Board retains responsibility for:

  - approving the Charity Strategy;
  - approving the Charity's investment strategy, policy and mandate;
  - approving the Charity's annual report and accounts;
  - approving these Terms of Reference and the Committee's membership;
  - approving the Scheme of Delegation, Standing Financial Instructions and matters expressly reserved to the Board;
  - approving expenditure, investments or other decisions above the Committee's delegated limits; and
  - considering significant matters that could materially affect the Charity's purposes, assets, reputation or regulatory position.

- The Board shall discharge these responsibilities through decisions on matters reserved to it, consideration of quarterly reports and recommendations from the Committee, and an Annual General Meeting to review the Charity's work and

consider its Annual Report and Accounts. Matters requiring Board approval shall be explicitly identified and supported by a recommendation from the Committee.

- The Board delegates authority to the Committee to:
    - develop and recommend the Charity Strategy and oversee its implementation;
    - oversee fundraising, grant-making, investments, financial stewardship, risk, compliance and charitable impact;
    - approve, reject or recommend charitable expenditure within the agreed delegated limits;
    - oversee investments within the strategy, policy and mandate approved by the Board;
    - oversee the development and review of policies relevant to the Committee's remit, approving those within its delegated authority and recommending to the Board for approval those of strategic significance or otherwise reserved to the Board; and
    - provide assurance, advice and recommendations to the Board.
- The Committee may act only within its delegated authority. Any matter outside that authority, or which could materially affect the Charity's purposes, assets, reputation or regulatory position, shall be referred to the Board.

6.2. Committee Authorisation

- The Committee is authorised to:
    - investigate any activity within its Terms of Reference;
    - access any relevant records, documents or other information held by the Trust;
    - seek information from any employee or contractor working on behalf of the Trust, all of whom are required to cooperate with reasonable requests from the Committee;
    - require the attendance of Trust officers, employees, auditors or advisers where this is necessary to support its work;
    - obtain legal, financial or other independent professional advice, subject to the Trust's procurement, budgetary and other requirements;
    - invite individuals with relevant experience or expertise to attend its meetings;
    - approve policies relevant to the Committee's remit where this authority has been delegated by the Board; and
    - approve, reject or recommend charitable expenditure within the limits set out in the Scheme of Delegation and Standing Financial Instructions.

6.3. Investment management

- The Committee is authorised to oversee the management of the Charity's investments in accordance with the investment strategy approved by the Board and the requirements of the Standing Financial Instructions.
- Where appropriate, the Committee may oversee the appointment of an investment manager or adviser and the delegation of the day-to-day management of some or all of the Charity's investments. In doing so, the Committee shall ensure that:
    - appropriate internal controls and procedures are in place;
    - the scope of the delegated authority is clearly documented and communicated;

- the delegated authority is exercised properly and prudently;
- performance is regularly monitored and reviewed; and
- the investment manager or adviser is appropriately authorised and regulated by the Financial Conduct Authority where required.

- Any material acquisition or disposal outside the approved Investment Strategy shall require prior Board approval, supported by a recommendation from the Committee. Where urgent action is required, approval shall be sought through the approved arrangements for urgent Board decision-making.
- Decisions concerning the investment or redemption of funds shall take account of the Charity's immediate and future expenditure commitments, liquidity requirements and approved approach to investment risk.
- The Committee may agree to the operation of an investment pool where this is appropriate and compliant with charity law and Charity Commission guidance. The basis for allocating income and gains between individual funds shall be recommended to the Board for approval.
- The Committee may recommend that the Board establish or discontinue a formal body to undertake specified functions on its behalf. Any such body shall operate under Board-approved terms of reference and remain accountable to the Board through the Committee.

7. Research Development and Innovation Committee

The Research, Development and Innovation (RD&I) Committee shall provide the appropriate route for clinical, scientific, ethical and organisational scrutiny of research, development and innovation proposals seeking charitable funding.

The Charitable Funds Committee shall consider such proposals only where the relevant scrutiny has been completed and shall retain responsibility for funding decisions within its delegated authority.

Proposals for charitable funding outside the RD&I remit shall follow an equivalent scrutiny process and be referred to the appropriate management group, such as the Cancer Charity Leadership Group (CCRG), and the Advancing Radiotherapy Fund (ARF) Programme Board for review and endorsement before submission to the Charitable Funds Committee or other authorised decision-maker for approval within the relevant delegated limits.

8. Membership and Attendance

8.1. Members

- The committee shall comprise a minimum of five members
  - Chair: Independent Member of the Board
  - Deputy Chair: Independent Member of the Board
  - Member: Independent Member of the Board
  - Member: Executive Lead
  - Member: Executive Director of Finance
- Membership of the Board does not, of itself, confer membership or voting rights at meetings of the Committee. Committee membership is limited to those individuals formally appointed by the Board

- Where either the Executive Lead or Executive Director of Finance is unable to attend, they may be represented by a suitably briefed nominated deputy, subject to the agreement of the Committee Chair.
- The Committee may invite independent or specialist advisers to attend where charity, fundraising, investment, governance, legal, clinical, research or community expertise would support its work. Attendance does not confer membership or voting rights.

8.2. Attendees

- Attendees will include:
    - Director of the Charity
    - Director of Corporate Governance, as Charity Governance Lead;
    - An appropriate senior finance representative; and
    - A patient, donor or beneficiary representative.
    - Director of Communication.
- The Investment Manager or Adviser shall attend where investment matters are being considered.
- Other Executive Directors, senior officers, professional advisers or subject-matter experts shall attend where required by the agenda or invited by the Committee Chair
- Attendance does not confer membership or voting rights
- The Committee Chair may invite any other Trust officer, adviser or individual from within or outside the organisation to attend all or part of a meeting where their experience or expertise would assist the Committee's consideration of a particular matter.
- The Chair of the Trust and other Independent Members of the Board may attend meetings of the Committee with the agreement of the Committee Chair but shall not have voting rights unless formally appointed as members of the Committee.

8.3. Appointments

- The membership of the Committee shall be determined by the Board on the recommendation of the Trust Chair, taking account of the balance of skills, knowledge and expertise required to discharge the Committee's responsibilities and any applicable requirements or directions issued by Welsh Government.
- Independent Members shall normally be appointed to the Committee for a period of up to three years. Appointments may be renewed, subject to the individual's term of office and a review of the Committee's membership and requirements.
- A member may resign from the Committee or be removed by the Board at any time.
- In determining the Committee's membership and attendance arrangements, the Board shall consider how visible independence and appropriate beneficiary or public perspectives can be incorporated into the Committee's work.

8.4. Role of the Trust Chair

- The Trust Chair shall:
    - lead the Board in the collective discharge of its responsibilities in relation to the Charity;
    - ensure that matters reserved to the Board are brought forward for appropriate consideration and decision;

- support an effective relationship and flow of assurance between the Board and the Committee;
- recommend the appointment of the Committee Chair and other Committee members to the Board; and
- receive notification of any urgent or significant matter requiring the Board's attention.

- ensure that the Board considers the CFC Terms of Reference on an annual basis.

- The role of Trust Chair is distinct from the role of Committee Chair. The Trust Chair shall not chair the Committee unless formally appointed as Committee Chair and shall not vote or count towards the quorum unless formally appointed as a Committee member.

8.5. Secretariat and member support

- Secretarial support shall be provided as determined by the Director of Corporate Governance, working in conjunction with the Lead Executive and Executive Director of Finance to support the effective operation of the Committee.

- The Director of Corporate Governance, on behalf of the Committee Chair, shall:
  - arrange appropriate advice and support for Committee members in relation to their roles; and
  - coordinate relevant induction, development and training to enable members to discharge their responsibilities effectively.

8.6. Quorum

- The Quorum for the meeting will be:
  - The committee Chair or another Independent Member appointed to chair the meeting;
  - One other Independent Member and
  - the Lead Executive or the Executive Director of Finance, or their suitably briefed nominated representatives.

- If the meeting becomes inquorate, the Chair may continue the meeting to discuss the business on the agenda, but no formal decisions may be made. Any matters requiring decision shall be referred to a subsequent quorate meeting or addressed through the approved arrangements for urgent action.

8.7. Frequency

- The Committee shall meet quarterly and otherwise as the Committee Chair considers necessary, consistent with the Trust's annual plan of board and committee business
- Additional meetings may be convened by the Chair where urgent or significant matters require consideration before the next scheduled meeting.
- An Annual General Meeting shall be held with all members of the Board, acting collectively as Corporate Trustee, to review the Charity's work and consider its Annual Report and Accounts.

8.8. Conduct of meetings

- The agenda and supporting papers shall be agreed with the Committee Chair and circulated sufficiently in advance to enable members to consider the matters presented
- The Committee's agenda shall be informed by its annual workplan, the Charity's strategy and principal risks, matters arising from previous meetings and any issues referred by the Board or requiring escalation
- Accurate minutes and an action log shall be maintained. The minutes shall record the decisions made, the principal matters considered, any significant challenge or concerns raised and any declarations of interest
- The Committee may ask any or all attendees who are not members to withdraw for all or part of a meeting where this is necessary to facilitate open and frank discussion or protect confidential information
- Where an urgent decision is required between scheduled meetings, the Committee Chair may act within the Committee's delegated authority following consultation with the Executive Lead, Executive Director of Finance and at least one other Independent Member. Any decision shall be recorded and reported to the next Committee meeting. Chair's action shall not be used for a matter reserved to the Board.

8.9. Interests

- Members and attendees shall declare any actual or potential interest relating to the business under consideration in accordance with the Trust's Standing Orders and relevant policies
- The Chair shall determine the appropriate arrangements for managing a declared interest. This may include requiring the individual to withdraw from the discussion or decision. An individual who has a material interest in a matter shall not participate in, or vote on, the relevant decision.

9. Relationships and Accountabilities

The Committee is directly accountable to the Board for the performance of the responsibilities and exercise of the authority delegated through these Terms of Reference. Its reporting shall support the Board in exercising the Trust's responsibilities as Corporate Trustee.

The Committee shall work collaboratively with other Committees of the Board where matters fall within their respective remits. This shall include:

- coordinating the planning and consideration of related business;
- sharing relevant information and assurance in a timely manner;
- referring matters to the Committee best placed to provide oversight or assurance;
- escalating significant concerns, risks or decisions that fall outside the Committee's delegated authority; and
- avoiding gaps or unnecessary duplication in oversight and assurance.

The Committee shall coordinate with the Research, Development and Innovation Committee to ensure that proposals seeking charitable funding receive the appropriate strategic, scientific, ethical and governance scrutiny before funding decisions are made.

The Committee shall coordinate with the Audit, Risk and Assurance Committee on matters relating to the Charity's risk management, internal control and assurance arrangements, and

shall refer significant audit findings, control weaknesses or gaps in assurance where these require wider oversight.

The Committee shall contribute to the integration of effective governance across the Trust and ensure that assurance relating to the Charity is reflected appropriately within the Board's overall governance, risk and assurance arrangements.

The Committee shall receive assurance on the Charity's activities and expenditure within its remit and escalate matters requiring wider oversight or action to the Board.

The Committee shall embed the Trust's values, standards and priorities in the conduct of its business and shall have due regard to equality, diversity, inclusion and human rights in its decision-making.

Where a matter relates both to the Charity and to the Trust's wider NHS responsibilities, the Committee shall ensure that the respective responsibilities and decision-making capacities of the Board are clearly distinguished and appropriately recorded.

10. Reporting and Assurance Arrangements

Following each meeting, the Committee Chair shall provide a written report to the Board summarising:

- the principal matters considered;
- the assurance received;
- decisions made under delegated authority;
- any significant risks, concerns or gaps in assurance;
- matters referred to the RD&I Committee, where relevant; and
- matters requiring consideration or approval by the Board.

The Committee Chair shall bring any urgent or significant matter to the attention of the Trust Chair, Chief Executive or Board without waiting for the next scheduled meeting.

The Committee shall submit an annual report to the Board describing how it has discharged its responsibilities during the year. The report shall include:

- delivery against the Committee's annual workplan;
- assurance over the governance, management and performance of the Charity;
- oversight of the Charity's strategy, finances, investments, fundraising, expenditure, risks and impact;
- the effectiveness of its working relationship with the RD&I Committee, and other forums involved in the scrutiny of bids, where relevant;
- attendance by Committee members; and
- the outcome of the Committee's annual effectiveness review.

The Committee shall provide any additional reports or assurance requested by the Board and shall ensure that decisions made under delegated authority are appropriately recorded and reported

11. Applicability of Standing Orders

The requirements for the conduct of business set out in the Trust's Standing Orders shall apply to the operation of the Committee unless alternative arrangements are expressly provided for within these Terms of Reference.

Where these Terms of Reference specify particular arrangements for the Committee, including its membership, quorum and delegated authority, those arrangements shall be read alongside the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

In the event of any uncertainty or inconsistency, the matter shall be referred to the Director of Corporate Governance for advice and, where necessary, to the Board for determination.

12. Review and Effectiveness

The Committee shall review these Terms of Reference at least annually and recommend any proposed changes to the Board for approval.

The review shall consider whether the Committee's purpose, responsibilities, membership, authority and reporting arrangements remain appropriate and reflect applicable legal, regulatory and organisational requirements.

The Committee shall undertake an annual assessment of its effectiveness, including:

- delivery against its annual workplan;
- the quality and timeliness of the information and assurance it receives;
- the effectiveness of its oversight, challenge and decision-making;
- members' attendance, skills and development needs; and
- the effectiveness of its working relationship with the RD&I Committee, and other forums undertaking scrutiny of bids, where relevant.

The outcome of the assessment and any resulting improvement actions shall be reported to the Board through the Committee's annual report.

APPENDIX 1

Operational arrangements common to all committees

1. AUTHORITY

Velindre University NHS Trust's Standing Orders provide that:
"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work conducted on its behalf by Committees."

Committees operate with no executive powers other than those specifically delegated within their Terms of Reference. Committees are directly accountable to the Board and are authorised to investigate any activity within their remit.

Committees may seek any information required from any employee, contractor, committee, sub-committee, or group of the Trust, all of whom are required to cooperate with such requests. In discharging their responsibilities, Committees will support effective engagement with staff, patients, donors, service user communities and key stakeholders, including partnership working and citizen voice arrangements.

Subject to Board approval, Committees may establish sub-committees or task and finish groups to support the discharge of their responsibilities.

Committees are authorised to secure the attendance of legal advisers, external advisers, specialists, or independent experts where necessary, in accordance with the Trust's procurement, budgetary and governance requirements.

Committees will conduct their business in a manner consistent with the Trust's commitment to openness, transparency, equality, diversity, inclusion, human rights, and the Welsh language.

Committees will exercise any authority delegated by the Board within these Terms of Reference, approve matters delegated to them, and make recommendations to the Board on matters reserved for Board approval. Committees will ensure that significant risks, assurance concerns and matters requiring Board consideration are escalated through the Trust's governance arrangements.

2. STATUTORY AND MANDATORY COMPLIANCE

Committees will operate in accordance with the Trust's strategic objectives, governance framework and all relevant statutory, regulatory, and mandatory requirements, codes of practice, case law, and legislation applicable to NHS Wales organisations. This includes compliance with relevant Welsh Government legislation, NHS Wales governance and accountability requirements, mandatory compliance obligations, equality, workforce, Welsh language, social partnership, and quality standards, together with associated national and international best practice guidance.

3. GOVERNANCE FRAMEWORK

These Terms of Reference should be read alongside the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and other Board-approved governance frameworks. Together, these documents define the authority, roles, responsibilities,

accountabilities, decision-making arrangements and expected behaviours that support effective governance across the Trust.

Board committees provide strategic oversight, scrutiny and assurance on behalf of the Board. They do not manage operational delivery or assume executive responsibility for services or functions.

4. COMMON PRINCIPLES

In exercising their responsibilities, Committees will have due regard to the following principles across all aspects of their work:

- **Equality, Diversity and Inclusion (EDI)** – Ensure that equality, diversity, inclusion and health inequalities are appropriately considered within relevant strategies, policies, business cases, decisions and assurance processes, seeking assurance that potential impacts have been identified, understood and appropriately addressed.
- **Patient, Service User and Donor Voice** – Ensure that the views, experiences and insights of patients, service users, donors, carers and communities are appropriately reflected in decision-making, assurance and improvement activities, recognising lived experience as an essential component of high-quality, person-centred services and the achievement of the Trust's values and strategic objectives.
- **Value for Money and Sustainability** – Ensure that decisions are informed by considerations of value for money, long-term sustainability and the effective stewardship of public resources, recognising the need to balance quality, outcomes, workforce, financial sustainability and environmental impact, where appropriate.
- **Partnership and System Working** – Ensure that opportunities for collaboration, partnership working and system-wide impact are considered within relevant decisions, recognising the Trust's role in improving outcomes across the wider health and care system.
- **Organisational Intelligence and Triangulation** – Ensure that strategic themes, risks, opportunities and assurance are effectively triangulated across the Board committee structure, drawing upon relevant governance arrangements and wider organisational intelligence, including performance, risk, audit, regulatory reviews, patient, donor, service user and staff feedback, incidents, complaints and system learning, to support a coherent organisation-wide view of performance, risk and assurance.
- **Quality of Assurance** – Ensure that assurance is reliable, complete, timely and evidence-based, enabling the Committee to determine whether risks are being effectively managed and intended outcomes are being achieved.
- **Impact Assessment –** Ensure that significant strategies, policies, service changes, business cases and decisions are informed by appropriate Quality Impact Assessments, Equality Impact Assessments and other relevant impact assessments, seeking assurance that potential impacts have been appropriately identified, considered and addressed before decisions are taken.

5. COMMITTEE INTERFACES

Committees will:

- Collaborate with other Committees and refer matters to the appropriate Committee where issues fall outside its remit or require broader organisational oversight or assurance. This includes the People, Culture and Engagement Committee (PCEC), Quality, Safety and Experience Committee (QSEC), Performance and Finance Committee (PFC), Audit, Risk and Assurance Committee (ARAC), Research,

Development and Innovation Committee (RD&I), and the new Velindre Cancer Centre Committee (nVCC).
- Refer matters to the Audit, Risk and Assurance Committee (ARAC) where concerns relate to the overall risk management framework, internal control environment, assurance gaps, or audit findings.
- Receive matters referred by the Board or other Committees where they fall within the Committee's remit.

6. GOVERNANCE AND RISK

Committees will:

- Undertake horizon scanning to identify emerging organisational risks, opportunities, and external developments, relating to its domain, which may impact the Trust's strategic objectives or delivery of high-quality services.
- Seek assurance that domain specific risks on the Board Assurance Framework (BAF) and Trust Risk Register entries are appropriately monitored, mitigated, and escalated.
- Seek assurance that recommendations arising from internal and external reviews are implemented effectively and on a timely basis.
- Review relevant Internal Audit and External Audit findings within the Committee's remit, ensuring actions are implemented and learning is shared.
- Seek assurance that hosted services operate in compliance with the Trust's domain specific assurance requirements, including the Hosted Services Assurance Schedule, and that robust escalation arrangements are in place for risks, incidents, concerns, or gaps in assurance.

7. COMMITTEE EFFECTIVENESS AND PROGRAMME OF WORK

Committees will:

- Develop and maintain an annual cycle of business aligned to Board priorities, strategic objectives, regulatory requirements and key risks, designed to support the effective discharge of the Committee's responsibilities as set out within these Terms of Reference.
- Use findings, assurance activity, and emerging themes to inform future work planning and continuous improvement.

8. CROSS COMMITTEE MEMBERSHIP AND ATTENDANCE

- The Board will seek to ensure appropriate cross-membership and alignment between Committees to support effective integration, triangulation of assurance and coordination of oversight across the Trust's governance framework.
- Committee membership should collectively provide an appropriate balance of skills, knowledge, experience, and diversity relevant to the Committee's remit.
- The Chair of the Board and CEO may attend Committee meetings but are not designated members.
- In exceptional circumstances Deputies may attend where formally nominated and agreed by the Chair. Where an Executive member is unable to attend, a formally nominated Deputy must attend.
- Meetings may be open to observation by staff members and the public in accordance with the Trust's arrangements for openness and transparency.

9. REPORTING TO THE BOARD

- Committees are directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.
- While each Committee will oversee matters within its delegated remit, integrated oversight of organisational performance, governance and assurance across all domains will remain the responsibility of the Board. The Board may remit more detailed review of specific matters to Committees and Committees may advise the Board on any issues requiring ongoing oversight, escalation, or cross-committee consideration.
- Minutes will be circulated to the Board.
- A formal exception report will be submitted to the Board following each meeting, highlighting matters requiring Board attention, escalation or decision, including material risks, significant concerns, issues requiring cross-committee consideration, or where assurance is insufficient or outside agreed tolerance.
- Where urgent decisions are required between scheduled meetings, the Committee Chair, supported by the Director of Corporate Governance, may act on behalf of the Committee following consultation with the other Committee member. Any action taken will be formally recorded and reported to the next meeting for ratification.
- The Committee will undertake any other responsibilities delegated by the Board.

10. QUORUM

- A minimum of two Independent Members
- A minimum of two Executive Directors from the list above in Section 5, Attendance.
- Members with a conflict of interest will not count towards the quorum for that item or meeting.

11. SECRETARIAT AND COMMITTEE BUSINESS SUPPORT

- Secretariat support will be provided by the Corporate Governance function which will:

    - Ensure that there are appropriate arrangements in place to support Committee proceedings including alignment with relevant equality and Welsh language legislation.
    - Ensure that agendas, papers, minutes, and actions are available to the Committee in line with the standards outlined in Standing Orders and supporting documentation.
    - Arrange an agenda-setting meeting with the Committee Chair and Lead Director at least four weeks prior to each meeting.
    - Ensure that agendas are informed by the Committee work plan, matters arising, identified risks, emerging issues and requests from Committee members.
    - Circulate the agenda and timetable for paper submission to members following approval by the Chair and Lead Director,
    - Obtain approval for all papers from the relevant Lead Director prior to submission.
    - Circulate agendas and papers at least seven days in advance of the meeting.
    - Prepare a draft table of actions within two working days of the meeting.
    - Draft minutes and the action log for circulation to the Lead Director for accuracy review within seven days of the meeting, before circulation to Chair and then Committee members for comment.
    - Submit final minutes and actions to the Committee Chair for approval.

- Members should submit amendments to the Committee Secretariat within seven calendar days of receipt.

12. EFFECTIVENESS REVIEW

- At the conclusion of each meeting, the Chair will facilitate a brief reflection on the Committee's effectiveness, considering the quality of discussion, challenge and assurance; use of meeting time; strategic focus; alignment with the Committee's Terms of Reference; the quality of papers and information; member participation and behaviours; and the extent to which the meeting added value to the Board's assurance and decision-making. Opportunities for improvement will be identified, recorded and used to support the Committee's ongoing development.
- Terms of Reference for each committee will be reviewed annually and approved by the Board.
- Committees will undertake an annual self-assessment of its effectiveness and provide an annual report to the Board on its assurance activities, effectiveness, and delivery of its work programme.

TRUST BOARD		
Updated Standing Orders		
DATE OF MEETING	26th November 2026	
STATUS	Public	
REPORT AUTHOR	JOLENE DALTON	
PRESENTED BY	NON GWILYM	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	Audit and Risk Assurance Committee
	DD/MM/YYYY	
	Agreed under Chair's Urgent Actions	
ONWARD SCRUTINY ROUTE	Not applicable	
PURPOSE OF THE REPORT	FOR APPROVAL	
	This report is presented to Trust Board for their consideration of amendments to the Trust Standing Orders following Board Approval of revised Committee Terms of Reference. Approval is required to ensure alignment between the Trust's governance framework and its approved committee arrangements. The Audit and Risk Assurance Committee have considered the proposed amendments and now recommend to Board for approval.	
EXECUTIVE SUMMARY	The Trust Board approved revised Terms of Reference for of its Board Committees at its meeting on 30 July 2026 (Charity Finance Committee to be presented at November Board) as part of the wider review of the Trust's Governance arrangements. A consequential review of the Standing Orders has now been completed to ensure consistency across the governance framework. The proposed amendments are primarily administrative in nature and do not alter the statutory responsibilities, delegated authority levels, or decision-making powers of the Board or it's committees.	

	The amendments principally relate to: • Committee name changes; • Updates to references within governance documents; • Alignment with approved Committee Terms of Reference; • Minor updates to role and policy titles.
ACTION / DECISION	The Committee is asked to: 1. Note the review undertaken of the Trust Standing Orders and associated schedules; 2. Endorse the proposed amendments to ensure the Standing Orders alignment with the Board approved Terms of Reference; and 3. Recommend approval of the revised Standing Orders to Trust Board.
ADDITIONAL RESOURCES	**Not applicable**

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

- Outstanding for quality, safety, and experience

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

- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Wales of more Cohesive Communities
- A Wales of Vibrant Culture and Thriving Welsh Language
- A globally responsible Wales

QUALITY AND SAFETY IMPLICATIONS

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

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

QUALITY IMPACT ASSESSMENT (QIA)

A completed and signed QIA must be attached for all reports requiring a strategic decision.

Status: QIA not required - not a strategic decision

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

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

	Appendix no.	Appendix title
APPENDICES	Appendix 1	Model Standing Orders
	Appendix 2	Schedule 1 Scheme of Delegation
	Appendix 3	Schedule 2 Standing Financial Instructions
	Appendix 4	Schedule 3 Board and Committee Arrangements
	Appendix 5	Schedule 4 Advisory Group Terms of Reference and Operating Arrangements
	Appendix 6	Schedule 5 Shared Services Partnership

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

1.1 The Trust Board agreed changes to the Terms of Reference for all of its Board Committees at its meeting on 30 July 2026 (Charity Finance Committee to be presented at November Board). The Trust Standing Orders must be amended to reflect these changes.

2. BACKGROUND

2.1 The Trust undertook a review and restructure of its committee arrangements to ensure that they remained fit for purpose, proportionate and aligned to the organisational strategic priorities, assurance requirements and operating context.

2.2 The Trust Board agreed the new committee structure in March 2026, and subsequently agreed the new Terms of Reference in July 2026

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 The Trust Standing Orders require that they are reviewed annually by the Audit and Risk Assurance Committee following which, they are presented to Trust Board for approval.

3.1.2 A comprehensive review has been undertaken to ensure consistency between the revised Committee Terms of Reference and the Standing Orders framework. No material inconsistencies have been identified. The proposed amendments do not alter accountability arrangements, reserved matters or statutory responsibilities.

3.1.3 This annual review has been carried out alongside incorporating the necessary changes to reflect the new Committee structure and Terms of Reference. The changes that have been made are as follows:

- Appendix 1 – Model Standing Orders, updated to reflect revised policy name and removed *'and Chief of Staff'* from the role of Director of Corporate Governance.
- Appendix 2 - Schedule 1 Scheme of Delegation, updated to reflect new committee names and change of title for Executive Director of Workforce & OD (previously Executive Director of OD & Workforce).
- Appendix 3 - Schedule 2 Standing Financial Instructions, updated to reflect revised policy name and new committee name of Audit and Risk Assurance Committee (ARAC).
- Appendix 4 – Schedule 3 Board and Committee Arrangements, updated to include all Terms of Reference that have been agreed by Board. Please note that further update will be required subject to changes to the Charity Committee Terms of Reference being agreed by Board at its meeting in November

- Appendix 5, Schedule 4 Advisory Group Terms of Reference and Operating Arrangements. No changes, included for completeness
- Appendix 6 - Schedule 5 Shared Services Partnership. No changes since being agreed in March 2026, included for completeness.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None associated with this report

3.3 LEGAL IMPLICATIONS

3.3.1 Standing Orders form part of the Trust's statutory governance framework. It is therefore important that they remain accurate, current and aligned with Board-approved governance arrangements and committee structures.

3.4 PEOPLE IMPLICATIONS

3.4.1 None associated with this report

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None associated with this report

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

08 - Governance

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- Note the review undertaken of the Trust Standing Orders and associated schedules;
- Approve the revised Standing Orders.

Model Standing Orders

Reservation and Delegation of Powers

Velindre University NHS Trust

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's GC03 Standards of Good Governance and Probity (in Public Services Roles) Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Director of Corporate Governance will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

- **Foreword** **2**

- **Section A – Introduction** **6**

- **Statutory Framework** **6**
- **NHS Framework** **11**
- **NHS Trust Framework** **12**
- **Applying Standing Orders** **11**
- **Variation and Amendment of Standing Orders** **11**
- **Interpretation** **12**
- **The Role of the Director of Corporate Governance** **12**

- **Section B – Standing Orders** **14**

- **1. THE TRUST** **14**

- **1.1 Membership of the Trust** **14**
- ***Executive Directors*** **15**
- ***Non-Executive Directors [to be known as Independent Members]*** **15**
- ***Use of the Term 'Independent Members'*** **15**
- **1.2 Joint Directors** **16**
- **1.3 Tenure of Board members** **16**
- **1.4 The Role of the Trust, its Board and Responsibilities of Members** **16**
- ***Role*** **16**
- ***Responsibilities*** **17**

- **2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS** **18**

- **2.1 Chair's Action on Urgent Matters** **18**
- **2.2 Delegation of Board Functions** **19**
- **2.3 Delegation to Officers** **19**

- **3. COMMITTEES** **20**

- **3.1 NHS Trust Committees** **20**
- ***Use of the Term "Committee"*** **20**
- **3.2 Sub-Committees** **20**
- **3.3 Committees Established by the Trust** **20**
- ***Quality and Safety*** ***20***
- ***Audit*** ***20***
- ***Information Governance*** ***20***
- ***Charitable Funds [as appropriate]*** ***20***
- ***Remuneration and Terms of Service*** ***21***
- ***Mental Health Act Requirements [as appropriate].*** ***21***
- **3.4 Other Committees** **22**
- **3.5 Confidentiality** **22**

□ **3.6 Reporting activity to the Board 22**

□ **4. NHS WALES SHARED SERVICES PARTNERSHIP 22**

□ **5. ADVISORY GROUPS 23**

□ **5.1 Advisory Groups Established by the Trust 23**
□ **5.2 Terms of Reference and Operating Arrangements 23**
□ **5.3 Support to Advisory Groups 24**
□ **5.4 Confidentiality 24**
□ **5.5 Advice and Feedback 24**
□ **5.6 Reporting Activity 25**
□ **5.7 The Local Partnership Forum (LPF) 25**
□ ***Role* 25**
□ **5.8 Relationship with the Board and Others 25**

□ **6. WORKING IN PARTNERSHIP 26**

□ **6.1 The Citizen Voice body for health and social care (to be known as Llais) Error! Bookmark not defined.**
□ ***Relationship with the Board* 28**

□ **7. MEETINGS 28**

□ **7.1 Putting Citizens first 28**
□ **7.2 Annual Plan of Board Business 28**
□ ***Annual General Meeting (AGM)* 29**
□ **7.3 Calling Meetings 29**
□ **7.4 Preparing for Meetings 30**
□ ***Setting the Agenda* 30**
□ ***Notifying and Equipping Board Members* 30**
□ ***Notifying the Public and Others* 31**
□ **7.5 Conducting Board Meetings 31**
□ ***Admission of the Public, the Press and Other Observers* 31**
□ ***Addressing the Board, its Committees and Advisory Groups* 32**
□ ***Chairing Board Meetings* 32**
□ ***Quorum* 33**
□ ***Dealing with Motions* 33**
□ ***Voting* 40**
□ **7.6 Record of Proceedings 35**
□ **7.7 Confidentiality 41**

□ **8. STANDARDS OF GOOD GOVERNANCE AND PROBITY (IN PUBLIC SERVICE ROLES) .....Error! Bookmark not defined.**

□ **8.1 Declaring and Recording Board Members' Interests 36**
□ **8.2 Dealing with Members' Interests During Board Meetings 37**
□ **8.3 Dealing with Officers' Interests 39**
□ **8.4 Reviewing How Interests are Handled 39**
□ **8.5 Dealing with Offers of Gifts, Hospitality and Sponsorship 39**

□ **8.6 Sponsorship** **46**
□ **8.7 Register of Gifts, Hospitality and Sponsorship** **46**

9. SIGNING AND SEALING DOCUMENTS **42**

□ **9.1 Register of Sealing** **42**
□ **9.2 Signature of Documents** **42**
□ **9.3 Custody of Seal** **42**

□ **10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS** **43**

□ **10.1 The Role of Internal Audit in Providing Independent Internal Assurance** **43**
□ **10.2 Reviewing the Performance of the Board** **44**
□ **10.3 External Assurance** **50**

□ **11. DEMONSTRATING ACCOUNTABILITY** **50**

□ **12. REVIEW OF STANDING ORDERS** **51**

Section A – Introduction

Statutory framework

i) Velindre University National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838),** as amended, "the Establishment Order".]

ii) The principal place of business of the Trust is –
Velindre University NHS Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff, CF15 7QZ

iii) All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions are set out in their Establishment Order, but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

xi) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven Health Boards in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) specialised services for –
  (i) cancer and blood disorders,
  (ii) cardiac conditions,
  (iii) mental health and vulnerable groups,

(iv) neurosciences, and
(v) women and children,

(b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
(c) emergency medical services,
(d) non-emergency patient transport services,
(e) emergency medical retrieval and transfer services,
(f) NHS 111 services,
(g) sexual assault referral centres, and
(h) other services as directed by the Welsh Ministers.

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Wales Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29))**, which make provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

xii) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

xiii) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

xiv) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xv) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xvi) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

xviii) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

xix) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and behaviours that are expected at all levels of the service, locally and nationally.

xx) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xxi) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of

Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxii) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Trust is considered a public body under the Act.

xxiii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

xxiv) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxv) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by Velindre National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

xxvi) NHS Trusts shall ensure that an official is designated to undertake the role of the Director of Corporate Governance (the role of which is set out in paragraph xxxvi) below).

xxvii) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as “the Board” or “Board members”; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SO 1.1.2 refers.

Applying Standing Orders

xxviii) The SOs of NHS Trusts (together with SFIs and GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

xxix) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Director of Corporate Governance as soon as they are aware of any circumstance that has not previously been reported.

xxx) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual’s dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxxi) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxii) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxiii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance

xxxiv) The role of the Director of Corporate Governance is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within NHS Trusts. The Director of Corporate Governance is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and behaviour framework; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the Director of Corporate Governance's role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal

responsibilities.

Further details on the role of the Director of Corporate Goverance within Velindre University NHS Trust, including details on how to contact them, is available from the Trust by contacting the Trust on 02920 196161 or visiting the Trust's public internet site.

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to:

(a) to own and manage Velindre Hospital, Velindre Road, Whitchurch, Cardiff CF4 7XL and associated hospitals and premises, and there to provide and manage hospital accommodation and services;

(b) to own and manage Welsh Blood Service Headquarters, Ely Valley Road, Talbot Green, Pontyclun CF72 9WB and associated premises, and there to provide and manage services relating to the collection, screening and processing of blood and its constituents and to the preparation and supply of blood, plasma and other blood products;

(c) services relating to prescribing and dispensing;

(d) to manage and provide Shared Services to the health service in Wales;

(e) to own or lease the premises associated with the provision of the services in paragraph (d), and

(f) to manage and administer the Wales Infected Blood Support Scheme in accordance with directions issued by the Welsh Ministers.

1.0.2 The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice-Chair, 6 non-executive directors and 6 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The

Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance, a medical or dental practitioner (to be known as the Medical Director), a registered nurse or registered midwife (to be known as the Nurse Director) and 2 others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

Non-executive directors [to be known as Independent Members]

1.1.7 A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

1.1.8 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement, no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term**.**]

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its standards of good governance and probity (in public service roles).
- Ensuring delivery of the organisation's aims and objectives through

effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing chair resumes their duties, or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the

appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty, the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other

Independent Members. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Trust shall delegate its Shared Services functions (that is, the provision and management of Shared Services to the health services in Wales) to the Shared Services Partnership Committee which they are required to establish and confer such functions on in accordance with the Shared Services Regulations.

Subject to Standing Order 2.2.2 the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may

periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees, they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;

- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, Trusts and Special Health Authorities setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Groups:

- Local Partnership Forum
- Advisory Consultants Appointment Committee

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Director of Corporate Governance, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (known as Llais)

6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales)**

Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of Llais to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly with Llais on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023 .

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.5 The Board shall ensure Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.6 The Board may determine that a designated Llais representative (s) shall be invited to attend Board meetings.

6.1.7 The Board shall ensure arrangements are in place for regular meetings between Trust officers and representatives of Llais.

6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through Llais.

7.2 Annual Plan of Board Business

7.2.1 The Director of Corporate Governance, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include

proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such

a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least **5 clear days** before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role

and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- On the Trust's website, as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *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*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and

relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Member, must be present to allow any formal business to take place at a Board meeting.]

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned, and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting, the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy or legislation such as the Freedom of Information Act 2000, etc.

8. STANDARDS OF GOOD GOVERNANCE AND PROBITY (IN PUBLIC SERVICE ROLES)

8.0.1 The Board must adopt a set of standards of good governance and probity for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These standards will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board is the Trust's Standards of Good Governance and Probity (in Public Service Roles) Policy (GC03) and will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy and their statutory duties under the Membership Regulations. Board members must notify the Chair and Director of Corporate Governance of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., GC03 the Standards of Good Governance and Probity (in Public Service Roles) Policy. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Director of Corporate Governance will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance must take reasonable steps to ensure that the citizens served by the Trust are made aware of and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Director of Corporate Governance, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy approved by the Audit Committee prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

[2] The term gift refers also to any reward or benefit.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;
- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and
- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition, gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with GC03 Standards of Good Governance and Probity (in Public Service Roles) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.7.5 The Director of Corporate Governance will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Director of Corporate Governance shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Director of Corporate Governance.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Director of Corporate Governance shall arrange for an appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

CONTENTS

- **Introduction 3**
- **Deciding What to Retain and What to Delegate: Guiding Principles 4**
- **Handling Arrangements for the Reservation and Delegation of Powers: Who Does What 5**
- **The Board 5**
- **The Chief Executive 5**
- **The Director of Corporate Governance 5**
- **The Audit and Risk Assurance Committee 5**
- **Individuals to Who Powers Have Been Delegated 6**
- **Scope of These Arrangements for the Reservation and Delegation of Powers 6**
- **Schedule of Matters Reserved to the Board 7**
- **Additional Areas of Responsibility Delegated to Chair, Vice Chair and Independent Members 14**
- **Delegation of Powers to Committees and Others 15**
- **Scheme of Delegation to Executive Directors, Other Directors and Officers 16**
- **Delegation of Budgetary Responsibility 21**
- **Financial Limits 22**
- **NHS Wales Shared Services Partnership Scheme of Delegation 23**
- **Losses and Compensation Limits 24**

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit and Risk Assurance Committee

The Audit and Risk Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's standards of good governance and probity (in public service roles) policy.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Director of Corporate Governance of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are detailed in Schedule 2.
3	FULL	GENERAL	Approve the Trusts Governance Framework.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit and Risk Assurance Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Standards of Good Governance and Probity (in Public Service Roles) Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.
21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
32	NO – Audit and Risk Assurance Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 of the Welsh Government Manual of Accounts specifies appropriate to delegate to a Committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers, but only up to the Trust limits in this Schedule 1 Model Scheme of Reservation and Delegation of Powers LOSSES & COMPENSATION LIMITS of the Standing Orders. For special payments relating to end of employment refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions
35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust's audit and assurance arrangements
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	VICE CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	CHAMPION/ NOMINATED LEAD		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. Independent Members will be identified as Champions/Leads for the following areas: • Armed Forces and Veterans • Digital • Hosted Organisations • Infection Prevention • Mental Health • Patient Information • Patient and Donor Engagement and Experience • Performance Framework • Research, Development and Innovation • Sustainable Development and Design • University Trust • Violence and Aggression • Vulnerability • Welsh Language

DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

The Board has delegated a range of its powers to the following Committees and others:

- Remuneration and Terms of Service Committee
- Audit and Risk Assurance Committee
- Quality, Safety and Experience Committee
- Performance and Finance Committee
- People, Culture and Engagement Committee
- Research, Development and Innovation Committee
- New Velindre Cancer Centre Committee
- Charitable Funds Committee
  - Charitable Funds Investment Performance Review Sub-Committee
- Advisory Consultants Appointment Committee (to be established for each consultant medical staff appointment as appropriate to the specialist nature of the post, in accordance with guidance from Welsh Government)
- NHS Wales Shared Services Partnership Committee (established as a direct result of Welsh Government regulations)
  - NHS Wales Shared Services Partnership Audit Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Directors	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	Directors	Yes	Authorisation matrix. Financial policies & procedures
Reimbursement of patient monies	Directors	Yes	Authorisation matrix. Financial policies & procedures
Management of Grant Agreements	Executive Director of Finance	No	Not Applicable.
Management of Legacy Income	Executive Director of Finance	No	Not Applicable.
Engagement of staff within funded establishment	Directors	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Chief Executive	Nominated deputy	In absence of Chief Executive
Staff re-grading and awarding of incremental points	Executive Director of Workforce & Organisational Development	Yes	Written authority to suitably qualified HR staff

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of overtime	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of leave without pay	Directors	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Reserved for Board Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Executive Director of Workforce & Organisational Development	No	
Approval of relocation costs	Executive Director of Workforce & Organisational Development	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • Directors • Other staff	Reserved for Board Directors / Divisional Directors	No	

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of redundancy, early retirement and ill-health retirement	Chief Executive	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Executive Director of Workforce & Organisational Development	Yes	Authorisation matrix. HR policies & procedures
Management of clinical and other operational capacity	Directors	Yes	Authorisation matrix. Annual Operating Framework and operational plans
Approval to procure goods and services within budget	Directors	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Chief Executive	Nominated deputy	In absence of Chief Executive
Approval to commission healthcare services from other NHS bodies	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from voluntary sector	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from private and independent providers	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval to amend the drugs formulary	Executive Medical Director	No	
Approval to prescribe drugs outside the formulary	Executive Medical Director	Yes	Prescribing policies & procedures
Authorisation of sponsorship	Chief Executive	No	Sponsorship policies & procedures
Approval of clinical trials	Executive Medical Director	Yes	Clinical policies & procedures
Approval of research projects	Chief Executive	Yes	Research policies & procedures
Management of complaints	Executive Director of Nursing, Allied Health Professionals & Health Sciences	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	Director of Corporate Governance	Yes	Communication policies & procedures
Investment of charitable funds	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval for use of charitable funds	Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose equipment	Directors	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Directors	No	Within authorised limits set by WG.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Small claims panel Director of Finance Chief Executive Approval by WG	 No No No No	
Approval of Clinical negligence and personal injury claims	Executive Director of Nursing, Allied Health Professionals & Health Sciences	Yes	Authorisation matrix and within limits set by WG.
Approval of staff tenancy agreements	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of capital expenditure	Chief Executive / Executive Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	Executive Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Chief Executive	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Executive Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Service Directors.
The calling down of new public dividend capital as identified in the Trust's External Financing Limit (EFL).	Executive Director of Finance	Yes	Further delegations subject to authorisation matrix. Financial policies and procedures.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Standing Financial Instructions detail the requirements for Budgetary Control, including:

- Budget Setting
- Budgetary Delegation
- Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Chief Executive will delegate the following Income and Expenditure budgetary responsibility:

- Velindre Cancer Centre budgets to Velindre Cancer Centre Divisional Director
- Welsh Blood Service budgets to Welsh Blood Service Divisional Director

In addition the Income and Expenditure budgetary responsibility for hosted organisations are delegated to the relevant Director/Senior Manager.

The Chief Executive and Divisional Directors will, in turn, delegate budgetary responsibility to other Directors and managers. The detailed schedule of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Executive Board as part of the annual Financial Strategy and Budget Setting process.

Within the budgetary delegation there are delegated powers of budget virement

- Budget virements between Divisions must be approved by the Chief Executive.
- Budget virements between budgets within the same Division must be approved by the Divisional Director.
- Budget virements between staff and non-staff within the same budget must be approved by the Budget Holder.
- These delegated powers of virement, from the Chief Executive to Divisional Directors and Budget Holders, assume that the Trust is achieving its financial targets and can be revised, in year, by the Chief Executive in the light of adverse financial performance.
- Budget virements within Divisions can be authorised by Divisional Director and Director of Finance up to the limit of £60,000.

FINANCIAL LIMITS

(All values exclude VAT)

Financial Limits	Band	Revenue £'000	Capital £'000	Charitable Funds £'000
Trust Board	N/A	No Limit	No Limit	0
Charitable Funds Committee	N/A	0	0	No Limit
Chief Executive	Exec Director	500	500	25
Executive Director of Finance	Exec Director	250	250	25
Deputy Chief Executive	Exec Director	150	150	5
Executive Director / Divisional Directors (VCS & WBS)	Exec / Director	100	100	5
Utility Bills (Assistant Director of Estates)	8c	80	0	0
Deputy Director	9 / 8d	40	40	0
Heads of Department	8c / 8b	20	20	0
Senior Managers	8b / 8a	10	10	0
Delegated Budget Holders	Various	5	0	0
Delegated Charitable Fund Holders	Various	0	0	5
For Pharmaceuticals: VCS Divisional Director VCS Director of Operations Chief Pharmacist	Various	150	0	0
Blood Wholesale Products: Chief Executive Executive Director of Finance WBS Divisional Director WBS Medical Director WBS Deputy Director Head of Transfusion Laboratory Services	Various	800	0	0
For Pharmaceutical Rebates Chief Executive	Exec Director	3,000	0	0

Further delegated financial limits which are **less than £500k** will be agreed by the Chief Executive and the Executive Management Board.

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF DELEGATION

Please refer to the Shared Services Partnership Committee Standing Orders contained within Schedule 5.

LOSSES & COMPENSATION LIMITS

NB All amounts are exclusive of VAT.	DELEGATED LIMITS							
	Trust Limit	Trust Board	Chief Executive	Director of Nursing	Director of Finance	Divisional Directors	Claims Manager / Q&S Manager	Small Claims Panel
	£	£	£	£	£	£	£	£
1. LOSSES OF CASH DUE TO:-								
a) Theft, Fraud etc.	50,000	50,000						
b) Overpayment of Salaries, Wages, Fees & Allowances	50,000	50,000						
c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. stamps due to fire (other than arson), accident and similar cause	50,000	50,000						
(2) FRUITLESS PAYMENTS (including abandoned capital schemes)	250,000	250,000						
(3) BAD DEBTS AND CLAIMS ABANDONED:-								
(a) Private Patients	50,000		50,000		10,000			
(b) Overseas Visitors	50,000		50,000		10,000			
(c) Causes other than a) – b)	50,000		50,000		10,000			
(4) DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE DUE TO:-								
(a) Culpable causes e.g. theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	50,000						
(b) Other causes	50,000	50,000						
(5) COMPENSATION PAYMENTS UNDER LEGAL OBLIGATION	FULL	FULL	100,000					
(6) EXTRA CONTRACTUAL PAYMENTS TO CONTRACTORS	50,000	50,000						
(7) EX GRATIA PAYMENTS:-								
(a) To patients and staff for loss of personal effects	50,000		50,000	50,000	10,000			1,000
(b) For Clinical Negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(c) For Personal Injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(d) Other clinical negligence and personal injury claims including Putting Things Right Arrangements - Concerns	50,000		50,000	50,000			5,000	
(e) Other[2], except cases of maladministration where there was no financial loss by the claimant	50,000		50,000	50,000				
(f) Maladministration where no financial loss by claimant	Nil							
(g) Patient referrals outside UK and EEA guidelines	Nil							
(8) EXTRA STATUTORY AND EXTRA REGULATIONARY	Nil							

[2] Refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Trust framework

The Trust's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Standards of Good Governance and Probity (in Public Service Roles) Policy***
- ***Board Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by the Trust intranet site or from the Director of Corporate Governance.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Good Governance and Probity (in Public Service Roles) Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

FOREWORD

1. INTRODUCTION
1.1 General
1.2 Overriding Standing Financial Instructions
1.3 Financial provisions and obligations of NHS Trusts

2. RESPONSIBILITIES AND DELEGATION
2.1 The Board
2.2 The Chief Executive and Director of Finance
2.3 The Director of Finance
2.4 Board members and Trust officers, and Trust Committees
2.5 Contractors and their employees

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT
3.1 Audit and Risk Assurance Committee
3.2 Chief Executive
3.3 Internal Audit
3.4 External Audit
3.5 Fraud and Corruption
3.6 Security Management

4. FINANCIAL DUTIES
4.1 Legislation and Directions
4.2 First Financial Duty – The Breakeven Duty
4.3 Second Financial Duty – The Planning Duty

5 FINANCIAL MANAGEMENT AND BUDGETARY CONTROL
5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Financial Management, Reporting and Budgetary Control
5.4 Capital Financial Management, Reporting and Budgetary Control
5.5 Reporting to Welsh Government - Monitoring Returns

6. ANNUAL ACCOUNTS AND REPORTS

7. BANKING ARRANGEMENTS
7.1 General
7.2 Bank Accounts
7.3 Banking Procedures
7.4 Review

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS
8.1 General
8.2 Petty Cash

9. INCOME, FEES AND CHARGES
9.1 Income Generation
9.2 Income Systems
9.3 Fees and Charges
9.4 Income Due and Debt Recovery

10. NON-PAY EXPENDITURE
10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability
10.2 The Director of Finance's responsibilities
10.3 Duties of Budget Holders and Managers
10.4 Departures from SFI's
10.5 Accounts Payable
10.6 Prepayments

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES
11.1 Procurement Services
11.2 Policies and Procedures
11.3 Legislation Governing Public Procurement
11.4 Procurement Principles and Objectives
11.5 Procurement Procedures
11.6 Notification to Welsh Government and Consent from the Welsh Ministers
11.7 Sustainable Procurement
11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.9 Planning Procurements
11.10 Procurement Process
11.11 Procurement Thresholds
11.12 Designing Competitions
11.13 Single Quotation Application (SQA) or Single Tender Application (STA) – 'Goods and Non-Health Services Only'
11.14 Disposals – 'Goods and Non-Health Services Only'
11.15 Evaluation, Approval and Award
11.16 Contract Management
11.17 Extending and Varying Contracts
11.18 Requisitioning
11.19 No Purchase Order, No Pay
11.20 Official orders

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES
12.1 Health Care Agreements
12.2 Statutory provisions
12.3 Reports to Board on Health Care Agreements (HCAs)

13. GRANT FUNDING
13.1 Legal Advice
13.2 Policies and procedures
13.3 Corporate Principles underpinning Grants Management
13.4 Grant Procedures

14. PAY EXPENDITURE
141 Remuneration and Terms of Service Committee
14.2 Funded Establishment
14.3 Staff Appointments
14.4 Pay Rates and Terms and Conditions
14.5 Payroll
14.6 Contracts of Employment

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS
15.1 Capital Plan
15.2 Capital Investment Decisions
15.3 Capital Projects
15.4 Capital Procedures and Responsibilities
15.5 Capital Financing with the Private Sector

15.6 Asset Registers
15.7 Security of Assets

16. STORES AND RECEIPT OF GOODS
16.1 General position
16.2 Control of Stores, Stocktaking, condemnations and disposal
16.3 Goods supplied by an NHS supplies agency

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS
17.1 Disposals and Condemnations
17.2 Losses and Special Payments

18. DIGITAL, DATA and TECHNOLOGY
18.1 Digital Data and Technology Strategy
18.2 Responsibilities and duties of the responsible Director
18.3 Responsibilities and duties of the Director of Finance
18.4 Contracts for data and digital services with other health bodies or outside agencies
18.5 Risk assurance

19. PATIENTS' PROPERTY
19.1 NHS Trust Responsibility
19.2 Responsibilities of the Chief Executive
19.3 Responsibilities of the Director of Finance

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)
20.1 Corporate Trustee
20.2 Accountability to Charity Commission and the Welsh Ministers
20.3 Applicability of Standing Financial Instructions to funds held on Trust

21. RETENTION OF RECORDS
21.1 Responsibilities of the Chief Executive

SCHEDULE 1: General Consent to Enter Individual Contracts

APPENDIX 1: Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors

Velindre University NHS Trust

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **Velindre University National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any

time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit and Risk Assurance Committee

3.1.1 An independent Audit and Risk Assurance Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit and Risk Assurance Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit and Risk Assurance Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit and Risk Assurance Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook. nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust.

The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from

the audit of the financial statements and use of resources work

- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the

mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Director of Finance of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,

- establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board

approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment

budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed

appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports

As a minimum the reports will cover:
- Current and forecast year end position on statutory financial duties
- Actual income and expenditure to date compared to budget and showing trends and run rates
- Forecast year end positions
- A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
- Explanations of material variances from plan
- Capital expenditure and projected outturn against plan
- Investigations and reporting of variances from financial, activity and workforce budgets.
- Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- Statement of performance against savings targets
- Key workforce and other cost drivers
- Income and expenditure run rates, historic trends, extrapolation and explanations
- Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans

and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully

understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of

payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations

(competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Director of Finance and Board

Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING

Any instruction or summary of legislation in this chapter of the Trust's SFIs is neither legal advice nor statutory guidance, is not intended to be exhaustive, nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the Trust. The law is subject to constant change and the Trust should seek its own legal advice as appropriate as well as consult with NHS Wales Shared Services Partnership (NWSSP) Procurement Services.

In the event of any conflict between what is contained in legislation and the Trust's SFIs, the former shall prevail.

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement, the service is delivered by NHS Wales Shared Services Partnership (NWSSP) Procurement Services ("**Procurement Services**").

11.1.2 Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term 'procurement staff' or 'department' is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of Procurement Services, e.g.; 'Pharmacy' and 'Works', who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the Trust maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised), and the Revised General Consent to enter Individual Contracts [included as Schedule 1 of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP's Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures are:

- kept up to date;
- conform to statutory requirements and regulations;
- adhere to guidance issued by the Welsh Ministers; and
- are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, , the Procurement Act 2023 and associated subordinate instruments (together "**the 2023 Act**") and the Health Services (Provider Selection Regime) (Wales) Regulations 2025 and associated subordinate instruments (together "**the PSR Wales Regulations**") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("**In-Scope Health Services**") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("**Goods and Non-Health Services**") fall within the scope of the 2023 Act.

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words **'In-Scope Health Services Only'** will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the 2023 Act, the words **'Goods and Non-Health Services Only'** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability. Any instruction or summary of legislation in the Trust's SFIs is

neither legal advice nor statutory guidance, is not intended to be exhaustive nor an authoritative statement of the law, nor is it intended to override existing legal obligations applicable to the Trust. The law is subject to constant change and the Trust should seek its own legal advice as appropriate.

11.3.3 **'Goods and Non-Health Services Only'** The 2023 Act governs the procurement of Goods and Non-Health Services. The Welsh Government's Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs. **In the event of any conflict between what is contained in the 2023 Act and the Trust's SFIs, the former shall prevail.**

11.3.4 **'In Scope Health Services Only'** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the Trust to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the Trust's SFIs, the former shall prevail.**

11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices and all associated subordinate instruments are the model upon which all procurement exercises should be based.

11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust's and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:

- Social Partnership and Public Procurement (Wales) Act 2023
- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Procurement Policy Framework, including:
    - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
    - The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

11.4.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:

- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
- Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 'In Scope Health Services Only' The legal and governing principles guiding procurement of In-Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the Trust doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government's Health service procurement: statutory guidance; and
- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the Trust is compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers' guidance and policy, the Trust shall, through Procurement Services, ensure that it shall have procedures that set out:

a) requirements for, and exceptions to, formal competitive tendering (**'Goods and Non-Health Services Only'**);
b) tendering processes including post tender discussions;
c) requirements and exceptions to obtaining quotations (**'Goods and Non- Health Services Only')**;
d) evaluation and scoring methodologies; and
e) approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirement and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the Trust to comply with Standing Orders, SFIs or to obtain any other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy and in support of social, environmental, economic and cultural goals in Wales, the Trust must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible and within the legislative framework. The principles of the Well-being of Future Generations (Wales) Act 2015 ("**the WBFG Act 2015**") should be adopted at the earliest stage of procurement planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a shared purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well- being of Wales.

11.7.3 The seven well-being goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a "sustainable development principle" which tells relevant public bodies how to go about meeting

their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies;
- The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- The importance of balancing short-term needs with the need to safeguard the long-term needs; and
- How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of actions designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The Trust shall make use of the tools developed by Welsh Government Commercial Delivery team in implementing the principles of the WBFG Act 2015. The Trust shall benchmark its performance against the WBFG Act 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, Trust's are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in the current and subsequent versions of the WPPS, the Trust shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders, depending on the value, risk and complexity of the procurement). The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost;
- the likely 'route to market' which will consider the legislative and policy framework set out above;
- the availability of funding to be able to award a contract following a successful procurement process; and
- that the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- equal partners through co-production;
- care for those with the greatest health need first;
- do only what is needed; and
- reduce inappropriate variation.

For **'Goods and Non-Health Services Only'** Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For **'In Scope Health Services Only'** Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the Trust, Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the Trust should be submitted by the Board Secretary to the Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance department, and the opinions of Procurement Services and NWSSP Legal and Risk prior to external opinion being sought, where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trusts's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government Commercial Delivery team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by public sector bodies outside of Wales.

11.10.2 'Goods and Non-Health Services Only' - In the absence of an existing suitable procurement framework to source the required item, a competition must be operated in accordance with the table below. The Trust must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other NHS Wales organisations:

TABLE 'Goods and Non-Health Services Only'

Goods/Services/Works Whole Life Cost Contract value **(figures excl. VAT)**	**Minimum competition** (1)	**Form of Contract**
Below £5,000	Evidence of value for money has been	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase
£25,000 plus to the prevailing Procurement Act 2023 threshold (2)	Advertised open call for competition. Minimum of 4 tenders received if	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route	Formal contract and Purchase Order
Contracts above £1 million	Welsh Government notification required	Formal contract and Purchase

(1) Subject to the existence of suitable suppliers
(2) The Procurement Act 2023 - Schedule 1 – threshold amounts
(3) In accordance with the requirements set out in Schedule 1.

11.10.3 **'In Scope Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, Trusts are required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the health service procurement: statutory guidance. Trusts should note that one of the key objectives of these regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for Trusts to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 **'Goods and Non-Health Services Only'** The Trust must consider the minimum thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in Schedule 1 of the 2023 Act.

11.11.2 **'Goods and Non-Health Services Only'** Advice from the Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).

11.11.3 **'Goods and Non-Health Services Only'** The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 **'Goods and Non-Health Services Only'** Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000 (excluding VAT), must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.

11.11.5 **'In Scope Health Services Only'** There is no minimum threshold for application of the PSR Wales Regulations.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- required timescales are achievable.
- specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities. **'Goods and Non-Health Services Only',** under the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI's) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to 'light touch regime' contracts).

11.12.3 **'Goods and Non-Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the "Most Advantageous Tender", which provides contracting authorities with greater flexibility to take into account wider social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life costs, including (where appropriate) the cost of change and / or end of life costs.

11.12.4 **'In-Scope Health Services Only'** Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:

- Key Criteria (regulation 6);
- Basic Selection Criteria (regulation 22); and
- Exclusions (regulations 25 and 26)

Trusts are required to ensure the appropriate criteria is set with regards the selected procurement process, as set out under the PSR Wales Regulations and Health service procurement: statutory guidance".

11.13 Single Quotation Application (SQA) or Single Tender Application (STA) - 'Goods and Non-Health Services Only'

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded

from open competition);
- a technical compatibility issue which needs to be met e.g., specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- when joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;
- an acceptable level of assurance is available before presentation for approval in line with the Trust's Scheme of Delegation; and
- an "or equivalent" test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA or STA are only used in exceptional circumstances the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of

Procurement Services to prevent repeated inappropriate use of SQA or STA by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the Trust to attend Audit Committee;
- escalate to the Board;
- request an internal Audit Review;
- request further training; or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. The Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, Procurement Services will retain a central register of all such activity including SQA/STA's not endorsed by Procurement Services or any exceptional matters.

11.14 Disposals - 'Goods and Non-Health Services Only'

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g., Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a

competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- retaining accurate records;
- monitoring contract performance measures;
- engaging suppliers to ensure performance delivery;
- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by Procurement Services.

11.16.3 Advice on Contract Management best practice is available from Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 'Goods and Non-Health Services Only'

11.17.1.1 Extending, modifying, or varying the scope of an existing contract is possible, if the provision to do so

was included as an option in the original awarded contract, e.g., scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.1.2 If there is no such provision, the 2023 Act defines such limitations. Further information on contract modifications can be found in sections 74-77 of the 2023 Act and in Guidance: Contract Modifications.

11.17.2 'In-Scope Health Services Only'

11.17.2.1 Modification of the scope of an existing contract is possible if the modification is clearly and unambiguously provided for in the original contract or framework agreement documents, or the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.

11.17.2.2 If provisions set out in 1 .17.2.1 are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:

- solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
- made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or
- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the Trust budget holder and the Trust's Head of Procurement. Budget

holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.5 This ensures an appropriate identification and assessment of potential risks to the Trust's compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.6 The budget holder must seek advice from Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods (**'Goods and Non-Health Services Only'**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those managed by Welsh Government Commercial Delivery team, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the Procurement Services to undertake quotation / tendering exercises (**'Goods and Non-Health Services Only'**) on their behalf in line with SFI 11.11 thresholds (**'Goods and Non-Health Services Only'**).

11.18.3 All orders for goods (**'Goods and Non-Health Services Only'**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All-Wales policy which was introduced to ensure that Procure to Pay continues to provide high-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes.

13.4.1 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.3 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.6 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds

specified by Welsh Government and in the Trust's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the Trust's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment

projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable,

stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Director

of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with

Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments. Refer to **Appendix 1** – Annex 5 to Chapter 6 of the Manual for Accounts –

Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors dated 24th May 2022).

17.2.15 **Appendix 1** of these SFI's details the Welsh Government approval requirements from an accounting perspective for individual end of employment payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and

IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken

and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as "General Consent to enter individual contracts" replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI's) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

"(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—
- *(a) acquire and dispose of property,*
- *(b) enter into contracts,*
- *(c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).*

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case)."

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 ("**the Investment Guidance**") includes the following in relation to Local Health Boards:

"Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular

WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements."

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC's mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

"Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above."

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;
- All eligible LHB and HEIW and DHCW contracts >£1m in total to be

submitted to the Director General HSCEY for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;

ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;

iii) Out of Hours contracts;

iv) All NHS contracts; that is where one health services body contracts with another health service body;

(v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and

(vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).

a) Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.

b) Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini- competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors

Y Grwp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Workforce and OD Directors
Assistant Workforce Directors

24th May 2022

Dear All

I wanted to take this opportunity to write to you again to remind you of Andrew Goodall's Governance in Recruitment letter dated 25 June 2021 which is attached in the covering email.

As well as a reminder of the Goverance in Recruitment principles I thought it would be helpful to set out the circumstances in which Welsh Government approval is required from an accounting perspective for individual end of employment payments. These are set out in the NHS Wales Manual for Accounts under the Losses and Special Payments chapter but in summary these are:

Contractual Redundancy – organisations have delegated authority from a financial accounting perspective to pay contractual entitlements so Welsh Government approval is not needed. However, for Executive Directors, Welsh Government do need to be aware before any such contractual arrangements are signed off with the individual and approved by Judith Paget as Accounting Officer.

Voluntary Early Release Scheme (VERS) – organisations have delegated authority for payments up to £50,000 as set out on the VERS Model Scheme rule. Payment over this level require Welsh Government Accounting Officer approval, and there is a template Business Case to submit to Welsh Government for approval. Both documents are attached in the covering email.

Ex gratia / Settlement payment – any payment amount above contractual entitlement requires Welsh Government approval. Given that cases will be based on individual circumstances there is no set template, however we have developed a spreadsheet with options to demonstrate that the course of action is cost effective and demonstrates value for public sector money, as any such payments should only be exceptional. The Losses and Special payment chapter also outlines the principles to follow and the checklist that must be

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

completed and signed off. The team and I would be happy to talk through any such cases and provide advice.

In all of the above scenarios your Renumeration and Terms and Conditions Committee provide an essential role and must sign off the payment before coming to Welsh Government for final approval. It is also worth noting that whilst myself and the team will take action on any approvals as soon as possible, please do bear in mind that advice needs to be prepared for Judith (and in some novel or contentious cases further internal governance sign off) and this does take time and resource availability so providing us with as much notice as possible would be appreciated.

As always if you have any questions regarding such payments, please do speak to me or my team.

Yours sincerely

Helen Arthur
Director of Workforce and Corporate Business
Cyfarwyddwr y Gweithlu a Busnes Corfforaethol

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

CONTENTS

Consolidated Committee Terms of Reference

Contents

People, Culture and Engagement Committee.....3
Quality, Safety and Experience Committee.....8
Performance and Finance Committee 14
Audit and Risk Assurance Committee.....21
Research, Development and Innovation Committee.....28
New Velindre Cancer Centre Committee 32
Remuneration and Terms of Service Committee.....36
Charity Trustee Meeting
Charitable Funds Committee
Charitable Funds Investment Performance Review Sub-Committee
APPENDIX 1 45
APPENDIX 2 51

People, Culture and Engagement Committee
Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the People, Culture and Engagement Committee (the Committee or PCEC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of excellence, openness, inclusion, continuous improvement, and collective leadership.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

purpose of the People, Culture and Engagement Committee (PCEC) is to support the Board by providing strategic oversight and assurance in relation to the Trust's people agenda, organisational culture, engagement, leadership, and organisational development.

The Committee will provide assurance that effective strategies, systems and organisational arrangements are in place to enable a compassionate, inclusive and high performing organisation that reflects the Trust's values and behaviours, engages effectively with staff and stakeholders, and supports the delivery of safe, high quality and person-centred services. The Committee will also ensure that strategic and operational workforce, culture and engagement priorities support delivery of the Trust's objectives, the quality and safety of healthcare, and a positive working environment.

In doing so, the Committee will oversee delivery of relevant strategic priorities, enabling strategies and associated elements of the Integrated Medium-Term Plan (IMTP), providing assurance that these are implemented effectively and deliver the intended organisational outcomes. The Committee will maintain oversight of workforce, culture and engagement performance, risks, portfolio activity and planning arrangements within its remit, ensuring that significant issues, risks, opportunities and interdependencies are identified, monitored and escalated appropriately.

The Committee will not manage operational delivery or assume executive responsibility for services.

In forming its judgement, the Committee will consider whether assurance is reliable,

complete, timely and demonstrates impact on outcomes, risk reduction or improvement.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Workforce strategy, planning, and sustainability

The Committee will:

- Oversee the development and implementation of workforce strategy and provide assurance that workforce priorities and plans support delivery of organisational priorities, the IMTP and service requirements.
- Oversee workforce sustainability, capability, and capacity across the organisation, ensuring the Trust is appropriately positioned to meet current and future service requirements.
- Oversee workforce intelligence, horizon scanning and strategic workforce insight to identify emerging workforce risks, opportunities and external developments that may impact delivery of the Trust's strategic objectives, IMTP priorities and long-term ambitions, informing future workforce priorities and strategic workforce planning.
- Oversee the development of an integrated workforce performance dashboard to inform Board oversight, planning and decision-making.
- Receive assurance on workforce related delivery risks and the implementation and outcomes of relevant Portfolio initiatives.
- Consider workforce implications arising from service transformation, strategic programmes, and organisational change.
- Maintain oversight of workforce supply, recruitment, retention, vacancy management, succession, and workforce productivity and workforce performance.
- Oversee arrangements to ensure the Trust’s values and associated behaviours are embedded and consistently demonstrated in practice across leadership, culture, workforce experience, and organisational delivery.

3.2. Culture and organisational experience

The Committee will:

- Provide oversight of organisational culture and seek assurance that the Trust promotes behaviours, leadership practices and ways of working that are consistent with its values and support a compassionate, inclusive, and high performing organisational culture.
- Oversee arrangements to support a compassionate, inclusive, and psychologically safe environment for staff.
- Receive assurance regarding staff wellbeing, experience, and engagement.
- Review organisational insight and thematic intelligence including staff stories, staff survey findings, engagement feedback, speaking up intelligence, workforce equality indicators, wellbeing measures, and workforce experience information.
- Seek assurance that learning arising from feedback and engagement activity is acted upon and embedded.

- Maintain oversight of Speaking Up Safely arrangements and psychological safety.
- Seek assurance that bullying, harassment, discrimination, and unacceptable behaviours are identified and addressed appropriately.

3.3. Engagement, Communications and Community Involvement

The Committee will:

- Provide strategic oversight of the Trust's approach to engagement and communications with external stakeholders and staff, ensuring that arrangements support openness, transparency, and effective dialogue with all stakeholders.
- Seek assurance that staff and external stakeholder communications and engagement activity is aligned to the Trust's strategic vision, objectives, values, organisational priorities, and organisational narrative.
- Seek assurance that communications activity supports a coherent organisational narrative and promotes understanding of the Trust's purpose, priorities and contribution across services and stakeholders.
- Seek assurance that all engagement and communications activity support delivery of the Trust's stakeholder strategy and contributes to organisational learning, improvement, and achievement of the Trust's organisational objectives.
- Monitor the effectiveness of staff and external stakeholder engagement and communications strategies, plans and delivery mechanisms, including how insight and feedback are captured, analysed, acted upon, and communicated back to stakeholders.
- Seek assurance that the Trust maintains constructive relationships with key external stakeholders, partners, and staff and that engagement activity supports trust, confidence, and collaboration.
- Receive assurance that engagement and communications activity reflect relevant statutory duties and organisational commitments, including equality, Welsh language, involvement, and social partnership requirements where applicable.

3.4. Leadership, learning, and organisational development

The Committee will:

- Oversee arrangements to strengthen leadership capability and organisational effectiveness.
- Seek assurance regarding leadership development, talent management, and succession planning.
- Maintain oversight of organisational development priorities and programmes.
- Monitor arrangements relating to education, learning, professional development, and continuous improvement.
- Seek assurance regarding statutory and mandatory training arrangements.
- Maintain oversight of appraisal, professional registration, and revalidation arrangements.
- Seek assurance that the Trust supports a culture of continuous learning and

improvement.

3.5. Equity, equality, diversity, and inclusion

The Committee will:

- Provide strategic oversight of equity, equality, diversity, inclusion, and human rights, helping shape the Trust's ambitions and priorities in these areas and ensuring these principles are embedded within its culture, leadership, engagement and organisational priorities.
- Review and monitor progress against relevant equality objectives, standards, and associated improvement plans, seeking assurance that actions are delivering meaningful and measurable outcomes and improvements.
- Seek assurance that inclusive leadership and equitable workforce practices are embedded across the organisation, supporting a culture in which people feel valued, respected, and able to contribute.
- Review workforce equality information, lived experience, staff feedback and other relevant intelligence to identify disparities, barriers, and opportunities for improvement.

3.6. Workforce governance, partnerships, and employee relations.

The Committee will:

- Provide oversight of workforce governance arrangements and professional standards.
- Seek assurance regarding compliance with workforce policies, professional obligations, and safeguarding responsibilities.
- Maintain oversight of arrangements relating to professional conduct, registration, and associated workforce governance requirements.
- Oversee strategic workforce partnerships with education providers, external organisations, and system partners in support of workforce sustainability, workforce development, and organisational capability.
- Seek assurance that workforce governance arrangements support safe, effective and high-quality services.
- Oversee employee relations arrangements, including partnership working with Trade Unions, collective engagement mechanisms, and approaches to promoting constructive employment relations and effective resolution of workforce matters.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
    - One Independent Member appointed as Chair
    - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the Quality, Safety and Experience Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Director of Organisational Development and Workforce is mandatory, and their Deputy should attend in exceptional circumstances such as annual leave, sickness, or other leave.

- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
    - Executive Director of Nursing, Allied Health Professionals and Health Science
    - Executive Medical Director
    - Executive Director of Finance
    - Chief Operating Officer
    - Director of Corporate Governance
    - Assistant Director of Communications and Engagement

- It is expected that the Director of Strategy, Planning and Performance; and Director of Place, Portfolio and Partnerships will attend additional parts of the meeting to support any analysis relating to IMTPs or Portfolios, respectively.

- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, Employee Relations representatives, and other Trust staff or external advisers as required by the Chair.
- Trade Union representatives will be invited to attend a minimum of two Committee meetings each year to support partnership working and provide workforce insight and engagement.

6. FREQUENCY

- Meetings will be held bi-monthly.
- Additional meetings may be convened by the Chair where urgent workforce, culture or organisational concerns require consideration.

Quality, Safety and Experience Committee
Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Quality, Safety and Experience Committee (the Committee or QSEC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of quality, safety, continuous improvement, learning and person-centred care.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of the Quality, Safety and Experience Committee (QSEC) is to support the Board by providing strategic oversight and assurance in relation to quality, safety, clinical effectiveness, patient, donor and service user experience, quality governance and continuous improvement across the Trust.

The Committee will provide evidence-based assurance that effective leadership, systems, processes, controls and governance arrangements are in place and operating effectively to support the delivery of safe, person-centred services, compliance with quality standards, continuous improvement, organisational learning and reduction of unwarranted variation.

In doing so, the Committee will oversee delivery of relevant quality priorities and associated elements of the Integrated Medium-Term Plan (IMTP), providing assurance that risks, concerns, learning and opportunities relating to quality, safety, experience and clinical outcomes are appropriately identified, monitored and addressed.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Quality Strategy, Governance and Improvement

The Committee will apply a structured assurance framework, and will:

- Seek assurance that quality governance arrangements support effective oversight, escalation and organisational learning.
- Undertake triangulation of quantitative, qualitative and intelligence-based information across domains such as patient, donor and service user safety, workforce, culture and professional standards to support high quality care,

and compliance with statutory requirements.
- Seek assurance that quality priorities, quality plans and delivery arrangements support organisational objectives, the IMTP and service requirements.
- Consider the quality implications of major service changes, pathway redesign, transformation programmes and organisational change.
- Seek assurance that robust quality impact assessment arrangements are in place for service redesign, transformation programmes, operational change and IMTP delivery.
- Maintain oversight of the Trust's Quality Management System and quality improvement arrangements.
- Review progress against quality priorities, improvement programmes and the Annual Quality Statement.
- Seek assurance that the Trust promotes a culture of continuous learning, improvement, openness and safety.
- Seek assurance that the Trust complies with the Duty of Quality and organisational quality governance requirements.

3.2 Patient, Donor and Service User Safety

The Committee will:

- Oversee arrangements to support patient, donor and service user safety and safeguarding.
- Seek assurance regarding compliance with patient, donor and service user safety requirements, Putting Things Right arrangements and relevant national guidance.
- Seek assurance that the Trust complies with the Duty of Candour, including openness, timely disclosure and learning.
- Review themes and trends arising from incidents, patient, donor and service user safety investigations, complaints, claims, inquests and serious events and seek assurance that reviews result in sustainable improvement.
- Ensure that safety systems support early identification and escalation of deteriorating risk trends.
- Maintain oversight of infection prevention and control arrangements.
- Receive assurance regarding medicines safety, medicines optimisation and high-risk therapies.
- Seek assurance that arrangements support the reduction of avoidable harm and continuous improvement in patient, donor and service user safety outcomes.
- Seek assurance that workforce capacity, capability, wellbeing and staffing arrangements support the safe, effective and sustainable delivery of high-quality care, recognising the relationship between workforce experience, organisational culture, patient safety and clinical outcomes, and drawing assurance from the People, Culture and Engagement Committee (PCEC) where appropriate.

3.3 Clinical Effectiveness and Outcomes

The Committee will:

- Oversee arrangements supporting clinical effectiveness and positive patient, donor and service user outcomes, ensuring improvement actions demonstrate measurable impact.
- Seek assurance regarding compliance with evidence-based standards, clinical guidelines and national requirements.
- Maintain oversight of clinical audit, quality improvement and clinical outcomes reporting.
- Review mortality, avoidable harm and learning from deaths arrangements where applicable.
- Maintain oversight of specialist standards, accreditations and peer review arrangements relevant to the Trust's services.
- Review benchmarking information and comparative data to identify opportunities for improvement.
- Review variation in clinical outcomes, performance and practice and seek assurance that unwarranted variation is identified, understood and addressed.

3.4 Patient, Donor and Service User Experience

The Committee will:

- Oversee implementation of strategy and arrangements supporting patient, donor, service user and community involvement and experience.
- Review themes and trends arising from feedback, complaints, concerns, surveys, engagement activity and patient, donor or service user stories.
- Receive assurance that the voice and lived experience of patients, donors, service users and communities informs continuous quality improvement and service development.
- Ensure that patient, donor, service user and community voice is systematically incorporated into assurance, decision-making and prioritisation.
- Seek assurance that experience data is used alongside safety and outcome data to inform triangulated assurance.
- Work with system partners to maintain oversight of patient, donor and service user experience across complex and long-term pathways.
- Seek assurance regarding end-of-life care experience.

3.5 Quality Intelligence, Assurance and Organisational Learning

The Committee will:

- Receive integrated quality intelligence and assurance drawn from national quality measures, the National Quality Management System, patient, donor and service user feedback, benchmarking information and external assurance activity.
- Ensure integration of quality, safety, experience, workforce and operational intelligence to form a whole-system view.
- Review quality indicators and quality metrics within the Integrated Performance Report.

- Undertake triangulation across quality, safety, experience, outcomes and assurance information to identify themes, trends, risks, opportunities and areas of unwarranted variation requiring action.
- Review findings arising from Internal Audit, External Audit and other assurance activity relevant to its remit.
- Seek assurance that recommendations arising from reviews, inspections and investigations are implemented effectively and learning embedded.
- Maintain oversight of high-risk and new innovative clinical pathways where quality, safety, experience or outcomes may be affected.
- Review quality trajectories and seek assurance where performance falls outside agreed standards, expectations or trajectories.

3.6 External Assurance, Regulation and Accreditation

The Committee will:

- Receive relevant national reports and Executive assurance regarding the Trust's response, implementation arrangements and progress against any associated recommendations.
- Receive all reports relating to WBS and VCC with regards to external assurance, regulation and accreditation and seek assurance that action plans are implemented, monitored and evaluated.
- Seek assurance that regulatory findings are translated into sustained continuous improvement and embedded learning across the organisation.
- Maintain oversight of compliance with relevant quality, safety and specialist service standards.
- Receive assurance on matters relating to Healthcare Inspectorate Wales, Llais, the Human Tissue Authority and other relevant bodies where applicable.
- Review significant concerns, findings or recommendations arising from Healthcare Inspectorate Wales, Audit Wales, regulators, inspectors, peer reviews, accreditation bodies and external reviews.

3.7 Digital Services, Transformation and Information Governance

The Committee will:

- Ensure digital risks are considered in the context of patient, donor and service user safety, clinical risk and service reliability.
- Oversee digital services, transformation programmes and digital governance arrangements within the remit of patient, donor and service user safety, clinical risk and service reliability.
- Seek assurance that digital systems and technologies support safe, effective and person-centred care.
- Maintain oversight of digital clinical safety arrangements and risks associated with clinical systems and digital pathways.
- Seek assurance that data supporting quality, safety, experience and clinical outcomes reporting is accurate, complete and timely.
- Receive assurance regarding information governance matters where these directly affect patient, donor and service user safety, clinical quality, confidentiality or patient, donor and service user experience.

- Sign off the annual Information Governance self-assessment and seek assurance on areas requiring improvement.
- Seek assurance regarding digital maturity, digital capability and the effectiveness of digital systems supporting Trust services.
- Review quality, safety and experience implications arising from digital transformation initiatives.
- Work collaboratively with the Performance and Finance Committee (PFC) to ensure digital investment, business cases and transformation priorities are considered alongside quality, safety, clinical risk and service delivery implications.

3.8 Research, Development and Innovation

The Committee will:

- Seek assurance regarding the quality, safety and governance implications of research, development and innovation activities to support safe effective and continuously improving services.
- Consider significant risks, concerns or learning arising from research and innovation activities that fall within the Committee's remit.
- Seek assurance that research and innovation activities support safe, effective and continuously improving services and are aligned with clinical governance and quality assurance frameworks.
- Work collaboratively with the Research, Development and Innovation Committee (RD&IC) to ensure appropriate oversight of the quality, safety and governance implications of research and innovation activities, referring significant quality, safety or clinical governance matters between Committees where appropriate.

4. MEMBERSHIP

Membership should collectively provide skills and expertise to support effective assurance, challenge and scrutiny and shall comprise:

A minimum of three Independent Members of the Board, including:

  - One Independent Member appointed as Chair
  - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Medical Director and the Executive Director of Nursing, AHPs and Health Science is mandatory. Where one of these Executive Directors is unable to attend due to annual leave, sickness or other absence, their nominated Deputy should attend in their place. Attendance by Deputies in place of both Executive Directors should be exceptional and agreed with the Committee Chair.

- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
    - Executive Director of Organisational Development and Workforce
    - Executive Director of Finance
    - Chief Operating Officer
    - Chief Digital Officer
- It is expected that the Director of Strategy, Planning and Performance; and Director of Place, Portfolio and Partnerships will attend additional parts of the meeting to support any analysis relating to IMTPs or Portfolios, respectively.
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, and other Trust staff or external advisers as required by the Chair.
- Patient, donor and service user representation in full or in part as required to support the effective conduct of business and consideration of agenda items.

6. FREQUENCY

- Meetings will be held bi-monthly.
- Additional meetings may be convened by the Chair where significant quality, safety, experience, clinical governance or regulatory matters require consideration.

Performance and Finance Committee
Terms of Reference

1. INTRODUCTION

In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a Committee to be known as the Performance and Finance Committee (referred to as the Committee or PFC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will support the effective stewardship of resources, delivery of organisational priorities and achievement of sustainable outcomes for patients, donors, service users and communities.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3 while common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of the Performance and Finance Committee (PFC) is to support the Board by providing strategic oversight and assurance in relation to operational performance, financial sustainability, strategic planning, and the effective use of resources.

The Committee will provide evidence-based assurance that effective systems, processes and controls are in place to support delivery of the Trust's strategic objectives, Integrated Medium-Term Plan (IMTP), operational priorities and transformation programmes. In doing so, it will oversee delivery against agreed operational, financial and planning objectives, ensuring alignment between organisational priorities, service delivery, financial sustainability and long-term organisational goals.

The Committee will oversee arrangements supporting operational delivery, financial stewardship, strategic planning, and organisational resilience. It will seek assurance that risks, concerns and opportunities relating to operational performance, finance, planning and delivery are appropriately identified, monitored and addressed, and that recovery and improvement actions are implemented where performance or financial sustainability fall outside agreed expectations or trajectories.

The Committee will also provide assurance that planning arrangements support coordinated delivery of organisational objectives, maintain alignment between operational, financial, workforce and quality priorities, and enable effective management of interdependencies, risks and benefits across the Trust.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Operational Performance and Delivery

The Committee will:

- Maintain oversight of operational performance and organisational delivery arrangements across the Trust with particular focus on areas presenting the greatest risk to the achievement of the Trust's strategic objectives.
- Review performance against key national, regional, local and internal operational targets, trajectories and priorities within the Committee's remit.
- Review operational performance through the Integrated Performance Report and associated delivery frameworks.
- Seek assurance where operational performance is deteriorating, outside agreed tolerance or where significant delivery risks are identified, including assurance regarding recovery, improvement and escalation arrangements.
- Review themes, trends, variation and emerging risks relating to operational delivery, productivity, capacity, flow and service performance.
- Maintain oversight of operational delivery across Velindre Cancer and Blood services, including high-risk, high-demand or high-impact pathways where delivery or sustainability may be affected.
- Seek assurance that operational delivery arrangements support sustainable delivery of safe, effective and person-centred services.
- Commission deep dives or focused reviews into operational services, pathways, programmes or areas of concern where appropriate.

3.2 Financial Planning, Performance and Sustainability

The Committee will:

- Maintain oversight of the Trust's financial planning, financial management and financial sustainability arrangements.
- Review of the Trust's Long-Term Agreements (LTA) arrangements.
- Review and recommend the Trust's Financial Plan and associated financial strategies to the Board.
- Review and recommend the Trust's Budget Setting Policy to the Board.
- Monitor financial performance against agreed plans, statutory financial duties and organisational objectives.
- Seek assurance regarding the Trust's cash management, liquidity, working capital and wider financial resilience.
- Seek assurance regarding financial recovery, mitigation and improvement arrangements where financial risks, pressures or variances are identified.
- Maintain oversight of productivity, efficiency and cost improvement programmes, seeking assurance regarding delivery, sustainability, value for money, quality impact and associated risks.
- Seek assurance that financial planning and resource allocation support delivery of the Trust's strategic objectives, operational priorities and IMTP commitments.
- Review long-term financial planning assumptions, affordability considerations and emerging financial pressures.

- Maintain oversight of financial risks associated with specialist, high-cost, high-demand or strategically significant services and pathways within the Committee's remit.
- Review relevant benchmarking information to support oversight of financial performance, productivity, value and organisational sustainability.

3.3 Strategic Planning and IMTP Delivery

The Committee will:

- Oversee the development, delivery and monitoring of relevant strategic plans, organisational delivery plans and Integrated Medium-Term Plan (IMTP) priorities within its remit.
- Review progress against strategic objectives, IMTP priorities, delivery trajectories and organisational milestones.
- Review barriers, dependencies, risks and emerging issues that may impact delivery of strategic objectives or IMTP commitments.
- Seek assurance that strategic planning arrangements align organisational priorities, operational delivery, financial sustainability, workforce requirements and quality objectives.
- Review strategic implications arising from national policy, regulatory developments, external reviews, audits or system-wide changes relevant to the Committee's remit.
- Seek assurance that enabling services, infrastructure and organisational arrangements support sustainable delivery of strategic objectives and organisational change.
- Seek assurance that relevant portfolio arrangements provide clear visibility of programme status, risks, dependencies, benefits and delivery confidence.

3.4 Capital Planning, Investment and Business Cases

The Committee will:

- Oversee the development and management of the Trust's capital planning arrangements and capital programme.
- Review and recommend the Capital Plan and associated investment priorities to the Board.
- Seek assurance regarding capital prioritisation, affordability, forecasting, delivery risks and mitigating actions.
- Review business cases, investment proposals and significant strategic developments in accordance with the Scheme of Delegation and Standing Financial Instructions.
- Recommend business cases above delegated approval thresholds to the Board where appropriate.
- Seek assurance that investment decisions support strategic objectives, operational delivery, organisational sustainability and long-term organisational priorities.
- Seek assurance that benefits realisation arrangements for major investments and programmes are clearly defined, measurable and effectively monitored.
- Review post-implementation evaluations, delivery outcomes and

organisational learning arising from significant investments, programmes or capital developments.
- Work collaboratively with the Quality, Safety and Experience Committee (QSEC) to ensure digital investment, business cases and prioritisation appropriately reflect quality, safety, clinical and operational considerations.

3.5 Procurement and Commercial Governance

The Committee will:
- Maintain oversight of procurement, commercial and contractual governance within its remit.
- Review and approve Procurement Strategies and associated plans where delegated by the Board.
- Seek assurance that procurement and commercial activity comply with relevant legislation, governance requirements and Standing Financial Instructions.
- Maintain oversight of significant contracts, commercial arrangements and procurement-related risks within its remit.
- Seek assurance regarding effective contractual management arrangements.
- Approve contract awards and procurement decisions within delegated authority.
- Seek assurance that procurement and commercial arrangements support strategic objectives, operational delivery, organisational sustainability and value for money.

3.6 Emergency Preparedness, Operational Resilience and Health and Safety

The Committee will:
- Seek assurance that effective arrangements are in place to support Emergency Preparedness, Resilience and Response (EPRR), business continuity and organisational resilience.
- Maintain oversight of organisational resilience arrangements, including preparedness for operational disruption, major incidents, critical infrastructure failure and service continuity risks.
- Review relevant emergency preparedness plans, statutory submissions, assurance reports and improvement actions within the Committee's remit.
- Seek assurance that effective health and safety governance arrangements are in place, including compliance with relevant statutory, regulatory and NHS Wales requirements.
- Maintain oversight of organisational health and safety risks, including fire safety, water safety, workplace safety and operational infrastructure risks within its remit.
- Seek assurance that resilience, infrastructure and health and safety arrangements support safe, sustainable and effective operational delivery.

3.7 Partnerships, Hosted Services and Collaborative Arrangements

The Committee will:

- Maintain oversight of partnerships, hosted services, collaborative working and joint arrangements within its remit.
- Seek assurance that governance, financial, operational and performance frameworks relating to hosted services and collaborative arrangements are effective and aligned with Trust requirements.
- Seek assurance that risks arising from partnerships, hosted services and collaborative arrangements are appropriately identified, monitored, mitigated and escalated.
- Receive assurance regarding operational delivery, performance, governance and compliance within partnership and collaborative arrangements relevant to the Committee's remit.
- Seek assurance that partnership and collaborative working arrangements support strategic objectives, operational delivery, organisational resilience and long-term sustainability.

3.8 Performance Intelligence, Assurance and Organisational Insight

The Committee will:

- Review operational, financial and planning information through the Integrated Performance Report and associated assurance frameworks.
- Seek assurance that operational, financial, planning and delivery risks recorded on the Board Assurance Framework and Trust Risk Register are appropriately identified, monitored, mitigated and escalated.
- Review relevant Internal Audit, External Audit, regulatory and external review findings within the Committee's remit and seek assurance that agreed actions are implemented effectively.
- Review significant findings, recommendations or concerns arising from regulators, inspections, external reviews, audits or assessments relevant to the Committee's responsibilities.
- Seek assurance that action plans arising from performance concerns, external reviews or regulatory findings are implemented effectively and monitored appropriately.
- Undertake horizon scanning to identify emerging operational, financial, strategic or delivery risks relevant to the Committee's remit.
- Seek assurance that governance, risk management and organisational resilience arrangements support sustainable delivery of strategic priorities and IMTP commitments.
- Maintain oversight of compliance with relevant NHS Wales planning, performance, financial and organisational governance requirements within the Committee's remit.

3.9 Estates, Facilities and Sustainability

The Committee will:

- Oversee the Trust's strategic estates, facilities and sustainability

arrangements, ensuring they support delivery of organisational priorities, strategic objectives and IMTP commitments.
- Seek assurance that estates, facilities and infrastructure planning is aligned with service development, operational requirements and long-term organisational sustainability.
- Maintain oversight of operational, financial, infrastructure and environmental risks arising from estates, facilities and sustainability matters.
- Review significant estates, facilities and sustainability programmes, developments and investment proposals within its remit.
- Seek assurance that equality and inclusion, sustainability and environmental objectives are appropriately reflected within strategic planning, estates development and operational delivery.
- Review significant incidents, risks or service impacts arising from estates, facilities or environmental matters and seek assurance regarding recovery and improvement actions.
- Seek assurance that relevant statutory, regulatory and NHS Wales requirements relating to estates, facilities, sustainability and the care environment are met.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
  - One Independent Member appointed as Chair
  - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, and the Quality, Safety and Experience Committee to ensure consideration of interdependencies.

5. ATTENDANCE

- Attendance by the Executive Director of Finance, Chief Operating Officer and Director of Strategy, Planning and Performance is mandatory. Attendance by Deputies in place of both Executive Directors should be exceptional and agreed with the Committee Chair.
- The Executive Director of Finance and the Chief Operating Officer will work collaboratively to coordinate agenda planning, report commissioning, assurance and escalation arrangements. The Executive Director of Finance will have executive responsibility for coordinating and leading the committee.
- In addition, as a minimum there must be one other Executive Director in attendance from the following:
  - Executive Director of Organisational Development and Workforce
  - Executive Director of Nursing, AHPs and Health Science
  - Executive Medical Director
- It is expected that the Director of Place, Portfolio and Partnerships will attend parts of the meeting to support any analysis relating to IMTPs or Estates, Facilities and Sustainability, respectively.

- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include other Executive Directors, subject matter leads, representatives from Cancer and Blood Services, and other Trust staff or external advisers as required by the Chair.

6. FREQUENCY

- Meetings will be held bi-monthly.
- The Chair may convene additional meetings where urgent or high-risk operational performance, finance, planning or organisational matters require consideration.

Audit and Risk Assurance Committee
Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Audit and Risk Assurance Committee (the Committee or ARAC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable. In doing so, the Committee will promote a culture of stewardship, accountability, openness, continuous improvement and effective assurance.
The Committee will operate using the Trust's System of Assurance Framework, which links strategic objectives, the principal risks to their achievement, the controls and mitigating actions in place, sources of assurance over the effectiveness of those controls, and reporting and escalation arrangements to the Board and Accountable Officer.

The Committee will use this Framework to plan and prioritise its work, assess whether assurance is comprehensive, reliable and evidence-based across all strategic objectives, evaluate the effectiveness of controls, and identify and monitor gaps in assurance or weaknesses in control, ensuring these are appropriately escalated.

In doing so, the Committee provides independent assurance to the Board and Accountable Officer on the effectiveness of the Trust's governance, risk management and internal control arrangements.
The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1.

2. PURPOSE

The purpose of ARAC is to support the Board and the Accountable Officer by providing strategic oversight and independent assurance in relation to governance, risk management, internal control and the effectiveness and adequacy of the Trust's overall assurance framework.

The Committee will advise the Board and Accountable Officer on whether the system of assurance is comprehensive, reliable and fit for purpose.

The Committee will assess the completeness of assurance coverage across all strategic objectives, the quality, reliability and integrity of assurance evidence received and the robustness of underpinning data and evidence.

The Committee will provide assurance that effective governance systems, control

arrangements and assurance mechanisms are in place to support accountability, stewardship, organisational resilience and informed decision making across the Trust.

In doing so, the Committee will oversee delivery of relevant governance priorities and assurance activities, providing assurance that governance, risk and control arrangements operate effectively and support delivery of the Trust's objectives. The Committee will also provide oversight of emerging governance and assurance matters and ensure that significant issues, risks and opportunities are identified, monitored and escalated appropriately.

The Committee does not manage operational risks, operate the Trust's system of internal control, or take executive decisions on governance matters. Instead, it provides independent oversight and challenge regarding the adequacy and effectiveness of the assurances provided by management, Internal Audit, External Audit and other independent assurance providers.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1 Governance, risk and assurance

The Committee will:

- Oversee governance, risk management and assurance arrangements across the Trust.
- Seek assurance regarding the effectiveness and maturity of governance, assurance processes and internal control arrangements including those applied in the Trusts committees.
- Provide assurance that governance arrangements support the Annual Governance Statement and Annual Quality Statement.
- Maintain oversight of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), seeking assurance that principal risks, assurance gaps and control weaknesses are appropriately identified, managed and escalated.
- Maintain oversight of the effectiveness and integration of the Trust's governance and organisational frameworks, including arrangements supporting risk management, performance management, strategic planning and portfolio management, seeking assurance that these collectively support effective decision making and delivery of strategic priorities, the IMTP and associated enabling strategies.
- Maintain oversight of assurance mapping and seek assurance that assurance arrangements are proportionate, integrated and support effective board oversight.
- Seek assurance that governance arrangements support effective integration across the Committee structure and avoid unnecessary duplication or gaps in assurance.
- Undertake horizon scanning to identify emerging governance, assurance, control and strategic risks which may impact organisational objectives, resilience or sustainability.
- Maintain oversight of governance arrangements supporting organisational

resilience and sustainability where these fall within the Committee's remit.

- Formally consider reports of non-compliance with Standing Orders and Standing Financial Instructions and make proposals to the Board on any action to be taken.
- Review annually the adequacy of arrangements for declaring, registering and handling board members' interests and report to the Board accordingly.
- Review at least annually the adequacy of arrangements for dealing with gifts, hospitality and sponsorship, informed by the relevant Trust registers and reports.
- Review annually the Standing Orders and all documents having effect as if incorporated within them, including Standing Financial Instructions and associated impact assessments, and report proposed amendments to the Board.
- Provide assurance to the Board on the effectiveness of arrangements for the reservation and delegation of powers.
- Assess the adequacy and effectiveness of the system of assurance, including whether controls are sound and complete, assurances are reliable and evidence-based and assurance gaps are clearly identified and addressed.
- Seek assurance that data underpinning assurances is valid, accurate, complete and timely.
- Provide assurance over clinical audit plans, effectiveness and delivery.
- Provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.
- The Committee will produce an annual report to the Board and Accountable Officer, including opinion on completeness and reliability of assurance, and view on effectiveness of risk management and internal control as well as commentary on the governance statement, quality statement and audit effectiveness.

3.2 Internal and external assurance

The Committee will:

- Oversee the effectiveness, independence and performance of Internal Audit arrangements.
- Review and approve the Internal Audit Strategy, Internal Audit Charter and annual Internal Audit Plan.
- Review Internal Audit and External Audit findings, recommendations and management responses.
- Seek assurance that agreed audit recommendations are implemented effectively and within agreed timescales.
- Receive and consider the Head of Internal Audit Opinion and relevant External Audit opinions and assess their implications for governance and assurance arrangements.
- Seek assurance that effective coordination exists across audit and assurance providers.
- Review the External Audit Annual Plan and associated fees, consider material changes to the Plan and seek assurance that an effective and cost-efficient external audit service is delivered.

- Ensure the external auditor is invited to attend each meeting of the Committee and that the Committee maintains an effective working relationship which respects auditor independence.
- Meet privately (without management present) at least annually with Internal Audit, External Audit, Counter Fraud and other assurance providers where appropriate to support independence of assurance arrangements.
- Undertake an annual review of the effectiveness of the Internal Audit function.

3.3 Counter fraud and governance concerns

The Committee will:

- Oversee arrangements to prevent, detect, investigate and respond to fraud, bribery, corruption and financial irregularity.
- Review and seek assurance on whistleblowing / speaking-up arrangements, enabling staff to raise concerns in confidence.
- Seek assurance regarding the effectiveness of counter fraud, anti-bribery and anti-corruption arrangements.
- Review significant investigations, governance concerns, emerging risks and control weaknesses relevant to the Committee's remit.
- Seek assurance that learning and recommendations arising from investigations and reviews are implemented effectively and embedded.
- Seek assurance that arrangements support a culture of openness, accountability and appropriate escalation of concerns.

3.4 Financial governance and stewardship

The Committee will:

- Seek assurance regarding the adequacy and effectiveness of financial governance, stewardship and internal financial control arrangements.
- Review the governance and assurance aspects of the annual accounts process, Annual Governance Statement and associated disclosures prior to Board approval.
- Review the annual accounts in detail, including significant accounting policies and judgments, unadjusted misstatements, management representations and external audit findings and ISA 260 reports.
- Review significant governance and control issues arising from financial reporting or audit findings.
- Seek assurance regarding compliance with relevant governance, accountability and public sector financial requirements.
- Seek assurance that arrangements support value for money, propriety and effective stewardship of public resources.
- Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' donors and service users' property and review assurance on their operation.
- Approve the write-off of losses and the making of special payments within delegated limits and receive regular reports on losses, special payments and related trends.
- Receive reports at each meeting on losses and special payments, including

frauds, thefts, arson, suspected irregularities and action taken.
- Receive reports on Single Quotation Applications, Single Tender Applications and exceptional procurement departures, and consider whether further action, review, training or escalation is required.
- Receive regular reports on free-of-charge services provided to the Trust and seek assurance that these do not create unmanaged governance, procurement or value for money risks.
- Receive the outcome of periodic reviews of banking arrangements and seek assurance that banking controls remain efficient, effective and represent value for money.

3.5 Information governance, cyber security and digital assurance

The Committee will:
- Oversee information governance, cyber security and digital assurance arrangements.
- Seek assurance regarding governance, risk management and internal control arrangements relating to cyber resilience, confidentiality, data protection, information assets and digital assurance.
- Seek assurance that significant information governance, cyber security and digital assurance risks are appropriately identified, monitored and escalated.
- Review organisational learning arising from cyber incidents, digital assurance reviews and information governance events.
- Maintain effective interfaces with other Board Committees where information governance, cyber security or digital assurance matters impact broader organisational priorities.

3.6 Hosted services and partnership governance

The Committee will:
- Seek assurance that hosted services, partnerships and collaborative arrangements operate within effective governance, accountability and assurance frameworks.
- Maintain oversight of governance arrangements supporting hosted services and partnership delivery models.
- Seek assurance that accountability, escalation and reporting arrangements are clearly defined and operate effectively.
- Seek assurance that governance and assurance arrangements support organisational resilience and effective stewardship across collaborative arrangements.

3.7 Governance reporting and statutory assurance

The Committee will:
- Review evidence supporting the Annual Governance Statement and Annual Quality Statement and advise the Board on completeness and accuracy. Provide formal advice to the Board on consistency of disclosures with assurance received and completeness of the assurance framework.

- Seek assurance that governance, assurance and accountability requirements are effectively implemented.
- Review findings arising from governance reviews, inspections and external assessments relevant to the Committee's remit.
- Seek assurance that actions arising from governance reviews and assessments are implemented effectively and within agreed timescales.
- Consider assurance and insight from other Board Committees and refer matters where detailed review is more appropriately undertaken elsewhere.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board including:
  - One Independent Member appointed as Chair
  - One Independent Member appointed as Vice Chair
- The three Independent Members must include a member of the People, Culture and Engagement Committee, the Quality, Safety and Experience Committee, and the Performance and Finance Committee to ensure consideration of interdependencies.
- At least one Independent Member must have significant financial, audit, governance or risk management expertise.

Members must receive induction and ongoing training in governance, risk and assurance.

The Chair of the Board should not be a member of ARAC.

5. ATTENDANCE

Attendance by the Director of Finance and Director of Corporate Governance is mandatory.

Regular attendees will include:

- Internal Audit representatives
- External Audit representatives
- Counter Fraud representatives

Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include Executive Directors and senior leaders with responsibility for governance, risk management, performance management, strategic planning, and portfolio management arrangements, together with information governance and cyber specialists, representatives from hosted services, external advisers and other Trust staff as required by the Chair.

The Committee may request private meetings with audit and assurance providers where appropriate to support independence of assurance arrangements.

7. FREQUENCY

- Meetings will be held quarterly.
- A minimum of five meetings per year, with the fifth meeting dedicated to the review of the Annual Accounts, Annual Report and Accountability Agreement.
- Additional meetings may be convened by the Chair where urgent governance, assurance, audit, cyber security, or risk matters require consideration.

Research, Development and Innovation Committee
Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall annually establish a Committee to be known as the Research, Development, and Innovation Committee (the Committee or RD&IC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable.

In doing so, the Committee will promote a culture of curiosity, learning, collaboration, innovation, and continuous improvement, recognising the important role that research, development and innovation play in improving outcomes for patients, donors and service users advancing knowledge and supporting organisational sustainability.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1. An overview of the RD&I governance structure and reporting arrangements is provided in Appendix 2.

2. PURPOSE

The purpose of the RD&I is to provide strategic oversight and assurance in relation to the Trust's research, development and innovation activities, ensuring they support delivery of the Trust's strategic objectives, improve outcomes for patients, donors and service users, and contribute to organisational learning, service transformation and long-term sustainability.

The Committee will oversee the development and delivery of the Trust's RD&I strategy, plans and priorities, ensuring alignment with the Trust's strategic objectives, Integrated Medium-Term Plan (IMTP), and long-term ambitions. It will seek assurance that appropriate arrangements are in place to support high-quality research, innovation, governance, workforce capability, and regulatory compliance.

The Committee will promote a culture in which research, development and innovation are recognised as core enablers of improved outcomes, continuous improvement, and future organisational success, while supporting the Trust's ambition to strengthen its research profile, partnerships, influence, and impact.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Research, Development and Innovation Strategy

The Committee will:

- Oversee the development, implementation and periodic review of the Trust's Research, Development, and Innovation Strategy.
- Provide strategic oversight of RD&I priorities, ensuring alignment with the Trust's strategic objectives, organisational priorities, IMTP and long-term ambitions.
- Undertake horizon scanning to identify emerging research, innovation, scientific, technological and policy developments that may create opportunities or risks for the Trust.
- Seek assurance that RD&I activity contributes to improved outcomes, organisational development, and delivery of strategic priorities.
- Receive assurance regarding the delivery of RD&I-related programmes, initiatives, and portfolio activities, ensuring they support delivery of the Trust's strategic objectives and RD&I priorities.
- Seek assurance that research, development and innovation activity delivers measurable benefits, impact and value for patients, donors, service users, staff and the wider organisation.

3.2. Research Governance, Assurance and Compliance

The Committee will:

- Oversee research governance arrangements and seek assurance that they are effective, proportionate and support delivery of high-quality research and innovation activity.
- Seek assurance that the safety, rights, dignity and wellbeing of participants remain paramount in all research activity.
- Seek assurance that RD&I activities comply with relevant legislation, regulatory requirements, ethical standards and national policy frameworks.
- Review significant governance concerns, incidents, risks, investigations and compliance matters relating to RD&I activities.
- Seek assurance that learning arising from reviews, audits, inspections and investigations is implemented effectively and embedded.
- Work collaboratively with the Quality, Safety and Experience Committee (QSEC) to ensure appropriate oversight of the quality, safety and governance implications of research, development and innovation activities, referring matters where they fall within the remit of the respective Committee.

3.3. Partnerships, Collaboration and External Influence

The Committee will:

- Maintain oversight of strategic partnerships that support research, development and innovation activity.
- Promote collaboration with NHS Wales organisations, universities, Cardiff Health Partners and other research and innovation networks.

- Seek assurance that partnership arrangements support the Trust's strategic objectives and maximise opportunities for collaboration, influence and impact.
- Monitor developments within the wider research and innovation landscape and consider opportunities for strategic engagement and leadership.
- Oversee arrangements to benchmark the performance of the Velindre Cancer Service and Welsh Blood Service against comparable leading UK and international research centres.
- Maintain oversight of the strategic approach to achieving and retaining Organisation of European Cancer Institutes (OECI) accreditation.

3.4. Innovation, Culture and Future Opportunities

The Committee will:

- Promote innovation and support the identification, evaluation and development of opportunities that may improve outcomes, services or organisational performance.
- Promote a culture in which research, development and innovation are embedded within clinical practice, service improvement, organisational learning and strategic decision-making.
- Seek assurance that staff are supported and encouraged to participate in research, development and innovation activity where appropriate.

3.5. Workforce, Capability and Organisational Learning

The Committee will:

- Oversee arrangements to develop and sustain the workforce capability required to deliver the Trust's RD&I ambitions.
- Seek assurance that workforce development, leadership development and succession arrangements support delivery of RD&I priorities.
- Promote continuous learning and knowledge sharing arising from research and innovation activity.

3.6. Funding, Investment and Business Cases

The Committee will:

- Oversee arrangements to secure, manage and maximise research, innovation and grant funding opportunities.
- Monitor the financial sustainability and effectiveness of the Trust's RD&I activities.
- Review significant RD&I investment proposals and business cases,
- Scrutinise proposals seeking charitable funding and provide recommendations to the Charitable Funds Committee where appropriate.
- Review and scrutinise proposals seeking funding from the Advancing Radiotherapy Cymru (ARC) programme.
- Seek assurance that RD&I investment and expenditure is appropriately governed, managed and reported.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
    - One Independent Member appointed as Chair
    - One Independent Member appointed as Vice Chair
- The Committee may co-opt additional independent members from outside the organisation where specialist knowledge or expertise would support the discharge of its responsibilities.

5. ATTENDANCE

- Attendance by the Executive Medical Director is mandatory, and their Deputy should attend in exceptional circumstances such as annual leave, sickness, or other leave.
- In addition, as a minimum there must be two other Executive Directors in attendance from the following:
    - Executive Director of Organisational Development and Workforce
    - Executive Director of Nursing, Allied Health Professionals and Health Science
    - Executive Director of Finance
    - Chief Operating Officer
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include Executive Directors, clinical leaders, research and innovation leads, finance representatives, patient, donor, and service user representatives, university and NHS Wales partners, charitable funding representatives and other individuals as required by the Chair.

6. FREQUENCY

- Meetings will be held quarterly.
- Additional meetings may be convened by the Chair where significant RD&I, governance, funding, partnership or strategic matters require consideration.

New Velindre Cancer Centre Committee
Terms of Reference

1. INTRODUCTION

In line with the Standing Orders and Scheme of Delegation, the Board shall establish a Committee to be known as the new Velindre Cancer Centre Committee (the Committee or nVCC).

The Committee will undertake its responsibilities in a manner aligned to the Trust's vision of Excellent Care, Inspirational Learning and Healthier People, together with the Trust's values and associated behaviours of being Caring, Respectful and Accountable.

The Committee has been established as a time-limited Board Committee to provide strategic oversight of the new Velindre Cancer Centre (nVCC) Programme and its constituent projects, including construction, commissioning, operational readiness and transition into the new facility. In doing so, the Committee will provide enhanced scrutiny, challenge and assurance regarding programme delivery, governance, financial performance, risk management, dependencies and benefits realisation.

The Committee will remain in place until the Board is satisfied that the Programme has achieved its objectives, services have successfully transitioned into the new facility, and appropriate arrangements have been established to support transition into operational and business-as-usual governance arrangements.

The purpose and responsibilities of the Committee are set out in Sections 2 and 3. Common operating arrangements applicable across all board committees are set out in Appendix 1. An overview of the nVCC governance structure and reporting arrangements is provided in Appendix 2.

2. PURPOSE

The purpose of the nVCC Committee is to provide strategic oversight, independent scrutiny and assurance to the Board regarding the successful delivery of the nVCC Programme and its constituent projects.

The Committee will seek assurance that the Programme is delivered in accordance with approved objectives, scope, timescales, budget and anticipated benefits, and that effective arrangements are in place to support commissioning, operational readiness, service transition and the safe commencement of services within the new facility.

In doing so, the Committee will provide constructive challenge and independent scrutiny of programme governance, performance, financial management, risks, dependencies and assurance arrangements, ensuring that significant issues, opportunities and decisions are identified, managed and escalated appropriately to support successful delivery of the Programme.

3. SPECIFIC DUTIES / RESPONSIBILITIES

3.1. Programme Strategy, Scope and Benefits Realisation

The Committee will:

- Oversee the strategic direction of the Programme, ensuring continued alignment with Board approved objectives, scope and intended outcomes.
- Seek assurance that the Programme remains aligned with organisational priorities, external requirements and the wider strategic context within which the Trust operates.
- Maintain oversight of Programme benefits, ensuring appropriate arrangements are in place to monitor, evaluate and realise anticipated benefits and outcomes.
- Consider significant proposed changes to Programme scope, objectives, benefits or strategic direction and provide assurance to the Board as appropriate.

3.2. Programme Delivery, Performance and Dependencies

The Committee will:

- Scrutinise Programme delivery and performance, seeking assurance that progress remains consistent with approved plans, milestones and timescales.
- Receive assurance regarding delivery of constituent projects and workstreams, including progress against the master programme plan and critical path.
- Maintain oversight of key dependencies, interfaces and enabling activities, seeking assurance that these are appropriately managed and coordinated.
- Seek assurance that programme delivery confidence, readiness assessments and exception reporting provide an accurate and timely assessment of the Programme's ability to achieve key milestones and operational objectives.

3.3. Governance, Risk and Assurance

The Committee will:

- Oversee Programme governance arrangements and seek assurance that they remain effective, proportionate and aligned with recognised project and programme management standards.
- Scrutinise Programme risks, issues and mitigating actions, seeking assurance that risks are appropriately identified, managed, escalated and monitored.
- Receive and review relevant internal audit reports, gateway reviews, independent assurance reviews and other sources of assurance relating to the Programme.
- Seek assurance that recommendations arising from audits, reviews and assurance activity are implemented effectively and on a timely basis.
- Provide assurance to the Board regarding the effectiveness of Programme governance, risk management and assurance arrangements.

3.4. Financial Stewardship and Commercial Oversight

The Committee will:

- Maintain oversight of Programme expenditure, affordability and financial performance.
- Seek assurance that Programme resources are managed effectively and that expenditure remains within approved budgets and delegated authorities.
- Review significant financial, commercial and contractual matters relating to the Programme, including the Mutual Investment Model, and provide assurance to the Board where appropriate.
- Seek assurance that robust arrangements are in place to support value for money, financial control and effective stewardship of public resources.
- Seek assurance that contractual obligations, key commercial milestones and associated commitments are being delivered in accordance with approved agreements and that significant contractual risks are identified and managed appropriately.

3.5. Operational Readiness, Transition and Mobilisation

The Committee will:

- Oversee arrangements supporting operational readiness, transition, mobilisation and safe occupation of the new Velindre Cancer Centre.
- Seek assurance that transition and mobilisation plans are aligned to Programme milestones and support safe, effective and uninterrupted service delivery.
- Maintain oversight of organisational readiness across workforce, clinical, operational, digital, estates and support services, including testing, commissioning and contingency arrangements.
- Receive assurance that statutory, regulatory, licensing, compliance and governance requirements necessary for occupation and operation of the facility have been achieved.
- Monitor readiness for opening and receive assurance that criteria for safe occupation, service transfer, stakeholder engagement and commencement of operations have been met.
- Seek assurance that arrangements support the safe continuity of patient care and minimise disruption to patients, staff and services throughout transition and mobilisation.
- Receive assurance that operational readiness, commissioning, rehearsals, testing and contingency arrangements have been completed and demonstrate readiness for safe occupation and commencement of services.

3.6. Programme Closure, Handover and Benefits Realisation

The Committee will:

- Maintain oversight of arrangements supporting Programme closure, handover and transition to business-as-usual arrangements.
- Seek assurance that Programme deliverables have been completed, accepted and transferred to operational ownership, together with any

associated assets, services, risks and ongoing obligations.
- Receive assurance that the Programme has delivered its intended objectives and benefits, and that arrangements are in place to monitor ongoing benefits realisation.
- Provide assurance to the Board on Programme closure, residual risks and organisational learning, supporting the Senior Responsible Owner in determining readiness for formal closure.

4. MEMBERSHIP

The Committee shall comprise:

- A minimum of three Independent Members of the Board, including:
  - One Independent Member appointed as Chair
  - One Independent Member appointed as Vice Chair
- The Committee may co-opt additional independent members from outside the organisation where specialist knowledge or expertise would support the discharge of its responsibilities.

5. ATTENDANCE

- Attendance by the Chief Executive Officer, as Senior Responsible Officer (SRO) for the Programme, is mandatory and a nominated Deputy should attend only in exceptional circumstances such as annual leave, sickness or other leave.
- In addition, as a minimum there must be two other Executive Directors or designated senior officers in attendance from the following:
  - Director of Place, Portfolio & Partnerships
  - Chief Operating Officer
  - Executive Director of Finance
  - Executive Medical Director
  - Executive Director of Nursing, Allied Health Professionals and Health Science
  - Executive Director of Organisational Development and Workforce
  - Director of Corporate Governance
- Additional attendees may attend meetings, in full or in part, as required to support the effective conduct of business and consideration of agenda items. Additional attendees may include the nVCC Project Director, Director of Estates, programme and project leads, technical advisers, external assurance providers, commercial advisers, Welsh Government representatives, NWSSP representatives and other individuals as required by the Chair.

6. FREQUENCY

- Meetings will normally be held monthly.
- Additional meetings may be convened by the Chair where significant programme, governance, financial, risk, assurance or strategic matters require consideration.

Remuneration and Terms of Service Committee

Terms of Reference

1. INTRODUCTION

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

- In line with Standing Orders and the Trust's Scheme of Delegation, the Board shall nominate annually a Committee to be known as the **Remuneration & Terms of Service Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

- The committee will play an important role in supporting the Board in the fulfilment of its responsibilities by:
    - Providing advice on strategic development and performance within its Terms of Reference;
    - Undertaking scrutiny and gaining assurance on key aspects of organisational performance and supporting the achievement of the Trust's specific goals;
    - Carrying out responsibilities as detailed below on the Board's behalf.

2. PURPOSE

- The purpose of the Remuneration & Terms of Service Committee (the Committee) is to:
    - ***Approve*** on behalf of the Board, matters relating to the appointment, termination, remuneration, terms of service and appraisal for the Chief Executive, Executive Directors, and other senior staff (including Interim Director roles) within the framework set by Welsh Government and in accordance with Standing Orders; and
    - ***Provide Assurance*** to the Board in relation to the Board's arrangement for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales

- Perform certain, specific tasks as set out in delegated powers on behalf of the Board.

- The Committee shall have no powers to develop of modify existing pay schemes.

- In alignment with the Wellbeing of Future Generations (Wales) Act 2015, this committee will adopt a long-term perspective in its deliberations and decisions and consider the broader implications of its actions,

3. DELEGATED POWERS

- With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Remuneration Committee will comment specifically upon:

    - Remuneration, terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) (including Interim arrangements) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently.
    - Approve on behalf of the Board the appointment, appraisal, discipline and dismissal of any Board level Executive appointments and other senior employees, including interim arrangements.
    - Note the objectives set for the CEO by the Chair as required by the Cabinet Minister for Health and Social Care and review performance of the Chief Executive, Executive Directors and other VSMs.
    - Ensure that Performance Management systems are in place for those in the positions mentioned above and review and ratify performance assessments
    - Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the regulations and in accordance with Ministerial Instruction and Welsh Government.
    - Consideration of anonymous correspondence relating to complaints relevant to the committee as set out within the Anonymous Communications Policy.
    - Consideration and approval of Voluntary Early Release Scheme (VERS) applications and redundancy/ severance payments in respect of Executive Director/ Director posts, in line with Standing Orders and extant Welsh Government Guidance.

- The Committee is to be advised of all VERS applications and severance payments and will seek assurance that these posts are not re-introduced.

- Approve any Strategic Advisor arrangements, including scope and pay.

- In developing remuneration packages the Committee will ensure that there is:
    - A clear statement of responsibilities of the individual posts and their accountabilities of meeting objectives of the organisation.

- A means of assessing the comparative job weight.
- Comparative salary information from the NHS, other public sector organisations and industry service organisation

- The committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf aspects of committee business.

4. RISK AND AUDIT

- The committee will monitor the principal risks relevant to its remit and consider the control and mitigation of high-level related risks and provide assurance to the Board that such risks are being effectively controlled and managed. It will also review and audit findings relevant to its remit.

5. AUTHORITY

- The committee is authorised to approve those matters listed above.
- The committee is authorised by the Trust Board to investigate, or have investigated, any activity within its Terms of Reference. In doing so, it will have the right to seek any information it requires from any employee or inspect any books, records or documents relevant to its remit, ensuring patient/client and staff confidentiality as appropriate. All employees are directed to cooperate with any reasonable requests made by the committee.
- The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements
- The Chair of the Committee, may, when it is not practicable to convene a meeting have the authority to approve VERS applications between meetings with advice from the Director of Organisational Development and Workforce and the Board Secretary as appropriate. In such instances the Board Secretary will ensure that the action is formally recorded and reported to the next meeting of the committee for consideration and ratification.

6. MEMBERSHIP

- A minimum of four members comprising:
  - Chair or Vice-Chair of the Board, in the event of the Chair being absent for any reason then the Vice-Chair would automatically substitute with full voting rights
  - Chair of the Audit and Risk Assurance Committee
  - Chair of the People, Culture and Engagement Committee
  - One other nominated Independent Member
  - The Trust Chair may, from time to time determine that the business of the Remuneration and Terms of Service Committee requires the attendance of all Independent Members, and as such may extend an

invitation to Independent Members to attend for a single item of business or a meeting as appropriate.
    - In the event of long-term absence of a member of the committee, the Chair will be authorised to appoint an alternative independent member of the Board as a long term substitute without the need for a Board decision, whilst a more permanent arrangement is sought.

- In attendance by invitation of the Committee Chair:
    - The Chief Executive (except when issues relating to the personal remuneration are being discussed)
    - The Executive Director of Organisational Development and Workforce.
    - Any other Trust officials, including a Trade Union Representative and/or any others from within or outside the organisation to attend for a single item of business or a meeting as appropriate (except when issues relating to their personal remuneration are being discussed)
    - Executives may send deputies in their absence who will act with their full authority. To instigate a substitute arrangement, the Executive Director must notify the Board Secretary before the day of the meting that they are unable to attend and provide the name of the appointed substitute.

7. COMMITTEE MEETINGS

- **Quorum**

  At least two members must be present to ensure the quorum of the meeting, including either the Chair or Vice Chair of the Committee.

- **Secretariat**

  As determined by the Director of Corporate Governance.

- **Membership Appointments**

  Members shall be appointed to hold office for a period of one year at a time by the Board, up to a maximum of their term in office taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by Welsh Government.

  During their period of appointment, a member may resign or be removed by the Board**.**

- **Support to Committee Members**

  The Director of Corporate Governance, on behalf of the Committee Chair, shall:
    - Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
    - Ensure the provision of programme of organisational development for committee members as part of the health board's overall organisational development programme developed by the Executive Director of

Organisational Development and Workforce.

- **Frequency of meetings**
  The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.
  Any additional meetings will be arranged under exceptional circumstances and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

- **Withdrawal of individuals in attendance**
  The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussions of any particular matter.

- **Agendas**
  The agenda and papers will be distributed five working days in advance of the meeting.
  The agenda will be based on the Committee workplan, identified risks, matters arising from previous meetings, action lists, issues emerging throughout the year and requests from other committees.

8. REPORTING AND ASSURANCE ARRANGEMENTS

- The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business, including information sharing. In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- The Committee Chair, supported by the Committee Secretary shall:
  - Report formally, regularly and on a timely basis to the Board on the Committee's activities.
  - Bring to the Board's specific attention any significant matters under consideration by the Committee; and
  - Ensure appropriate escalation arrangements are in place to alert the Chief Executive and/or other Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board

9. RELATIONHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

- Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters:
  - The Committee is directly accountable to the Board for its performance in exercising the functions set out in the delegated powers listed above.

- The Committee will consider the assurance provided through the work of the Board's other committees and subgroups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.
- The Committee shall embed the Health Trust's corporate standards, priorities and requirements, eg, equality and human rights through the conduct of its business.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Charity Trustee Meting

Terms of Reference

Charitable Funds Committee

Terms of Reference

Charitable Funds Investment Performance Review Sub-Committee

Terms of Reference

APPENDIX 1

Operational arrangements common to all committees

1. AUTHORITY

Velindre University NHS Trust's Standing Orders provide that:
"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work conducted on its behalf by Committees."

Committees operate with no executive powers other than those specifically delegated within their Terms of Reference. Committees are directly accountable to the Board and are authorised to investigate any activity within their remit.

Committees may seek any information required from any employee, contractor, committee, sub-committee, or group of the Trust, all of whom are required to cooperate with such requests. In discharging their responsibilities, Committees will support effective engagement with staff, patients, donors, service user communities and key stakeholders, including partnership working and citizen voice arrangements.

Subject to Board approval, Committees may establish sub-committees or task and finish groups to support the discharge of their responsibilities.

Committees are authorised to secure the attendance of legal advisers, external advisers, specialists, or independent experts where necessary, in accordance with the Trust's procurement, budgetary and governance requirements.

Committees will conduct their business in a manner consistent with the Trust's commitment to openness, transparency, equality, diversity, inclusion, human rights, and the Welsh language.

Committees will exercise any authority delegated by the Board within these Terms of Reference, approve matters delegated to them, and make recommendations to the Board on matters reserved for Board approval. Committees will ensure that significant risks, assurance concerns and matters requiring Board consideration are escalated through the Trust's governance arrangements.

2. STATUTORY AND MANDATORY COMPLIANCE

Committees will operate in accordance with the Trust's strategic objectives, governance framework and all relevant statutory, regulatory, and mandatory requirements, codes of practice, case law, and legislation applicable to NHS Wales organisations. This includes compliance with relevant Welsh Government legislation,

NHS Wales governance and accountability requirements, mandatory compliance obligations, equality, workforce, Welsh language, social partnership, and quality standards, together with associated national and international best practice guidance.

3. GOVERNANCE FRAMEWORK

These Terms of Reference should be read alongside the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and other Board-approved governance frameworks. Together, these documents define the authority, roles, responsibilities, accountabilities, decision-making arrangements and expected behaviours that support effective governance across the Trust.

Board committees provide strategic oversight, scrutiny and assurance on behalf of the Board. They do not manage operational delivery or assume executive responsibility for services or functions.

4. COMMON PRINCIPLES

In exercising their responsibilities, Committees will have due regard to the following principles across all aspects of their work:

- **Equality, Diversity and Inclusion (EDI)** – Ensure that equality, diversity, inclusion and health inequalities are appropriately considered within relevant strategies, policies, business cases, decisions and assurance processes, seeking assurance that potential impacts have been identified, understood and appropriately addressed.

- **Patient, Service User and Donor Voice** – Ensure that the views, experiences and insights of patients, service users, donors, carers and communities are appropriately reflected in decision-making, assurance and improvement activities, recognising lived experience as an essential component of high-quality, person-centred services and the achievement of the Trust's values and strategic objectives.

- **Value for Money and Sustainability** – Ensure that decisions are informed by considerations of value for money, long-term sustainability and the effective stewardship of public resources, recognising the need to balance quality, outcomes, workforce, financial sustainability and environmental impact, where appropriate.

- **Partnership and System Working** – Ensure that opportunities for collaboration, partnership working and system-wide impact are considered within relevant decisions, recognising the Trust's role in improving outcomes across the wider health and care system.

- **Organisational Intelligence and Triangulation** – Ensure that strategic themes, risks, opportunities and assurance are effectively triangulated across the Board

committee structure, drawing upon relevant governance arrangements and wider organisational intelligence, including performance, risk, audit, regulatory reviews, patient, donor, service user and staff feedback, incidents, complaints and system learning, to support a coherent organisation-wide view of performance, risk and assurance.

- **Quality of Assurance** – Ensure that assurance is reliable, complete, timely and evidence-based, enabling the Committee to determine whether risks are being effectively managed and intended outcomes are being achieved.

- **Impact Assessment –** Ensure that significant strategies, policies, service changes, business cases and decisions are informed by appropriate Quality Impact Assessments, Equality Impact Assessments and other relevant impact assessments, seeking assurance that potential impacts have been appropriately identified, considered and addressed before decisions are taken.

5. COMMITTEE INTERFACES

Committees will:

- Collaborate with other Committees and refer matters to the appropriate Committee where issues fall outside its remit or require broader organisational oversight or assurance. This includes the People, Culture and Engagement Committee (PCEC), Quality, Safety and Experience Committee (QSEC), Performance and Finance Committee (PFC), Audit and Risk Assurance Committee (ARAC), Research, Development and Innovation Committee (RD&I), and the new Velindre Cancer Centre Committee (nVCC).

- Refer matters to ARAC where concerns relate to the overall risk management framework, internal control environment, assurance gaps, or audit findings.

- Receive matters referred by the Board or other Committees where they fall within the Committee's remit.

6. GOVERNANCE AND RISK

Committees will:

- Undertake horizon scanning to identify emerging organisational risks, opportunities, and external developments, relating to its domain, which may impact the Trust's strategic objectives or delivery of high-quality services.
- Seek assurance that domain specific risks on the Board Assurance Framework (BAF) and Trust Risk Register entries are appropriately monitored, mitigated, and escalated.
- Seek assurance that recommendations arising from internal and external reviews are implemented effectively and on a timely basis.
- Review relevant Internal Audit and External Audit findings within the Committee's remit, ensuring actions are implemented and learning is shared.

- Seek assurance that hosted services operate in compliance with the Trust's domain specific assurance requirements, including the Hosted Services Assurance Schedule, and that robust escalation arrangements are in place for risks, incidents, concerns, or gaps in assurance.

7. COMMITTEE EFFECTIVENESS AND PROGRAMME OF WORK

Committees will:

- Develop and maintain an annual cycle of business aligned to Board priorities, strategic objectives, regulatory requirements and key risks, designed to support the effective discharge of the Committee's responsibilities as set out within these Terms of Reference.
- Use findings, assurance activity, and emerging themes to inform future work planning and continuous improvement.

8. CROSS COMMITTEE MEMBERSHIP AND ATTENDANCE

- The Board will seek to ensure appropriate cross-membership and alignment between Committees to support effective integration, triangulation of assurance and coordination of oversight across the Trust's governance framework.
- Committee membership should collectively provide an appropriate balance of skills, knowledge, experience, and diversity relevant to the Committee's remit.
- The Chair of the Board and CEO may attend Committee meetings but are not designated members.
- In exceptional circumstances Deputies may attend where formally nominated and agreed by the Chair. Where an Executive member is unable to attend, a formally nominated Deputy must attend.
- Meetings may be open to observation by staff members and the public in accordance with the Trust's arrangements for openness and transparency.

9. REPORTING TO THE BOARD

- Committees are directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.
- While each Committee will oversee matters within its delegated remit, integrated oversight of organisational performance, governance and assurance across all domains will remain the responsibility of the Board. The Board may remit more detailed review of specific matters to Committees and Committees may advise the Board on any issues requiring ongoing oversight, escalation, or cross-committee consideration.
- Minutes will be circulated to the Board.
- A formal exception report will be submitted to the Board following each meeting, highlighting matters requiring Board attention, escalation or decision, including material risks, significant concerns, issues requiring cross-committee consideration, or where assurance is insufficient or outside agreed tolerance.
- Where urgent decisions are required between scheduled meetings, the

Committee Chair, supported by the Director of Corporate Governance, may act on behalf of the Committee following consultation with the other Committee member. Any action taken will be formally recorded and reported to the next meeting for ratification.

- The Committee will undertake any other responsibilities delegated by the Board.

10. QUORUM

- A minimum of two Independent Members
- A minimum of two Executive Directors from the list above in Section 5, Attendance.
- Members with a conflict of interest will not count towards the quorum for that item or meeting.

11. SECRETARIAT AND COMMITTEE BUSINESS SUPPORT

- Secretariat support will be provided by the Corporate Governance function which will:
    - Ensure that there are appropriate arrangements in place to support Committee proceedings including alignment with relevant equality and Welsh language legislation.
    - Ensure that agendas, papers, minutes, and actions are available to the Committee in line with the standards outlined in Standing Orders and supporting documentation.
    - Arrange an agenda-setting meeting with the Committee Chair and Lead Director at least four weeks prior to each meeting.
    - Ensure that agendas are informed by the Committee work plan, matters arising, identified risks, emerging issues and requests from Committee members.
    - Circulate the agenda and timetable for paper submission to members following approval by the Chair and Lead Director,
    - Obtain approval for all papers from the relevant Lead Director prior to submission.
    - Circulate agendas and papers at least seven days in advance of the meeting.
    - Prepare a draft table of actions within two working days of the meeting.
    - Draft minutes and the action log for circulation to the Lead Director for accuracy review within seven days of the meeting, before circulation to Chair and then Committee members for comment.
    - Submit final minutes and actions to the Committee Chair for approval.
- Members should submit amendments to the Committee Secretariat within seven calendar days of receipt.

12. EFFECTIVENESS REVIEW

- At the conclusion of each meeting, the Chair will facilitate a brief reflection on the Committee's effectiveness, considering the quality of discussion,

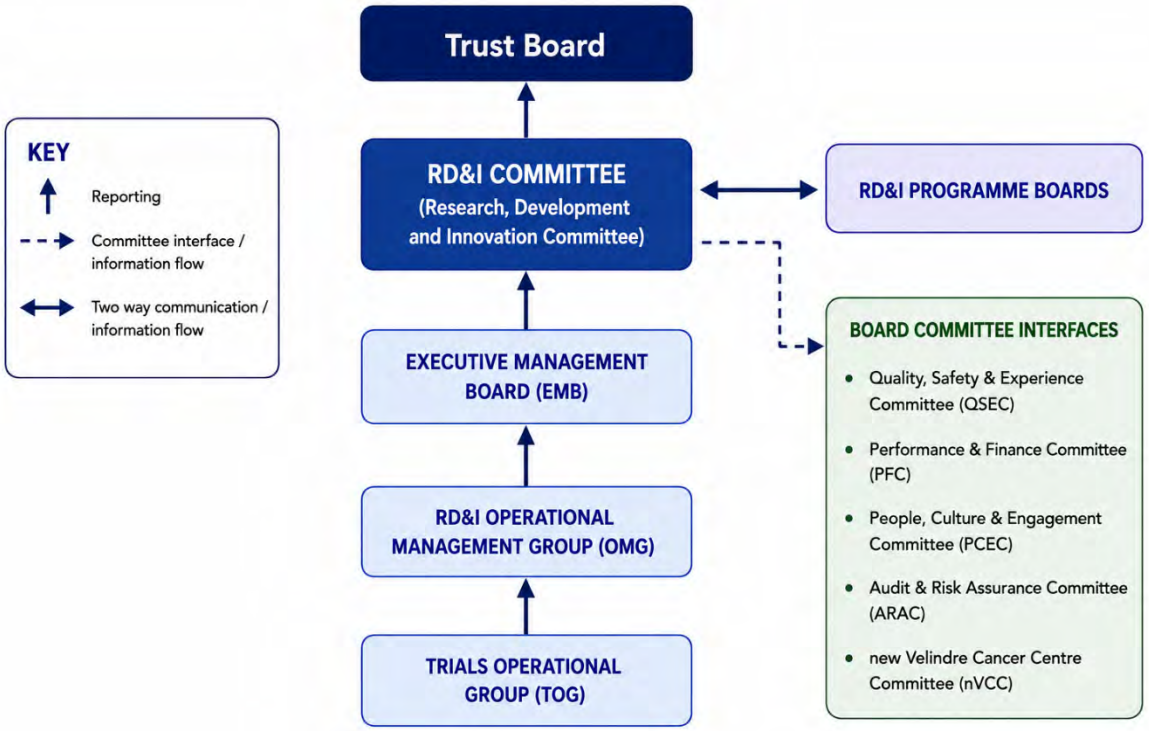
challenge and assurance; use of meeting time; strategic focus; alignment with the Committee's Terms of Reference; the quality of papers and information; member participation and behaviours; and the extent to which the meeting added value to the Board's assurance and decision-making. Opportunities for improvement will be identified, recorded and used to support the Committee's ongoing development.

- Terms of Reference for each committee will be reviewed annually and approved by the Board.

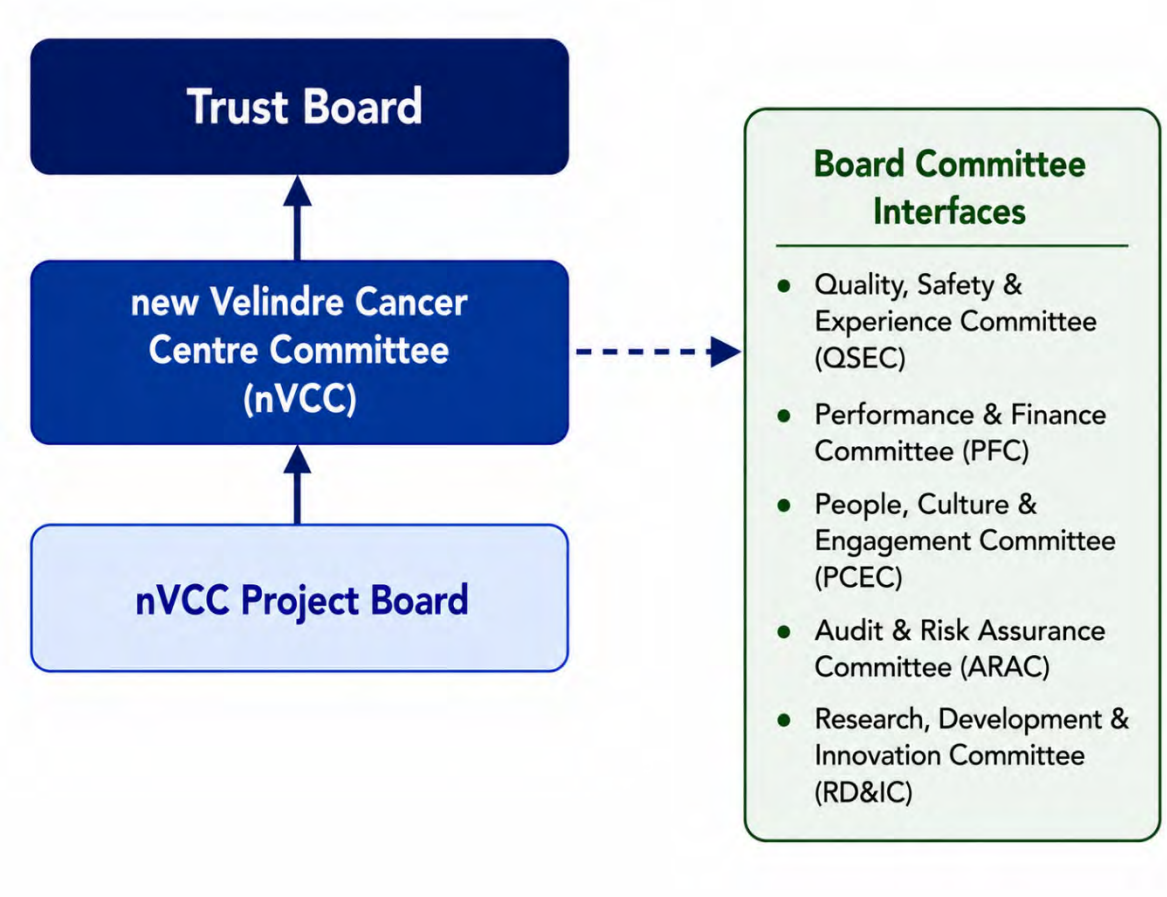
- Committees will undertake an annual self-assessment of its effectiveness and provide an annual report to the Board on its assurance activities, effectiveness, and delivery of its work programme.

APPENDIX 2

RD&I Committee governance structure and reporting arrangements



nVCC governance structure and reporting arrangements



Schedule 4

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Terms of Reference and Operating Arrangements for;

- Local Partnership Forum
- Advisory Consultants Appointment Committee

CONTENTS

1.	Local Partnership Forum	3
2.	Advisory Consultants Appointment Committee	11
3.	Academic Partnership Board	16

Local Partnership Forum

Terms of Reference & Operating Arrangements

Reviewed:	July 2025
Next Review Due:	July 2026

1. INTRODUCTION

1.1 The Trust's standing orders provide for the establishment of a Local Partnership Forum (LPF) and that the Board must formally approve terms of reference and operating arrangements for the LPF.

The LPF will also operate in accordance with the Trade Union Congress (TUC) six principles of partnership working, namely;

- A shared commitment to the success of the organisation.
- A focus on quality of working life.
- Recognition of the legitimate roles of the employer and trade union.
- A commitment by the employer to employment security.
- Openness on both sides and willingness by the employer to share information and discuss future plans of the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

1.2 The detailed terms of reference and operating arrangements set by the Board in respect of this forum are set out below.

2. PURPOSE

2.1 The purpose of the Local Partnership Forum (LPF) is;

To provide a formal mechanism where the Trust, as employer and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

2.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

2.3 The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board:

- In written advice or
- In any other form specified by the Board.

2.4 The Local Partnership Forum will seek consensus and compromise through effective consultation in Trust's strategic decisions that have significant impact on our people.

2.5 The Local Partnership Forum will Seek consensus and compromise though effective consultation on the Trust's delivery of its well-being objectives, including those set under section 3(2)(a) of the WFGA 2015.

2.6 Compliance with Duty of Quality legislation

3. MEMBERSHIP

Joint Chairs

3.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the Board.

The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

3.2 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

3.3 Membership of the LPF comprises;

	Staff Representative	**Management Representative**
Joint Chair	TBC	Executive Director of Organisational Development & Workforce (WF&OD)
Joint Vice Chair	Social Partnership Lead	
	All accredited staff reps within the Trust	Chief Executive Officer
		Deputy Director of OD & Workforce
		Executive Director of Finance
		Executive Director of Nursing, Allied Health Professionals and Health Science
		Chief Operating Officer
		Director VCC
		Director WBS

All members of the LPF are full and equal members and collectively share responsibility for its decisions.

All members must:

- Be prepared to engage with and contribute to the LPFs activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes and

- Promote the work of the LPF within the professional discipline they represent.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF and their attendance has been agreed by the Joint Chairs/Vice Chairs prior to the meeting.

Appointment and Terms of Office

3.4 Management representative members shall be determined by the Board.

Staff representatives shall be determined by the staff organisations recognised by the Trust, subject to the following conditions:

- Staff representatives must be employed by the Trust and accredited by their respective trade union and
- A member's tenure of appointment will cease in the event that they are no longer employed by the Trust or cease to be a member of their nominating trade union.

The Management Representative Chair shall be appointed by the Board.

The Staff Representative Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Chair's term of office shall be for one (1) year.

The Management Representative Vice Chair shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

The Staff Representative Vice Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Vice Chair's term of office shall be for one (1) year.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

Removal, suspension and replacement of members

3.5 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from officer unless they are satisfied that:

(a) The absence was due to a reasonable cause and
(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

If the LPF considers that it is not conductive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

3.6 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

3.7 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4. SUB FORA

4.1 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions / Directorates / Service areas: and or
- Detailed discussion in relation to a specific issue(s).

Sub fora that have been established;

- The LPF Policy Sub-Group.

5. MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the LPF, one of whom should be the Management Chair or Vice Chair or the staff representative Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Joint Chairs deem necessary. Where joint Chairs agree, an extraordinary meeting of the LPF may be scheduled with 7 calendar days notice.

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

6.1 The LPF's main link with the Board is through the Executive Members of the LPF.

6.2 The Board may determine that designated Trust Members or staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Trust members or staff, subject to the agreement of the Trust Chair.

6.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

6.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

6.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

7. SUPPORT TO THE LPF

7.1 The LPF's work shall be supported by two designated Secretary's one of whom shall support the staff representative members and one shall support the management representative members.

7.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

7.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representatives.

7.4 Both Secretaries shall work closely with the Trust's Board Secretary who is responsible for the overall planning and co-ordination of the Trust's programme of Board business, including that of its Committees and Advisory Groups.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Joint Chairs shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the LPF's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
- The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the LPF;
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

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

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum – as per section 5.1 above.

Cross reference with the Trust Standing Orders.

10. REVIEW

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

11. CHAIR'S ACTION ON URGENT MATTERS

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

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

Date Terms of Reference Approved: 24 July 2025

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid ‘put downs’ of views or points made by colleagues
- Respect a colleague’s point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No ‘side-meetings’ to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as ‘staff organisations’ within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Advisory Consultant Appointment Committee

Terms of Reference and Operating Arrangements

1. INTRODUCTION

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

1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Advisory Appointment Committees (AACs)** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on and compliant with the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

1.4 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

2. PURPOSE

2.1 The arrangements for appointments to NHS Consultant posts are stipulated in statutory regulations: "The NHS (Appointment of Consultants) Regulations 1996", as amended. These are supported by "The National Health Service (Appointment of Consultants) Regulations Good Practice Guidance", published by the Department of Health in January 2005.

2.2 The regulations provide for appointments to be made via Advisory Appointments Committees (AACs).

3. DELEGATED POWERS AND AUTHORITY

3.1 The Trust Board has delegated to the Committee the authority to make decisions on all appointments and for appointments to be reported to the Trust Board at a subsequent meeting where the decision to appoint is unanimous. Cross reference section 5.5 and Annex B of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005

3.2 If the Committee cannot make a unanimous decision, the majority recommendation will be referred to the Trust Board for ratification, before an offer of appointment is made.

4. MEMBERSHIP

4.1 The NHS (Appointment of Consultants) Regulations 1996 set out the governing membership for the AAC. In meeting these provisions the Trust should seek to secure a balanced Committee.

4.2 An outgoing consultant should not be a member of the Committee set up to select his/her successor.

4.3 Particular care needs to be taken in relation to Committee membership when appointing to posts across two or more Trusts, or to appointments made in conjunction with universities. For example, it is possible to contract an employee jointly between two Trusts. When constituting the AAC in such cases, the requirements in the Regulations for joint appointments will need to be met.

4.4 Trusts must ensure that no close relative of any candidate or candidate's partner serves on the Committee. If it becomes apparent during the short-listing of candidates that any member of the Committee is a close relative or partner of a candidate, that member should be invited to stand down and a replacement nomination sought.

4.5 Occasionally, one of the candidates will be well known to the 'local' members of the Committee. Such prior experience must not be allowed to interfere with an objective assessment of the candidates. A member may also have provided a reference for a candidate. On such occasions, the member must declare an interest and be careful not to show a bias.

4.6 The core membership of the Committee, as specified in Regulations, is set out below:

Chair	Chairman of the Board (Independent Member)
Members	Chief Executive Officer

Medical Director (Clinical Director to deputise in their absence)

Clinical Director or Consultant from relevant specialty as their deputy.

External Professional Assessor from the College or University.

4.7 The Trust is free to add additional members, but the balance of the Committee must continue to have local and a medical majority. The Trust must seek to ensure that the size of the Committee is, in all cases, kept to a minimum.

Attendees

4.8 The Committee may require the attendance for advice, support and information routinely at meetings from:

- Faculty Consultant Lead
- Executive Director of Workforce & Organisational Development
- Trust Secretary
- Assistant Director of Research & Development

Secretariat

4.9 Secretary as determined by the Medical Director or the Executive Director of Workforce & Organisational Development who is involved in the recruitment procedure. Cross-reference section 4.9 of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

Member Appointments

4.10 Appointed Independent Members shall hold office for a period that corresponds with their appointment to the Trust Board.

Support to Committee Members

4.11 The Executive Director of Workforce & Organisational Development, on behalf of the Committee Chair, shall:

- Ensure all Committee members receive the NHS Appointment of Consultants Regulations outlining their individual and collective role on the Committee.

- Retain all records and documents in connection with the short-listing and interviewing, including formal records of the decision and informal notes taken by members of the Committee, for a minimum of five years,

confidentiality being secured in case an applicant were to bring a claim against the Trust (e.g. alleging discrimination), as an employment tribunal may require these papers.

- Ensure all members of the Committee will have received appropriate training. It is the responsibility of the Trust to ensure that training has been provided. This should cover all aspects of the appointments process and concentrate on those areas where difficulties may arise:
    - Equal opportunities (refer to Annex E of the guidance)
    - Matters which should not be discussed at the interview other than in exceptional circumstances.

4.12 The role of the Board Secretary shall be to:

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

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

5. COMMITTEE MEETINGS

Quorum

5.1 The Committee may not proceed if any core member (or their appointed deputy) is not present.

5.2 Prospective members of the Committee should notify the Trust immediately they become aware they are no longer able to attend the Committee on the set date. The Trust should then find an appropriate replacement.

Frequency of meetings

5.3 Meetings shall be held as required to ensure support to the timely recruitment of consultants and otherwise as the Committee Chairs deems necessary.

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

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

6.2 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and

- appropriate sharing of information

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 A brief report of the Committee should be prepared and signed by the Chair.

7.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board via the Workforce & Organisational Development Committee and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of Committee minutes and written reports as necessary throughout the year.

7.2 The Trust Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

7.4 Formal records of the decision made by the Committee should be retained for a minimum of five years, confidentiality being secured.

7.5 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Chairs Action on Urgent Matters

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the NHS (Appointment of Consultants) Regulations and the Board.

Schedule 5

STANDING ORDERS FOR THE OPERATION OF THE SHARED SERVICES PARTNERSHIP COMMITTEE

This Annexe forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Table of Contents

Foreword 5
Section: A – Introduction 7
Statutory Framework 7
NHS Framework 9
Shared Services Partnership Committee Framework 10
Applying Shared Services Standing Orders 10
Variation and amendment of SSPC Standing Orders 12
Interpretation 12
Relationship with Velindre University NHS Trust Standing Orders 13
The Role of the Board Secretary Support Function 13
Section B – Standing Orders 14
1. THE SHARED SERVICES PARTNERSHIP COMMITTEE(SSPC) 14
1.1 Purpose, Role, Responsibilities and Delegated Functions 14
1.2 Membership of the SSPC 16
1.3 Member and Staff Responsibilities and Accountability 16
1.4 Appointment and tenure of (SSPC) members 18
1.5 Termination of Appointment of SSPC Chair and Vice Chair 19
1.6 Appointment of NWSSP Staff 19
1.7 Responsibilities and Relationships with each Health Board, Trust and Special Health Authority's Board, Velindre University NHS Trust as the Host and Others 20
2 RESERVATION AND DELEGATION OF SHARED SERVICES FUNCTIONS 20
2.1 Chair's Action on Urgent Matters 22
2.2 Delegation to Sub-Committees and Others 22
2.3 Delegation to Officers 22
3 SUB-COMMITTEES 23
3.1 Sub-Committees Established by the SSPC 23
3.2 Other Groups 24
3.3 Reporting Activity to the 24
4 EXPERT PANEL AND OTHER ADVISORY GROUPS 25
4.1 Expert Panels and Advisory Groups Established by the SSPC 25
4.2 Confidentiality 25
4.3 Reporting Activity 25
4.4 Terms of Reference and Operating Arrangements 26
4.5 The Local Partnership Forum (LPF) 26
4.6 Terms of Reference and Operating Arrangements 27
4.7 Membership 28
4.8 Member Responsibilities and Accountability 28
4.9 Appointment and Terms of Office 30
4.10 Removal, Suspension and Replacement of Members 30

4.11 Relationship with the SSPC and others 31
4.12 Support to the LPF 31
5 WORKING IN PARTNERSHIP 32
6 MEETINGS 32
6.1 Putting Citizens first 32
6.2 Working with Llais 33
6.3 Annual Plan of Committee Business 34
6.4 Calling Meetings 34
6.5 Preparing for Meetings 34
6.6 Conducting Meetings Admission of the public, the press and other observers 36
6.7 Record of Proceedings 41
6.8 Confidentiality 41
7 VALUES AND STANDARDS OF BEHAVIOUR 41
7.1 Declaring and Recording Members' Interests 41
7.2 Dealing with Members' interests during Shared Services Partnership 43
Committee meetings 43
7.3 Dealing with Officers' Interests 44
7.4 Reviewing How Interests are Handled 45
7.5 Dealing with Offers of Gifts[2] and Hospitality 45
7.6 Register of Gifts and Hospitality 46
8 SIGNING AND SEALING DOCUMENTS 47
8.1 Register of Sealing 47
8.2 Signature of Documents 47
8.3 Custody of Seal 48
9 GAINING ASSURANCE ON THE CONDUCT OF BUSINESS 48
9.1 The Role of Internal Audit in Providing Independent Internal assurance 48
9.2 Reviewing the Performance of the , its Sub-Committees, Expert Panel and Advisory Groups 49
9.3 External Assurance 49
10 DEMONSTRATING ACCOUNTABILITY 50
11 SUPPORT FOR THE 50
12 REVIEW OF STANDING ORDERS 51
Annex 1 52
MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS 53
DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES 54
HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT 55
SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS 56
SECTION 1 57
ANNEXE OF MATTERS RESERVED TO THE SSPC[3] 57
SECTION 2 62

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS 62
SECTION 3 65
ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS 65
SECTION 4 72
ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY 72
SECTION 5 73
NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION 73
Annexe 2 78
KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS 78
NHS Wales Framework 78
Annexe 3 79
SUB-COMMITTEE ARRANGEMENTS 79
Annexe 4 96
ADVISORY GROUPS AND EXPERT PANELS 96
Annexe 5 109
Process for the Selection, Appointment and Termination of the Chair of the 109
SSPC

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Originally Introduced June 2015

(updated)

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006. Velindre University NHS Trust (Velindre) must agree Standing Orders (SOs) for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC SOs form an Annexe to Velindre's own SOs and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261

(W.156)) and Velindre's Standing Order 3 into day-to-day operating practice. Together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegation to NHS Wales Shared Services Partnership officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

These documents, together with the NWSSP Memorandum of Co-operation dated **[June 2012]** made between the seven Health Boards and three Trusts and two Special Health Authorities within NHS Wales, that defines the obligations of the 12 NHS bodies (the Partners) to participate in the SSPC and to take collective responsibility for the delivery of the services, a Hosting Agreement dated **[June 2012]** between the Partners that provides for the terms on which Velindre will host the NHS Wales Shared Services Partnership (NWSSP) and the Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of NWSSP (as the Accountable Officer for NWSSP) dated **[June 2012]** that defines the respective roles of the two Accountable Officers, form the basis upon which the SSPC governance and accountability framework is developed. Together with the adoption of a Standards of Behaviour Framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All SSPC members, NWSSP staff and Velindre staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Assistant Director of Corporate Services, NWSSP (Board Secretary for the SSPC) will be able to provide further advice and guidance on any aspect of the SOs or the wider governance arrangements for the SSPC. Further information on governance in the NHS in Wales may be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

Section: A – Introduction

Statutory Framework

i) Velindre University National Health Service Trust (Velindre) is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (1993/2838)** (the Establishment Order).

ii) The Velindre University NHS Trust (to be known as the SSPC for operational purposes) was established under the **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (2012/1261 (W.156))** (the Shared Services Regulations). The Shared Services Regulations define Shared Services at regulation 2 and the functions of the SSPC at regulation 4. The SSPC functions are subject to variations to those functions agreed from time to time by the SSPC**.** The SSPC is hosted by Velindre on behalf of each of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the Partners).

iii) The principal place of business of the SSPC is:

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

iv) All business shall be conducted in the name of the NHS Wales Shared Services Partnership on behalf of the Partners.

v) Velindre is a corporate body and its functions must be carried out in accordance with its statutory powers and duties. Velindre's statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation, which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

vi) The National Health Service Trusts (Membership and Procedure) Regulations 1990 (1990/2024), as amended (the Membership

Regulations) set out the membership and procedural arrangements of the Trust.

vii) Sections 18 and 19 of Annexe 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give Directions about how they exercise those functions. Trusts must act in accordance with those Directions. Velindre's statutory functions are set out in its Establishment Order but many functions are also contained in other legislation such as the NHS (Wales) Act 2006.

viii) However, in some cases, the relevant function may be contained in other legislation. In exercising its powers, Velindre must be clear about the statutory basis for exercising such powers.

ix) Under powers in paragraph 4(1)(f) of Annexe 3 to the NHS (Wales) Act 2006 the Minister has made the Shared Services Regulations which set out the constitution and membership arrangements of the . Certain provisions of the Membership Regulations will also apply to the operations of the SSPC, as appropriate.

x) In addition to Directions, the Welsh Ministers may from time-to-time issue guidance relating to the activities of the SSPC, which the Partners must take into account when exercising any function.

xi) The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers think about the quality of health services when making decisions (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. NWSSP shall ensure they consider these responsibilities in the discharge of their duties.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/nhs-duty-candour

xii) Velindre shall issue an indemnity to the NWSSP Chair, on behalf of the Partners.

NHS Framework

xiii) In addition to the statutory requirements set out above, the SSPC, on behalf of each of the Partners, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Minister's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance Principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xiv) Adoption of the principles will better equip the SSPC to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xv) The overarching NHS governance and accountability framework within which the SSPC must work incorporates Velindre's SOs; Annexes of Powers reserved for the Board and Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the Health and Care Quality Standards 2023, , the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xvi) The Welsh Ministers, reflecting their constitutional obligations, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.

xvii) Full, up to date details of the other requirements that fall within the NHS

framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders.

Directions or guidance on specific aspects of Trusts' business are also issued in hard copy, usually under cover of a Ministerial letter.

Framework

xviii) The specific governance and accountability arrangements established for the SSPC are set out within the following documents (which is not an exhaustive list):

- these SSPC SOs and Annexe 1: Scheme of Powers reserved for the SSPC and Delegation to others;
- the Velindre University NHS Trust SFIs;
- a Memorandum of Co-operation that defines the obligations of the Partners to participate in the SSPC and to take collective responsibility for the delivery of the services defining the respective roles of the Partners;
- a Hosting Agreement between the Partners that provides for the terms on which Velindre will host NWSSP;
- an Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of Shared Services (as the Accountable Officer for NWSSP) that defines the respective roles of the two Accountable Officers; and
- an Accountability Agreement between the Chair of the SSPC and the Managing Director of Shared Services (as the Accountable Officer for NWSSP).

xix) Annexe 2 to these SOs provides details of the key documents that, together with these SOs, make up the SSPC's governance and accountability framework. These documents must be read in conjunction with these SSPC SOs.

xx) The SSPC may from time to time, subject to the prior approval of Velindre's Board, agree operating procedures which apply to SSPC members and/or members of NWSSP staff and others. The decisions to approve these operating procedures will be recorded in an appropriate SSPC minute and, where appropriate, will also be considered to be an integral part of these SSPC SOs and SFIs. Details of the SSPC's key operating procedures are also included in Annexe 2 of these SOs.

Applying Shared Services Standing Orders

xxi) These SSPC SOs (together with the Velindre University NHS Trust SFIs

and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Sub-Committees established by the SSPC, including any Advisory Groups. These SSPC SOs may be amended or adapted for the Sub-Committees or Advisory Groups as appropriate, with the approval of the SSPC. Further details on Sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these NWSSP, respectively.

Full details of any non-compliance with these SSPC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Assistant Director of Corporate Services, who will ask the Velindre Audit Committee to formally consider the matter and make proposals to the SSPC on any action to be taken. All SSPC members and SSPC officers have a duty to report any non-compliance to the Assistant Director of Corporate Services as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with SSPC SOs is a disciplinary matter.**

Variation and amendment of SSPC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the SSPC determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the SSPC, advised by the Assistant Director of Corporate Services, shall submit a formal report to the Velindre Trust Board, setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the SSPC members are in favour of the amendment; or
- In the event that agreement cannot be reached, the Velindre Trust Board determine that the amendment should be approved.

Interpretation

xxiii) During any SSPC meeting where there is doubt as to the applicability or interpretation of the SSPC SOs, the Chair of the SSPC shall have the final say, provided that their decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Board Secretary support function.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SSPC SOs, when interpreting any term or provision covered by legislation.

Relationship with Velindre University NHS Trust Standing Orders

xxv) These SSPC SOs form an Annexe to Velindre's own SOs and shall have effect as if incorporated within them.

The Role of the Board Secretary Support Function

xxvi) The role of the Board Secretary support function is crucial to the ongoing development and maintenance of a strong governance framework within the SSPC and is a key source of advice and support to the Chair and SSPC members. Independent of the SSPC, the Board Secretary support function will act as the guardian of good governance within the SSPC and shall ensure that the functions outlined below are delivered:

- providing advice to the SSPC as a whole and to individual Committee members on all aspects of governance;
- facilitating the effective conduct of SSPC business through meetings of the SSPC, its Sub-Committees and Advisory Groups;
- ensuring that SSPC members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- ensuring that in all its dealings, the SSPC acts fairly, with integrity, and without prejudice or discrimination;
- contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- monitoring the SSPC's compliance with the law, Shared Services SOs and the framework set by Velindre and Welsh Ministers.

xxvii) As advisor to the SSPC, the Board Secretary support function role does not affect the specific responsibilities of SSPC members for governing the Committee's operations. The Board Secretary Support role is directly accountable for the conduct of their role to the Chair of the SSPC and reports to the Managing Director of NWSSP on a regular basis.

Section B – Standing Orders

1. THE (SSPC)

1.1 Purpose, Role, Responsibilities and Delegated Functions

1.1.1 The SSPC has been established for the purpose of exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Boards and Trusts in Wales.

1.1.2 The purpose of the SSPC is to:

- set the policy and strategy for NWSSP;
- monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- seek to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners;
- ensure the efficient and effective leadership direction and control of NWSSP; and
- ensure a strong focus on delivering savings that can be re-invested in direct patient care.

1.1.3 The role of the SSPC is to:

- take into account NHS Wales organisations' plans and objectives when considering the strategy of NWSSP;
- encourage and support the aims and objectives of NWSSP;
- identify synergies between each of the Shared Services and ensure that future strategies incorporate synergistic opportunities;
- foster and encourage partnership working between all key stakeholders and staff;
- oversee the identification and sharing of financial benefits to NHS Wales' organisations on a fair basis that minimises administrative costs and financial transactional arrangements;
- seek to identify potential opportunities for further collaboration across the wider public sector;
- consider implications for Shared Services in relation to any reviews / reports undertaken by internal auditors, external auditors, and regulators, including Healthcare Inspectorate Wales; and
- seek assurance, through the Managing Director of NWSSP, on the adequacy and robustness of systems, processes, procedures, and

risk management, staffing issues and that risks and benefits are shared on an equitable basis in relation to Shared Services.

1.1.4 The responsibilities of the SSPC are to:

- produce an Integrated Medium-Term Plan, including the balanced Medium-Term Financial Plan for agreement by the Committee, following the publication of the individual Health Board, Trust, and Special Health Authority Integrated Medium-Term Plans;
- agree, on an annual basis, Service Improvement Plans (prepared by the Managing Director of NWSSP) for the delivery by services;
- be accountable for the development and agreement of policies and strategies in relation to Shared Services and for monitoring the performance and delivery of agreed targets for Shared Services through the Managing Director of NWSSP;
- take the lead in overseeing the effective and efficient use of the resources of Shared Services;
- benchmark the performance of Shared Services against the best in class;
- consider extended-scope opportunities for Shared Services;
- monitor compliance of best practice within Shared Services with NHS Wales recommended best practice;
- oversee the identification and delivery of "invest to save" opportunities;
- explore future Shared Services organisational delivery models across the NHS and the broader public sector*; and*
- embed NWSSP's strategic objectives and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations (Wales) Act 2015, the Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains.

1.1.5 The SSPC must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each Health Board, Trust, and Special Health Authority, shall be bound by the decisions of the SSPC in the exercise of its roles. In the event that the SSPC is unable to reach unanimous agreement in relation to the funding levels to be provided by each Health Board, Trust, and Special Health Authority, then this matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the SSPC shall lead and scrutinise the operations, functions and decision making of the NWSSP Senior Leadership Group (SLG) undertaken at the direction of the SSPC.

1.1.7 The SSPC shall work with all its Partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the SSPC

1.2.1 The membership of the SSPC shall be 14 voting members, comprising:

- the Chair (appointed by the SSPC in accordance with the Chair Selection Process at Annexe 5 to these SOs):
- the Chief Executives of each of the Health Boards, Trusts, and Special Health Authority (or their nominated representatives); and
- the Managing Director of NWSSP, who has been designated as the Accountable Officer for Shared Services.

1.2.2 *Vice Chair* – The SSPC shall appoint a Vice Chair from one of the Chief Executives (or their nominated representative) SSPC members. A Vice Chair cannot be appointed if the current Chair is employed by the same Partner organisation.

1.2.3 *Nominated Representatives* – Nominated deputies for Chief Executives should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights.

1.2.4 *Co-opted Members* – The SSPC may also co-opt additional independent 'external' members from outside NHS Wales to provide specialist skills, knowledge, and expertise. Co-opted members will not be entitled to vote.

1.2.5 *Attendees* – The NWSSP Director of Finance and Corporate Services / Director of Planning, Performance, and Information, NWSSP Director of People & Organisational Development (or nominated representative) and the Medical Director may attend the SSPC meetings but will not be entitled to vote. Other NWSSP Service Directors / Heads of Service may only attend SSPC meetings, as and when invited.

1.2.6 *Use of the Term Independent Member* - For the purposes of these SPC SOs, use of the term 'Independent Member' refers to the non-officer members of a Health Board or the independent members of a Trust, or Special Health Authority.

1.3 Member and Staff Responsibilities and Accountability

1.3.1 The SSPC will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the SSPC.

1.3.2 All members must comply with the terms of their appointment to the SSPC.

They must equip themselves to fulfil the breadth of their responsibilities on the SSPC by participating in relevant personal and organisational development programmes, engaging fully in the activities of the SSPC and promoting understanding of its work.

The Chair

1.3.3 The Chair of the SSPC must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.4 The Chair is responsible for the effective operation of the SSPC:

- chairing SSPC meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all SSPC business is conducted in accordance with these SSPC SOs; and
- developing positive and professional relationships amongst the SSPC's membership and between the SSPC and each Health Board, Trust and Special Health Authority's Board.

1.3.5 The Chair shall work in close harmony with the Chief Executives of each of the Health Board, Trust and Special Health Authority (or their nominated representatives) and supported by the Assistant Director of Corporate Services, shall ensure that key and appropriate issues are discussed by the SSPC in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is accountable to the SSPC in relation to the delivery of the functions exercised by the SSPC on its behalf and, through Velindre's Chair, as the hosting organisation, for the conduct of business in accordance with the defined governance and operating framework.

The Vice Chair

1.3.7 The Vice Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing Chair resumes their duties, or a new Chair is appointed.

1.3.8 The Vice Chair is accountable to the Chair for their performance as Vice Chair.

Managing Director of NWSSP and the Chief Executive of Velindre

1.3.9 **Managing Director of NWSSP** – The Managing Director of NWSSP, as

head of the Senior Leadership Group, reports to the Chair and is responsible for the overall performance of NWSSP. The Managing Director of NWSSP is the designated Accountable Officer for NWSSP (see 1.3.11 below). The Managing Director of NWSSP is accountable to the SSPC in relation to those functions delegated to them by the SSPC. The Managing Director of NWSSP is also accountable to the Chief Executive of Velindre University NHS Trust in respect of the hosting arrangements supporting the operation of NWSSP.

1.3.10 **Chief Executive of Velindre** – The Chief Executive of Velindre University NHS Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust (see 1.3.11 below). As the host organisation, the Chief Executive (and the Velindre Trust Board) has a legitimate interest in the activities of NWSSP and has certain statutory responsibilities as the legal entity hosting NWSSP.

1.3.11 **Accountable Officers** – The Managing Director of NWSSP (as the Accountable Officer for NWSSP) and the Chief Executive of Velindre (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of their roles, as set out in their respective Accountable Officer Memoranda. Both Accountable Officers shall co-operate with each other so as to ensure that full accountability for the activities of the NWSSP and Velindre is afforded to the Welsh Ministers whilst minimising duplication.

Senior Leadership Group (SLG)

1.3.12 The Managing Director of NWSSP will lead a SLG to deliver the SSPC's annual Business Plan. The SLG will be determined by the Managing Director of NWSSP.

1.4 Appointment and tenure of (SSPC) members

1.4.1 The ***Chair*** is appointed by the SSPC in accordance with the appointment process outlined in Annexe 5 and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Chair can be reappointed but may not serve as the Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term. Through the appointment process, the SSPC must satisfy itself that the person appointed has the necessary skills and experience to perform the duties. In accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012, the first chair of the Committee would be appointed by Velindre for a period of six months.

1.4.2 The ***Vice Chair*** is appointed by the SSPC from its Chief Executive (or their nominated representatives) members and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Vice Chair may not serve as the Vice Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in term.

1.4.3 The appointment and removal process for the Chair and Vice Chair shall be determined by the SSPC. In making these appointments, the SSPC must ensure:

- a balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the SSPC;
- that wherever possible, the overall membership of the SSPC reflects the diversity of the population;
- potential conflicts of interest are kept to a minimum;
- the Vice Chair is not employed by the same Partner organisation as the Chair; and
- that the person has the necessary skills and experience to perform the duties of the chair.

1.5 Termination of Appointment of SSPC Chair and Vice Chair

1.5.1 The Committee may remove the SSPC Chair or Vice Chair by the process outlined in Annexe 5 to these SOs if it determines:

- It is not in the interests of the SSPC; or
- It is not conducive to good management of the SSPC

for that Chair or Vice Chair to continue to hold office.

1.5.2 All SSPC members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant Regulations. Any member must inform the SSPC Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

1.5.3 The SSPC will require its Chair and members to confirm their continued eligibility on an annual basis in writing.

1.6 Appointment of NWSSP Staff

1.6.1 NWSSP staff shall be appointed by Velindre. The appointments process shall be in line with the workforce policies and procedures of Velindre and any directions made by the Welsh Ministers.

1.7 Responsibilities and Relationships with each Health Board, Trust and Special Health Authority's Board, Velindre University NHS Trust as the Host and Others

1.7.1 The SSPC is not a separate legal entity from each of the Health Boards, Trusts, and Special Health Authorities. It shall report to each Health Board, Trust, and Special Health Authority Board on its activities, to which it is formally accountable in respect of the exercise of the Shared Services functions carried out on their behalf. Velindre's Trust Board will not be responsible or accountable for exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Board, Trust, and Special Health Authority. Velindre's Board, as the host organisation, shall be responsible for ensuring that NWSSP staff act in accordance with the administrative policies and procedures agreed between Velindre and the SSPC.

1.7.2 Each Health Board, Trust and Special Health Authority shall determine the arrangements for any meetings with the Managing Director of NWSSP and their organisation through the SSPC.

1.7.3 The Health Board, Trust, and Special Health Authority Chairs, through the lead Chair, shall put in place arrangements to meet with the SSPC Chair on a regular basis to discuss the SSPC's activities and operation.

2 RESERVATION AND DELEGATION OF SHARED SERVICES FUNCTIONS

Within the framework agreed by Velindre, and set out within these SSPC SOs, and subject to any directions that may be given by the Welsh Ministers, the SSPC may make arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the SSPC may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the SSPC must set out clearly the terms and conditions upon which any delegation is being made.

The SSPC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Scheme of matters reserved to the SSPC;
ii Scheme of Delegation to Sub-Committees of the SSPC and others; and

iii Scheme of Delegation, including financial limits, to Velindre NWSSP officers and non-NWSSP officers

all of which must be formally agreed by Velindre and adopted by the SSPC.

The SSPC retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's Action on Urgent Matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the SSPC need to be taken between scheduled meetings, and it is not practicable to call a meeting of the SSPC. In these circumstances, the SSPC Chair and the Managing Director of NWSSP may deal with the matter on behalf of the SSPC - after first consulting with at least one other Health Board, Trust, or Special Health Authority Chief Executive (or their representative). The Assistant Director of Corporate Services must ensure that any such action is formally recorded and reported to the next meeting of the SSPC for consideration and ratification.

2.2 Delegation to Sub-Committees and Others

2.2.1 The SSPC shall agree the delegation of any of their functions to Sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by Velindre.

2.2.2 The SSPC shall agree and formally approve the delegation of specific powers to be exercised by Sub-Committees which it has formally constituted or to others.

2.3 Delegation to Officers

2.3.1 The SSPC will delegate certain functions to the Managing Director of NWSSP. For these aspects, the Managing Director of NWSSP, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other Velindre officers to undertake the remaining functions. The Managing Director of NWSSP will still be accountable to the SSPC for all functions delegated to them, irrespective of any further delegation to other Velindre officers.

2.3.2 This must be considered and approved by the SSPC (subject to any amendment agreed during the discussion) and agreed by Velindre. The Managing Director of NWSSP may periodically propose amendment to the Scheme of Delegation and any such amendments must also be

considered and approved by the SSPC and agreed by Velindre.

2.3.3 Individual members of the NWSSP SLG are in turn responsible for delegation within their own teams in accordance with the framework established by the Managing Director of NWSSP and agreed by the SSPC and Velindre.

3 SUB-COMMITTEES

In accordance with SSPC Standing Order 4.0.3, the SSPC may and, where directed by Velindre must, appoint Sub-Committees of the SSPC either to undertake specific functions on the SSPC's behalf or to provide advice and assurance to others (whether directly to the SSPC, or on behalf of the SSPC). Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs. NWSSP officers may only be appointed to serve as members on any committee, where that committee does not have the function of holding that officer to account.

These may consist wholly or partly of SSPC members or of persons who are not SSPC members.

3.1 Sub-Committees Established by the SSPC

The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or utilise Velindre's Committee arrangements to assist it in discharging its governance responsibilities. The SSPC shall ensure its Sub-Committee structure meets the needs of Velindre University NHS Trust, as the host organisation, and also the needs of its Partners. As a minimum, it shall ensure arrangements are in place to cover the following aspects of SSPC business:

- Audit

3.1.1 The SSPC may make arrangements to receive and provide assurance to others through the establishment and operation of its own Sub-Committees or by placing responsibility with Velindre, as the host. Where responsibility is placed with Velindre, the arrangement shall be detailed within the Hosting Agreement between the SSPC and Velindre as the host organisation and/or the Interface Agreement between the Managing Director of NWSSP (as the Accountable Officer for NWSSP) and Velindre's Chief Executive (as Accountable Officer for the Trust).

The SSPC has the following Sub-Committees:

- Velindre Audit Committee for SSPC
- Welsh Risk Pool Committee

Full details of the Sub-Committee structure established by the SSPC, including detailed Terms of Reference for each of these Sub-Committees, are set out in Annexe 3 of these SSPC SOs.

3.1.2 Each Sub-Committee established by or on behalf of the SSPC must have its own Terms of Reference and operating arrangements, which must be formally approved by the SSPC and agreed by Velindre. These must establish its governance and ways of working, setting out, as a minimum:

- the scope of its work (including its purpose and any delegated powers and authority);
- membership and quorum;
- meeting arrangements;
- relationships and accountabilities with others;
- any budget and financial responsibility, where appropriate;
- secretariat and other support;
- training, development, and performance; and
- reporting and assurance arrangements.

3.1.3 In doing so, the SSPC shall specify which aspects of these SSPC SOs are not applicable to the operation of the Sub-Committee, keeping any such aspects to the minimum necessary.

3.1.4 The membership of any such Sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre. Depending on the Sub-Committee's defined role and remit, membership may be drawn from the SSPC or Velindre staff (subject to the conditions set in NWSSP Standing Order 3.1.5) or others.

3.1.5 Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to NWSSP officers. Designated NWSSP Directors or Heads of Services or other NWSSP officers shall, however, be in attendance at such Sub-Committees, as appropriate.

3.2 Other Groups

3.2.1 The SSPC may also establish other groups to help it in the conduct of its business.

3.3 Reporting Activity to the

3.3.1 The SSPC must ensure that the Chairs of all Sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the SSPC on their activities. Sub-Committee Chairs' shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

3.3.2 Each Sub-Committee shall also submit an annual report to the SSPC through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4 EXPERT PANEL AND OTHER ADVISORY GROUPS

4.1.1 The SSPC may appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the SSPC, including detailed terms of reference are set out in Annexe 4 of these Shared Services SOs.

4.1 Expert Panels and Advisory Groups Established by the SSPC

- Evidence Based Procurement Board
- Welsh Energy Group (WEG) and Welsh Energy Operating Group (WEOG)

4.2 Confidentiality

4.2.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

4.3 Reporting Activity

4.3.1 The SSPC shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the SSPC on their activities. Expert Panel or Advisory Group Chairs shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.3.2 Any Expert Panel or Advisory Group shall also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4.3.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

4.4 Terms of Reference and Operating Arrangements

4.4.1 The SSPC and the Velindre Board must formally approve terms of reference and operating arrangements in respect of any Expert Panel or Advisory Group. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development, and performance; and
- Reporting and assurance arrangements.

4.4.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

4.4.3 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre.

4.4.4 The SSPC may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the SSPC approves such action.

4.5 The Local Partnership Forum (LPF)

4.5.1 The LPF's role is to provide a formal mechanism where the SSPC, as employer, and trade unions/professional bodies representing NWSSP's employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the NWSSP – achieved through a regular and timely process of consultation, negotiation, and communication. In doing so, the LPF must effectively represent the views and interests of the NWSSP workforce.

4.5.2 It is the forum where the NWSSP and staff organisations will engage with each other to inform, debate, and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

4.5.3 NWSSP may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by NWSSP. The LPF may provide advice to the SSPC:

- In written advice; or
- In any other form specified by the Board.

4.6 Terms of Reference and Operating Arrangements

4.6.1 The SSPC must formally approve terms of reference and operating arrangements for the LPF. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountability and terms and conditions of office);
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the Board, its Committees and Advisory Groups, and other relevant local and national groups);
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support; and
- Reporting and assurance arrangements.

4.6.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working.

4.6.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/ Directorates/ Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

4.7 Membership

4.7.1 NWSSP shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

- Management Representatives;
- Managing Director;
- Director of Finance & Corporate Services; and
- Director of People and Organisational Development.

together with the following:

- General Managers/Divisional Managers; and
- People and Organisational Development staff

4.7.2 The Trust may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

Staff Representatives

4.7.3 The maximum number of staff representatives shall be *agreed by the LPF* comprising representation from those staff organisations recognised by NWSSP.

In attendance

4.7.4 The Trade Union member of the Board shall attend LPF meetings in an ex officio capacity.

4.7.5 The LPF may determine that full time officers from those staff organisations recognised by the Trust shall be invited to attend LPF meetings.

4.8 Member Responsibilities and Accountability

Joint Chairs

4.8.1 The LPF shall have two Chairs, on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.8.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff

Representative and Management Representative Chairs;

- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the SSPC.

4.8.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of NWSSP's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.8.4 The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by NWSSP.

Joint Vice Chairs

4.8.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.8.6 Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.8.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

4.8.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.8.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional disciplinethey

represent.

4.9 Appointment and Terms of Office

4.9.1 Management representative members shall be determined by the SSPC.

4.9.2 Staff representatives shall be determined by the staff organisations recognised by the NWSSP, subject to the following conditions:

- Staff representatives must be employed by **NWSSP** and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by **NWSSP** or cease to be a member of their nominating trade union.

4.9.3 The *Management Representative Chair* shall be appointed by the LPF.

4.9.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.9.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.9.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.9.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.10 Removal, Suspension and Replacement of Members

4.10.1 If an LPF member fails to attend three consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.10.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.10.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.10.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.11 Relationship with the SSPC and others

4.11.1 The LPF's main link with the SSPC is through the Managerial members of the LPF.

4.11.2 The Senior Leadership Group may determine that designated SLG members or NWSSP staff shall attend LPF meetings. The LPF's Chair may also request the attendance of SLG members or NWSSP staff, subject to the agreement of the Chair.

4.11.3 The SLG shall determine the arrangements for any joint meetings between the SLG and the LPF's staff representative members.

4.11.4 The Managing Director shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.11.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

4.12 Support to the LPF

4.12.1 The LPF's work shall be supported by two designated Secretaries, one of whom shall support the staff representative members and one shall support the management representative members.

4.12.2 The Director of People and Organisational Development will act as Management Representative Secretary and will be responsible for the

maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.12.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.12.4 Both Secretaries shall work closely with the NWSSP Assistant Director of Corporate Services who is responsible for the overall planning and co-ordination of the programme of SLG and Committee business, including that of its Advisory Groups.

5 WORKING IN PARTNERSHIP

5.1.1 The SSPC shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

5.1.2 The Chair shall ensure that the SSPC has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the NWSSP through:

- NWSSP's own structures and operating arrangements, e.g., Advisory Groups;

5.1.3 The SLG shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6 MEETINGS

6.1 Putting Citizens first

6.1.1 The SSPC's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The SSPC, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- active communication of forthcoming business and activities;
- the selection of accessible, suitable venues for meetings;

- the availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- requesting that attendees notify the Committee Secretariat of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and

where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Equality Act 2010 (Statutory Duties) (Wales) Regulations, Welsh Language (Health Sector) Regulations and Standards; as well as NWSSP's Communication Strategy and Velindre's Welsh Language Scheme.

6.1.2 The SSPC Chair will ensure that, in determining the matters to be considered by the SSPC, full account is taken of the views and interests of all citizens served by the SSPC on behalf of each Health Boards, Trust and Special Health Authority, including any views expressed formally. The Chair will ensure that, in determining the matters to be considered by the Committee, full account is taken of the views and interests of the Committee's stakeholders, including any views expressed formally to the Committee, e.g. through Llais.

6.2 Working with Llais

6.2.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations.

6.2.2 The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.2.3 The 2020 Act also places a statutory duty on LHBs and Trusts to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. LHBs

and Trusts must also have regard to the Code of Practice on access to premises when it comes into effect in June 2023.

6.2.4 The LHBs, NHS Trusts and the SPC will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning and commissioning services.

6.2.5 The SSPC shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretariat, on behalf of the SSPC Chair, shall produce an annual Business Plan of Committee business. This plan will include proposals on meeting dates, venues, and coverage of business activity during the year. The Business Plan shall also set out any standing items that shall appear on every SSPC agenda.

6.3.2 The Business Plan shall set out the arrangements in place to enable the SSPC to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing SSPC members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The Business Plan shall also incorporate formal SSPC meetings, regular Committee development sessions and, where appropriate, and the planned activities of Sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The SSPC shall agree the Business Plan for the forthcoming year by the end of March.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the SSPC, the SSPC Chair may call a meeting of the SSPC at any time. An individual SSPC member may request that the SSPC Chair call a meeting, provided that in at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from SSPC members, then those SSPC members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The SSPC Chair, in consultation with the Committee Secretariat and Managing Director of NWSSP, will set the agenda. In doing so, they will take account of the planned activity set in the annual cycle of SSPC business; any standing items agreed by the SSPC; any applicable items received from Sub-Committees and other groups as well as the priorities facing the SSPC. The SSPC Chair must ensure that all relevant matters are brought before the SSPC on a timely basis.

6.5.2 Any SSPC member may request that a matter is placed on the agenda by writing to the SSPC Chair, copied to the Committee Secretariat, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of SSPC business.

Notifying and equipping SSPC members

6.5.3 SSPC members should be sent an agenda and a complete set of supporting papers at least 10 calendar days before a formal SSPC meeting. This information may be provided to SSPC members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided after this time, provided that the SSPC Chair is satisfied that the SSPC's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the SSPC unless the SSPC Chair is satisfied (subject to advice from the Committee Secretariat, as appropriate) that the information contained within it is sufficient to enable the SSPC to take a reasonable decision. Equality Integrated Impact Assessments (EqIIAs) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the SSPC, and the outcome of that EqIIA shall be included within the report to the SSPC, to enable the SSPC to make an informed decision.

6.5.5 In the event that at least half of the SSPC members do not receive the agenda and papers for the meeting as set out above, the SSPC Chair must consider whether or not the SSPC would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the SSPC Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by SSPC members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with SSPC Standing Order 6.4, at least 10 calendar days before each meeting of the SSPC a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- at the SSPC's principal sites;
- on the SSPC's website, together with the papers supporting the public part of the agenda; as well as
- through other methods of communication as set out in the SSPC's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, the SSPC shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.6 Conducting Meetings Admission of the public, the press and other observers

6.6.1 The SSPC shall encourage attendance at its formal SSPC meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the SSPC. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility such as an induction loop system.

6.6.2 The SSPC shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter affecting a NWSSP officer, a patient, or a procurement contract. In such cases, the Chair (advised by the NWSSP Assistant Director of Corporate Services, where appropriate) shall Annexe these issues accordingly and requires that any observers withdraw from the meeting. In doing so, the SSPC shall resolve:

"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" [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

6.6.3 In these circumstances, when the SSPC is not meeting in public session, it shall operate in private session, formally reporting any decisions taken to the next meeting of the SSPC in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a SSPC meeting held in public session.

6.6.4 The NWSSP Assistant Director of Corporate Services, on behalf of the SSPC Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal SSPC meetings from members of the public and others, the SSPC shall make clear that attendees are welcomed as observers. The SSPC Chair shall take all necessary steps to ensure that the SSPC's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting. In doing so, the SSPC shall resolve:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the SSPC to reconvene the meeting and to complete business without the presence of the public".

6.6.6 Unless the SSPC has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the SSPC, its Sub-Committees, Expert Panel or Advisory Groups

6.6.7 The SSPC shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the SSPC, its Sub-Committees, expert panel, or Advisory Groups, and may change, alter, or vary these terms and conditions as it considers appropriate. In doing so, the SSPC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the SSPC (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

Chairing SSPC Meetings

6.6.8 The Chair of the SSPC will preside at any meeting of the SSPC unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent, then no formal business shall take place.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the SSPC to reach effective decisions on the matters before it. This includes ensuring that SSPC members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the SSPC must have access to appropriate advice on the conduct of the meeting through the attendance of the Assistant Director of Corporate Services. The Chair has the final say on any matter relating to the conduct of SSPC business.

Quorum

6.6.10 At least 6 voting members, at least 4 of whom are Health Board, Trust, or Special Health Authority Chief Executives (or their nominated representatives) and one is either the Chair or the Vice Chair, must be present to allow any formal business to take place at an SSPC meeting. If the Managing Director of NWSSP is not present, then no formal business should be transacted unless there is, in attendance, a properly authorised deputy for the Managing Director.

6.6.11 If a Health Board, Trust, or Special Health Authority Chief Executive (or their nominated representative) or the Managing Director of NWSSP is unable to attend a SSPC meeting, then a nominated deputy may attend in their absence which should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights, provided that the Chair has agreed the nomination before the meeting.

6.6.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any SSPC member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.13 In the normal course of SSPC business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a SSPC member may put forward a motion proposing that a formal review of that service area is undertaken. The Board Secretary support role will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the SSPC unless moved by a SSPC member and seconded by another SSPC member (including the SSPC Chair).

6.6.14 **Proposing a formal notice of Motion** – Any SSPC member wishing to propose a motion must notify the SSPC Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the SSPC Chair has determined that the proposed motion is relevant to the SSPC's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the SSPC Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.15 The SSPC Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of SSPC business.

6.6.16 **Amendments -** Any SSPC member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the SSPC alongside the motion.

6.6.17 If there are a number of proposed amendments to the Motion, each amendment will be considered in turn, and if passed, the amended Motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.6.18 **Motions under discussion** – When a motion is under discussion, any SSPC member may propose that:

- the motion be amended;
- the meeting should be adjourned;
- the discussion should be adjourned and the meeting proceed to the next item of business;
- a SSPC member may not be heard further;
- the SSPC decides upon the motion before them;

- an ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.20 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconded and the SSPC Chair.

6.6.21 **Motion to rescind a resolution –** The SSPC may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months unless the motion is supported by the (simple) majority of SSPC members.

6.6.22 A motion that has been decided upon by the SSPC cannot be proposed again within six months except by the SSPC Chair, unless the motion relates to the receipt of a report or the recommendations of a Sub-Committee/Managing Director of NWSSP to which a matter has been referred.

Voting

6.6.23 The SSPC Chair will determine whether SSPC members' decisions should be expressed orally, through a show of hands, or by secret ballot or by recorded vote. The SSPC Chair must require a secret ballot if the majority of voting SSPC members request it. Where voting on any question is conducted, a record shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the minutes shall record the name of the individual and the way in which they voted.

6.6.24 In determining every question at a meeting, the SSPC members must take account, where relevant, of the views expressed and representations made by individuals who represent the interests of citizens in Wales. Such views may be presented to the SSPC through the Chairs of any Expert Panel, Advisory Group and/or the Llais representative(s).

6.6.25 Except for decisions related to the overall funding contribution from each of the Health Boards, Trusts, or Special Health Authority, the SSPC will make decisions subject to a 2/3 majority of voting. In no circumstances may an absent SSPC member (or their nominated deputy) vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal SSPC meetings (and any other meetings of the SSPC where the SSPC members determine) shall be drawn up as 'minutes'. These minutes shall include a record of SSPC member attendance (including the SSPC Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the SSPC, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with SSPC members' wishes, and, where providing a record of a formal SSPC meeting shall be made available to the public on the NWSSP website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act, the SSPC's Communication Strategy and Velindre's Welsh Language Scheme.

6.8 Confidentiality

6.8.1 All SSPC members, together with members of any Sub-Committee, Expert Panel or Advisory Group established by or on behalf of the SSPC and SSPC members and/or Health Board/Trust/Special Health Authority officials must respect the confidentiality of all matters considered by the SSPC in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the SSPC Chair or relevant Sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Standards of Behaviour Framework or legislation such as the Freedom of Information Act 2000, etc.

7 VALUES AND STANDARDS OF BEHAVIOUR

The SSPC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the SSPC, including SSPC members, Velindre NWSSP officers and others, as appropriate. The Framework adopted by the SSPC will form part of these SOs.

7.1 Declaring and Recording Members' Interests

7.1.1 **Declaration of interests** – It is a requirement that all SSPC members should declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a SSPC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the SSPC's business. SSPC members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. SSPC members must notify the SSPC of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as SSPC members.

7.1.2 SSPC members must also declare any interests held by family members or persons or bodies with which they are connected. The NWSSP Assistant Director of Corporate Services will provide advice to the SSPC Chair and the SSPC on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour Framework. If individual SSPC members are in any doubt about what may be considered as an interest, they should seek advice from the NWSSP Assistant Director of Corporate Services. However, the onus regarding declaration will reside with the individual SSPC member.

7.1.3 **Register of interests** – The Managing Director of NWSSP, through the NWSSP Assistant Director of Corporate Services, will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all SSPC members. The register will include details of all Directorships and other relevant and material interests which have been declared by SSPC members.

7.1.4 The register will be held by the NWSSP Assistant Director of Corporate Services, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by SSPC members. The NWSSP Assistant Director of Corporate Services will also arrange an annual review of the register, through which SSPC members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the SSPC's commitment to openness and transparency, the NWSSP Assistant Director of Corporate Services must take reasonable steps to ensure that citizens served by the SSPC are made aware of and have access to view the Register of Interests. This will include publication on the NWSSP website.

7.1.6 **Publication of declared interests in Annual Review** – SSPC members' directorships of companies or positions in other organisations likely or

possibly seeking to do business with the NHS shall be published in each Shared Services' Annual Review.

7.2 Dealing with Members' interests during Shared Services Partnership

Committee meetings

7.2.1 The SSPC Chair, advised by the NWSSP Assistant Director of Corporate Services, must ensure that the SSPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the SSPC's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the SSPC and as a member of the Board of a Health Board, Trust, or Special Health Authority.

7.2.2 Where individual SSPC members identify an interest in relation to any aspect of SSPC business set out in the SSPC's meeting agenda, that member must declare an interest at the start of the SSPC meeting. SSPC members should seek advice from the SSPC Chair, through the NWSSP Assistant Director of Corporate Services before the start of the SSPC meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the SSPCs minutes.

7.2.3 It is the responsibility of the SSPC Chair, on behalf of the SSPC, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i the declaration is formally noted and recorded, but that the SSPC member should participate fully in the SSPC's discussion and decision, including voting

ii the declaration is formally noted and recorded, and the SSPC member participates fully in the SSPC's discussion, but takes no part in the SSPC's decision;

iii the declaration is formally noted and recorded, and the SSPC member takes no part in the SSPC discussion or decision;

iv the declaration is formally noted and recorded, and the SSPC member is excluded for that part of the meeting when the matter is being discussed. A SSPC member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the SSPC.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a SSPC member is compatible with an identified conflict of interest.

7.2.5 Where the SSPC Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the SSPC.

7.2.6 In all cases the decision of the SSPC Chair (or the Vice Chair in the case of an interest declared by the SSPC Chair) is binding on all SSPC members. The SSPC Chair should take advice from the NWSSP Assistant Director of Corporate Services when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a SSPC member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The SSPC may determine that the SSPC member concerned shall be excluded from that part of the meeting.

7.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests, and these definitions always apply when determining whether a member has an interest. These SSPC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a SSPC meeting, an individual SSPC member may establish a clear conflict of interest between their role as a SSPC member and that of their professional role outside of the SSPC. In any such circumstance, the SSPC shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the NWSSP Assistant Director of Corporate Services.

7.3 Dealing with Officers' Interests

7.3.1 The SSPC must ensure that the NWSSP Assistant Director of Corporate Services, on behalf of the Managing Director of NWSSP, establishes and maintains a system for the declaration, recording and handling of

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other

NWSSP officers' interests in accordance with the Standards of Behaviour Framework.

7.4 Reviewing How Interests are Handled

7.4.1 The SSPC's Audit Committee will review and report to the Health Boards, Trusts, and Special Health Authority upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with Offers of Gifts[2] and Hospitality

7.5.1 The Committee will adopt the Values and Standards of Behaviour Framework Policy of Velindre University NHS Trust, which prohibits SSPC members and NWSSP officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits, or hospitality must never be solicited. Any SSPC member or NWSSP officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a SSPC member or NWSSP officer. Compliance with the Velindre University NHS Trust Standards of Behaviour Framework is mandatory for all Trust employees.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the NWSSP Assistant Director of Corporate Services as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case, accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the SSPC;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel, or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, sporting, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the SSPC; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures, or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Register of Gifts and Hospitality

7.6.1 The NWSSP Assistant Director of Corporate Services, on behalf of the SSPC Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts and hospitality made to SSPC members. NWSSP Director of Finance and Corporate Services together with Heads of Service, will adopt the Velindre University NHS Trust Policy on Gifts and Hospitality in relation to NWSSP officers working within their areas.

7.6.2 Every SSPC member and NWSSP officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality made in their capacity as SSPC members, including those offers that have been refused. The NWSSP Assistant Director of Corporate Services, on behalf of the SSPC Chair and Managing Director of NWSSP, will ensure the incidence and patterns of offers and receipt of gifts and hospitality is kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the register, NWSSP Officers must apply the principles as set out in the Velindre University NHS Trust Policy on gifts and hospitality.

7.6.4 SSPC members and NWSSP officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the SSPC;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The NWSSP Assistant Director of Corporate Services will arrange for a full report of all offers of Gifts and Hospitality recorded by the SSPC to be submitted to Velindre's Audit Committee at least annually. The Audit Committee will then review and report to the SSPC and the Velindre Trust Board upon the adequacy of the SSPC's arrangements for dealing with offers of gifts and hospitality.

7.6.6 Detailed arrangements for the handling of gifts and hospitality are set out within the Velindre University NHS Trust Standards of Behaviour Framework and its policy on Gifts and Hospitality.

8 SIGNING AND SEALING DOCUMENTS

The Common Seal of NWSSP's host is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

Where the Velindre Trust Board has decided that a NWSSP document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised Independent Member) and the Chief Executive (or another authorised individual) both of whom witness the seal.

8.1 Register of Sealing

8.1.1 The NWSSP Assistant Director of Corporate Services shall keep a register that records the sealing of every NWSSP document. Each entry must be signed by the person who approved and authorised the document and who witnessed the seal. A report of all sealing shall be presented to the SSPC at least biennially.

8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the NWSSP, it shall normally be signed by the Managing Director, except where the SSPC has been otherwise directed to allow or require another person to provide a signature.

8.2.2 The Managing Director or nominated officers may be authorised by the SSPC to sign on behalf of the NWSSP any agreement or other document (not required to be executed as a deed) where the subject matter has been approved by the SSPC.

8.3 Custody of Seal

8.3.1 The Common Seal of NWSSP's host is kept securely by the Board Secretary.at Velindre University NHS Trust.

9 GAINING ASSURANCE ON THE CONDUCT OF BUSINESS

The SSPC shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to Velindre on the conduct of SSPC business, its governance, and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The SSPC shall ensure that its assurance arrangements are operating effectively, advised by Velindre's Audit Committee.

9.1 The Role of Internal Audit in Providing Independent Internal assurance

9.1.1 The SSPC shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

9.1.2 The SSPC shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the SSPC. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Audit Committee facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and

- Ensure that the Head of Internal Audit reports periodically to the SSPC on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

9.2 Reviewing the Performance of the , its Sub-Committees, Expert Panel and Advisory Groups

9.2.1 The SSPC shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Sub-Committees, Expert Panel, and any other Advisory Groups. Where appropriate, the SSPC may determine that such evaluation may be independently facilitated.

9.2.2 Each Sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

9.2.3 The SSPC shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Committee Development Programme, as part of an overall Organisation Development framework; and
- inform its Partners through its annual report of its alignment with the Assembly Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

9.3 External Assurance

9.3.1 The SSPC shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on its operations, e.g. Audit Wales and Healthcare Inspectorate Wales.

9.3.2 The SSPC may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the SSPC itself may commission specifically for that purpose.

9.3.3 The SSPC shall keep under review and ensure that, where appropriate, the SSPC implements any recommendations relevant to its business

made by the Welsh Government Audit and Risk Assurance Committee, the Public Accounts Committee, or other appropriate bodies.

9.3.4 The SSPC shall provide the Auditor General for Wales with assistance, information, and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Annexe 8 to the Government of Wales Act 2006 (C.42).

10 DEMONSTRATING ACCOUNTABILITY

10.1.1 Taking account of the arrangements set out within these SSPC SOs, the SSPC shall demonstrate to its Partners, citizens, and other stakeholders and to Velindre, as host, a clear framework of accountability within which it:

- conducts its business internally;
- works collaboratively with NHS colleagues, partners, service providers and others; and
- responds to the views and representations made by those who represent the interests of the citizens it serves and its own NWSSP officers.

10.1.2 The SSPC shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report of the SSPC.

10.1.3 The SSPC shall also facilitate effective scrutiny of NWSSP's operations through the publication of regular reports on activity and performance, including publication of an Annual Review document providing a summary of annual performance.

10.1.4 The SSPC shall ensure that within the NWSSP staff, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

11 SUPPORT FOR THE SSPC

11.1.1 The NWSSP Assistant Director of Corporate Services, on behalf of the SSPC Chair, will ensure that the SSPC is properly equipped to carry out its role by:

- overseeing the process of nomination and appointment to the SSPC;
- co-ordinating and facilitating appropriate induction and organisational development activity;

- ensuring the provision of governance advice and support to the SSPC Chair on the conduct of its business and its relationship with its partners, Velindre, as the host and others;
- ensuring the provision of secretariat support for SSPC meetings;
- ensuring that the SSPC receives the information it needs on a timely basis;
- ensuring strong links to communities/groups;
- ensuring an effective relationship between the SSPC and Velindre as its host; and
- facilitating effective reporting to each Health Board, Trust, and Special Health Authority

thereby enabling each Health Board, Trust, and Special Health Authority's Board to gain assurance on the conduct of business carried out by SSPC on their behalf.

12 REVIEW OF STANDING ORDERS

12.1.1 These SSPC SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Trust Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SSPC SOs, including the Equality Integrated Impact Assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annexe forms part of, and shall have effect as if incorporated in the Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

As set out in Standing Order 2, the SSPC - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the NWSSP may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The SSPC may delegate functions to:

i A Committee, e.g., Audit Committee;
ii A Sub-Committee,
iii A Joint-Committee or Joint Sub-Committee, e.g., with other Health Boards established to take forward matters relating to specialist services; and
iv Officers of NWSSP (who may, subject to the SSPC's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the SSPC is notified of any matters that may affect the operation and/or reputation of NWSSP.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Annexe of matters reserved to SSPC;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officer.

all of which form part of the SSPC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The SSPC will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the SSPC unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs.
- The SSPC must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management.
- Any decision made to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility.
- The SSPC must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development.
- The SSPC must take appropriate action to assure itself that all matters delegated are effectively carried out.
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.
- Except where explicitly set out, the SSPC retains the right to decide upon any matter for which it has responsibility, even if that matter has been delegated to others.
- The SSPC may delegate authority to act, but retains overall responsibility and accountability.
- When delegating powers, the SSPC will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The (SSPC)

The SSPC will formally agree, review and, where appropriate revise Annexes of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Managing Director

The Managing Director will propose a Scheme of Delegation to officers, setting out the functions they will perform personally, and which functions will be delegated to other officers. The SSPC must formally agree this scheme.

In preparing the scheme of delegation to officers, the Managing Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Managing Director may re-assume any of the powers they have delegated to others at any time.

Board Secretary Governance Support/The NWSSP Assistant Director of Corporate Services

The Board Secretary Governance Support/the NWSSP Assistant Director of Corporate Services will support the SSPC in its handling of reservations and delegations by ensuring that:

- A proposed Annexe of matters reserved for decision by the SSPC is presented to the SSPC for its formal agreement;
- Effective arrangements are in place for the delegation of NWSSP's functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the SSPC, Audit Committee and Velindre University NHS Trust Board for revision and approval, as appropriate.

The Velindre University NHS Trust Audit Committee for NWSSP

The Velindre University NHS Trust Audit Committee for NWSSP will provide assurance to the SSPC and Velindre University NHS Trust Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Velindre University NHS Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary providing governance support to the SSPC of their concern, as soon as possible, so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the SSPC has set out alternative arrangements.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within NWSSP. The Scheme is to be used in conjunction with the system of control and other established procedures within NWSSP.

SECTION 1

ANNEXE OF MATTERS RESERVED TO THE SSPC[3]

SSPC		AREA	DECISIONS RESERVED TO THE SSPC
1	FULL	GENERAL	The SSPC may determine any matter for which it has statutory or delegated authority, in accordance with NWSSP SOs.
2	FULL	GENERAL	The SSPC must determine any matter that will be reserved to the whole SSPC in accordance with statutory and Welsh Government guidance.
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the SSPC, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary, and amend: ▪ NWSSP SOs ; ▪ NWSSP SFIs; ▪ Annexe of matters reserved to the SSPC; ▪ Scheme of delegation to SSPC others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[3] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements

5	FULL	OPERATING ARRANGEMENTS	Approve the SSPC Values and Standards of Behaviour Framework, including NWSSP's mission statement.
6	FULL	OPERATING ARRANGEMENTS	Approve the SSPC framework for performance management, risk, and assurance.
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the SSPC determines it so based upon its contribution/impact on the achievement of the SSPC's aims, objectives and priorities.
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Managing Director in accordance with NWSSP Standing Order requirements.
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with NWSSP SOs.
10	FULL	OPERATING ARRANGEMENTS	Approve procedures for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with NWSSP SFIs.
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write-off of losses or making of special payments above the limits of delegation to the Managing Director and officers.
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the NWSSP.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline, and dismissal of the Management Team and any other SLG level appointments, e.g., the Committee Secretary.

15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive, and determine action in response to the declaration of NWSSP members' interests, in accordance with advice received, e.g. from Audit Committee.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the NWSSP's top level organisation structure and SSPC policies.
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss SSPC sub-Committees, including any joint sub-Committees directly accountable to the SSPC.
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the SSPC.
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the SSPC on outside bodies and groups.
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the SSPC.
19	FULL	STRATEGY & PLANNING	Determine the SSPCs strategic aims, objectives, and priorities.
20	FULL	STRATEGY & PLANNING	Approve the SSPCs Integrated Medium Term Plan, including the balanced Medium Term Financial Plan.
21	FULL	STRATEGY & PLANNING	Approve the SSPCs Risk Management Strategy, including risk appetite, risk tolerance levels and treatment plans and managing risks in relation to public confidence.
22	FULL	STRATEGY & PLANNING	Approve the SSPCs citizen engagement and involvement strategy, including communication.

23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies.
24	FULL	STRATEGY & PLANNING	Approve NWSSP's key strategies and programmes related to: ▪ People and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪ Primary Care ▪ Communications & Engagement
25	FULL	STRATEGY & PLANNING	Approve the SSPCs budget and financial framework (including overall distribution of year end surplus/deficits including risk sharing agreements.
26	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Managing Director set out in the NWSSP SFIs.
27	FULL	PERFORMANCE & ASSURANCE	Approve the SSPC's audit and assurance arrangements.
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPC's NWSSP Directors on progress and performance in the delivery of the SSPC's strategic aims, objectives and priorities and approve action required, including improvement plans.

29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPC's Sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans.
30	FULL	PERFORMANCE & ASSURANCE	Receive reports on the SSPC's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise issue or concerns impacting on the NWSSP's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of SSPC sub-Committees (as appropriate).
31	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the SSPC's Head of Internal Audit and approve action required, including improvement plans.
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the SSPC's external auditor and approve action required, including improvement plans.
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the SSPC's performance against the Health and Care Standards for Wales and approve action required, including improvement plans.
34	FULL	PERFORMANCE & ASSURANCE	Approval of the Risk and Assurance Framework.
35	FULL	REPORTING	Approve the SSPC's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners, and stakeholders and nationally to the Welsh Government.
36	FULL	REPORTING	Receive, approve, and ensure the publication of SSPC reports, including its Annual Report.

SECTION 2

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Under Standing Order Section 2 it provides that the SSPC may delegate powers to SSPC Committees, Sub-Committees, and others. In doing so, the SSPC has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others;

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

Subject to Clauses within the Trust Standing Orders and to such directions as may be given by the Welsh Government, the SSPC may appoint ad-hoc committees of the NWSSP, whose membership can be wholly or partly of the Chairman and Directors of the NWSSP, or persons who are not Directors of the NWSSP.

A committee appointed under this regulation may subject to such directions as may be given by the Welsh Government or the SSPC appoint ad hoc Sub-Committees consisting wholly or partly of members of the committee (whether or not they are Directors of NWSSP) or wholly of persons who are not members of the committee (whether or not they include Directors of the NWSSP).

The Standing Orders, with appropriate alterations, apply to a committee or Sub-Committee and to a committee or Sub-Committee as they apply to the SSPC and apply to a member of such committee or sub-committee (whether or not they are a Director of the NWSSP) as it applies to a Director of the NWSSP.

The SSPC may make, vary and revoke Standing Orders relating to the quorum, proceedings, and place of meetings of a committee or Sub-Committee but, this shall be carried out in accordance with the identified procedures laid down for these changes as outlined in these Standing Orders.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the SSPC's Scheme of Delegation to Committees.

The SSPC has delegated a range of its powers to the following Sub-Committees and others:

- Welsh Risk Pool Committee
- Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Summary of matters delegated to Sub-Committees:

Sub-Committee: Welsh Risk Pool Committee

Delegated Matters:

The Sub-Committee will:

1. To approve the payment and reimbursement of claims and impose penalties in accordance with the WRPS Claims Reimbursement Procedure.
2. To enact the risk sharing arrangements as agreed by the NWSSP.
3. To receive and consider the annual statements of account.
4. To receive and consider the annual assessment reports and to approve recommendations for any necessary action.
5. To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
6. To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
7. To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
8. To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All-Wales basis.
9. To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

Sub-Committee: Velindre University NHS Trust Audit Committee for NWSSP

Delegated Matters:

The Committee will:

1. Approve any variation to, review annually and monitor compliance with Standing Orders and Standing Financial Instructions.
2. Review and report to the SSPC upon the adequacy of the arrangements for declaring, registering, and handling interests at least annually.
3. Receive a full report of all offers of Gifts and Hospitality recorded by the NWSSP and review the adequacy of NWSSP's arrangements for dealing with offers of gifts and hospitality.
4. Advise the Velindre Trust Board on the adequacy that its assurance arrangements are operating effectively.
5. Review and approve Internal Audit Strategy, Charter, operational plan, programme of work.
6. Review effectiveness of internal audit.
7. Review policies and procedures in respect of fraud and bribery set out in the Welsh Government Directions and to receive the Counter Fraud Annual Report and Plan.
8. Approve write-off of losses or making of special payments within delegated limits determined by the Welsh Ministers.
9. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities.
10. Review the assurance gained through the development of a Risk and Assurance Framework and to consider gaps in control and gaps in assurance and report results to the Board.
11. Review the adequacy of all risk and control related disclosure statements, including the Annual Governance Statement.
12. Receive quarterly assurance of Post Payment Verification (PPV) reports.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the NWSSP's Scheme of Delegation to Committees.

SECTION 3

ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS

The SSPC SOs, alongside the Trust SOs and the SFIs specify certain key responsibilities of the Chief Executive Velindre University NHS Trust, the Managing Director of NWSSP, Directors, Heads of Service and other officers. The Chief Executive and Managing Director of NWSSP Job Descriptions, together with their Accountable Officer Memorandums set out their specific responsibilities, and the individual job descriptions determined for Directors and Heads of Service level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the Annexe of additional delegations below and the associated financial delegations set out in the Velindre Trust SFIs form the basis of the Scheme of Delegation to Officers.

Standing Orders – List of Delegated Matters

SO REF	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
GENERAL			
	Non-compliance and variation of Standing Orders Final interpretation of Standing Orders Responsibility for providing advice to the Board on all aspects of governance/committee services	Assistant Director of Corporate Services Chair Assistant Director of Corporate Services	Board Secretary Support
CHAIR'S ACTION ON URGENT MATTERS			
SO 2.1	Use of Chair's Action and onward reporting to	Chair & Managing Director	Board Secretary Support
DELEGATION TO OFFICERS			
SO 2.3.1	Compilation of Scheme of Delegation for functions	Managing Director	Assistant Director of Corporate

	delegated to Managing Director for consideration and approval by the SSPC		Services
SO 2.3.1	Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Directors
WORKING IN PARTNERSHIP			
SO 5.0.2	Identification and engagement with all key partners and regular review of effectiveness	Chair	Deputy Director of Finance and Corporate Services
MEETINGS			
SO 6.2	Development of the Annual Plan of SSPC Business	Chair/Managing Director	Assistant Director of Corporate Services
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Assistant Director of Corporate Services
SO 6.4	Preparation of SSPC meetings	Chair/Managing Director	
SO 6.5	Report decisions made & review NWSSP business conducted in private session	Chair	Assistant Director of Corporate Services
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Assistant Director of Corporate Services
SO 6.6	A record of proceedings of SSPC meetings	Chair (Vice Chair in Chair's absence)	Chair (Vice Chair in Chair's absence) / Assistant Director of Corporate

VALUES AND STANDARDS OF BEHAVIOUR			
SO 7.1	Establishment, maintenance, and annual review of a Register of Interests declared by all SSPC members	Managing Director	Assistant Director of Corporate Services
SO 7.6	Establishment, maintenance and annual review of a Register of Gifts and Hospitality in respect of SSPC business for all SSPC members	Chair	Assistant Director of Corporate Services
SO 7.6	Establishment maintenance and annual review of a Register of Gifts and Hospitality for NWSSP Officers	Managing Director/Directors	Assistant Director of Corporate Services
SIGNING AND SEALING DOCUMENTS			
SO 8.1	Establishment, maintenance, and bi-annual reporting of a Register of Sealings undertaken by the Velindre NHS Trust Board for NWSSP business	Managing Director	Assistant Director of Corporate Services

This scheme only relates to matters delegated by the Velindre Board and the SSPC to the Managing Director and Directors, together with certain other specific matters referred to in SFIs. Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annexe of Additional Delegations

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Trust Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Managing Director of Shared Services	Nominated deputy	In absence of Director of Shared Services
Staff re-grading and awarding of incremental points	NWSSP Director of P&OD	Yes	Written authority to suitably qualified HR staff
Approval of overtime	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures

Approval of leave without pay	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or $^1/_2$ pay • Directors • Other staff	Managing Director of NWSSP NWSSP Directors	 No Yes	 Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Managing Director NWSSP/ NWSSP Director of W&OD	No	
Approval of relocation costs	NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • NWSSP Directors • Other staff	Managing Director of NWSSP NWSSP Finance Director	 No No	
Approval of redundancy, early retirement, and ill-health retirement	Managing Director of NWSSP	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Managing Director of NWSSP and NWSSP Director of P&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of NWSSP	Nominated deputy	In absence of the Managing Director of NWSSP
Approval to commission services from other NHS bodies	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures

Approval to commission services from voluntary sector	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from private and independent providers	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Management and Control of Stocks	NWSSP Director (Head of Procurement Services)/ NWSSP Director of Finance	Yes	Authorisation matrix
Work in relation to counter fraud and corruption	Trust Director of Finance/ NWSSP Director of Finance	Yes	Authorisation matrix Fraud & Corruption policies and procedures
Authorisation of sponsorship	Managing Director of NWSSP	No	Sponsorship policies & procedures
Approval of research projects	Managing Director of NWSSP	Yes	Research policies & procedures
Management of complaints	NWSSP Director of Finance	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	NWSSP Directors / Trust Board Secretary	Yes	Communication policies & procedures
Approval for use of charitable funds	Trust Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose of equipment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Managing Director of NWSSP	No	Within authorised limits set by WG.

Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Trust Small Claims Panel Managing Director of NWSSP Approval by WG	 No No No No	
Approval of clinical negligence and personal injury claims	Managing Director of NWSSP / NWSSP Director of Finance	Yes	Authorisation matrix and within limits set by WAG.
Approval of capital expenditure	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	NWSSP Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Managing Director of NWSSP	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Managing Director of NWSSP& NWSSP Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Heads of Service.

This scheme only relates to matters delegated by the SSPC to the Managing Director of NWSSP and the NWSSP Directors and Heads of Service, together with certain other specific matters referred to in SFIs. Each NWSSP Director and Head of Service is responsible for delegation within their department. They shall produce a Scheme of Delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SECTION 4

ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Velindre University NHS Trust Standing Financial Instructions detail the requirements for Budgetary Control, including:

5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Income and Expenditure budgetary responsibility for the NHS Wales Shared Services Partnership has been delegated to the Managing Director of NWSSP.

The Managing Director of NWSSP and other NWSSP Directors will, in turn, delegate budgetary responsibility to other Heads of Service and managers. The detailed Annexe of this second-tier delegation will be reviewed, revised and reapproved on an annual basis by the Managing Director of NWSSP and the Senior Leadership Group as part of the annual Financial Strategy and Budget Setting process. Within the budgetary delegation there are delegated powers of budget virement:

- between Divisions must be approved by the Managing Director of NWSSP.
- between budgets within the same Division must be approved by the relevant Director / Heads of Service.
- between staff and non-staff within the same budget must be approved by the Budget Holder.

These delegated powers of virement, from the Managing Director of NWSSP to Heads of Service and Budget Holders, assume that the NWSSP is achieving its financial targets and can be revised, in year, by the Managing Director of NWSSP in the light of adverse financial performance. Budget virements within Divisions can be authorised by the Head of Service and Director of Finance up to the limit of £60,000.

SECTION 5

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION

Financial Limits (All Values exclude VAT)	Revenue	Capital	All Wales Contracts**
	£000	£000	£000
Velindre:			
Trust Board	No Limit	No Limit	No Limit
NWSSP (excluding all Wales Procurement Contracts):			
Managing Director and NWSSP Chair	250	1m	1m
Managing Director of NWSSP	200	500	500
Director of Finance and Corporate Services	100	100	100
Director of People and Organisational Development	50	50	N/A
Director of Planning, Performance and Informatics	50	50	N/A
Service Directors/Heads of Services (within own area)	25	0	N/A
Service Directors/Heads of Service's Nominee (within Agreed area)	10	10	N/A
Heads of Function (within own area)	7.5	7.5	N/A
Deputy Director of Finance and Corporate Services	25	25	N/A
Head of Finance and Corporate Services	10	10	N/A
Other Senior Finance Staff	5	0	N/A
Delegated Budget Holders (within own area) Level 1	5	0	N/A
Delegated Budget Holders (within own area) Level 2	1	0	N/A
Notes:			
***Represents contracts where expenditure is directly incurred by NWSSP in respect of All Wales Contracts where the expenditure is either recharged to NHS Wales organisations or the expenditure is incurred for goods/services that will be directly consumed by NHS Wales organisations. All contracts >£1m require prior Welsh Government approval.*			

Welsh Infected Blood Support Services Limits

Scheme Designation	Payments to Claimants (£)
Managing Director/NWSSP Chair	Over 100k
Managing Director	Up to 100k
Director of Finance and Corporate Services	Up to 80k
Director of Planning, Performance, and Informatics	Up to 50k
Head of Function (WIBSS Manager)	Up to 10k

Corporate Areas

Scheme Designation	Area	Limits (£)
Managing Director/Director of Finance and Corporate Services	ESR Recharges	Up to £1m
Managing Director/Director of Finance and Corporate Services	Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution)	Up to £1m

Legal & Risk and Welsh Risk Pool Services Limits

Scheme Designation	Reimbursement of claims and redress cases following WRPC approval (£)	WRP Managed Claims (£)	
		(£)	(actions)
Managing Director & Welsh Risk Pool Committee Chair	Over 2m	Over 2m	
Managing Director of NWSSP	Up to 2m	Up to 2m	
Director of Finance and Corporate Services	Up to 1m	Up to 1m	
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k	Up to 500k	Agree settlement and make admissions
Deputy Director of Legal & Risk and Welsh Risk Pool	Up to £250k	Up to £250k	Agree settlement and make admissions
Deputy Director of Finance and Corporate Services	Up to 250k	Up to £250k	
Head of Safety and Learning	Up to 100k	£20k	

Note:

All cases submitted for reimbursement are reviewed by a Learning Advisory Panel and the Welsh Risk Pool Committee prior to approval.

Approval of Lessons Learned in cases where payments will exceed £1m are delegated by Welsh Government to the Welsh Risk Pool Committee. Payments above £1m are approved by Welsh Government prior to the Welsh Risk Pool Committee.

Claims above £2m will be signed by the Managing Director of NWSSP and Welsh Risk Pool Committee Chair.

Procurement Services Limits

Scheme Designation	Contracts for and on behalf of NHS Wales (£)*	NWSSP Stock Requisitions and Invoices (£)	NWSSP Stock Write offs (£)
Welsh Government (after noting by NWSSP Audit Committee for stock write-offs)	Over 1m		Over 50k
Managing Director of NWSSP and NWSSP Chair (after noting by NWSSP Audit Committee for stock write-offs)	Over 1m	Over 200k	Over 50k
Managing Director of NWSSP (after noting by NWSSP Audit Committee for stock write-offs)	Up to 1m	Up to 200k	Up to 50k
Director of Finance and Corporate Services NWSSP	Up to 750k	Up to 100k	Up to 25k
Director of Procurement Services	Up to 750k	Up to 50k	Up to 25k
Assistant Directors of Procurement		Up to 25k	Up to 10k
Senior Manager Procurement Services (Logistics)		Up to 25k	Up to 10k
Regional Supply Chain Manager			Up to 5k
Warehouse Manager (Bridgend/Denbigh) / Storage and Distribution Manager (IP5)			Up to 1k
Assistant Warehouse Manager (Bridgend/Denbigh) / Shift Manager (IP5)			Up to 1k
Note:			

**Contracts for and on behalf of NHS Wales (where expenditure is incurred directly by NHS organisations) > £1m require prior approval from Welsh Government with the exception of:*

- *contracts of employment between LHBs and their staff*
- *transfers of land or contracts*
- *out of hours contracts*
- *all NHS contracts where one health service body contracts with another*

Existing Liabilities Scheme Limits

Scheme Designation	Damages Limit (£)
Welsh Government	1M and over
Managing Director and NWSSP Chair	Up to 1M
Managing Director	Up to 500k
Director of Finance & Corporate Services	Up to 500k
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k
Deputy Director of Finance & Corporate Services	Up to 100k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 100k
Head of Function - GMPI Team Leader	Up to 50k
Note:	
Claims and payments will be made by NWSSP and approved in line with the above scheme of delegation. Any value of damages decisions greater than £1 million will require written Welsh Government approval. All other value of claims decisions below £1million will be approved in line with the Scheme of Delegation.	

Annexe 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

Framework

The SSPC's governance and accountability framework comprises these SSPC SOs, incorporating Annexes of Powers reserved for the SSPC and Delegation to others, together with the following documents agreed by the SSPC.

These documents must be read in conjunction with the SSPC SOs and will have the same effect as if the details within them were incorporated within the SSPC SOs themselves:

- Standing Financial Instructions (SFIs);
- Values and Standards of Behaviour Framework;
- Risk and Assurance Framework;
- SSPC Annual Plan of Committee Business;
- Welsh Language Scheme;
- Complaints Management Protocol;
- Annual Governance Statement; and
- Annual Review,

These documents may be accessed by viewing NWSSP's website (www.nwssp.wales.nhs.uk/opendoc/326169).

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at http://www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of SSPC business are also issued in hard copy, usually under cover of a Ministerial Letter.

Annexe 3

SUB-COMMITTEE ARRANGEMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. *Welsh Risk Pool Committee - Terms of Reference*

2. *Velindre University NHS Trust Audit Committee For NHS Wales Shared Service Partnership - Terms of Referenc*

1. Welsh Risk Pool Committee
Terms of Reference (September 2019)

1. Background

1.01 On 1 April 2019, the National Health Service Clinical Negligence Scheme Wales Regulations 2019 came into force. The Regulations create a Scheme for Clinical Negligence Claims in Wales and were brought into force inter alia for the management of clinical negligence claims against primary care providers in Wales, operating under sections 41, 42 and 50 of the National Health Service Wales Act 2006.

1.02 The scheme is operated by NHS Wales Shared Service Partnership (NWSSP) through Legal and Risk Services with the support of WRP using its powers as a shared service function under the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

1.03 NWSSP has responsibility for the administration of the Welsh Risk Pool Service including the management of the Welsh Risk Pool Budget.

1.04 The aim of the WRPS budget management is to align the financial governance relating to claims and Redress cases with the corporate and quality governance agenda.

1.05 The Welsh Risk Pool Services has responsibility for reimbursement of claims over £25,000 (the £25,000 threshold does not apply to GMPI matters) and reimbursement of permitted costs and damages arising from Redress cases. It is also required to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff.

1.06 In line with standing orders the Committee has resolved to establish a sub-committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub-committee of the NWSSP Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

2.01 The membership of the WRPC shall be determined by the NWSSPC, taking account of the balance of skills and expertise necessary to deliver the WRPC's remit and subject to any specific requirements or directions made by the Welsh Government.

2.02 The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services and the Welsh Government. The membership includes:

Chairman: Chairman of NWSSP
Members: Managing Director, NWSSP
Director Legal & Risk Services, NWSSP
Director of Finance & Corporate Services, NWSSP
Health Board or Trust Chair (1)
Health Board or Trust Chief Executive (1)
Health Board or Trust Medical Director (1)
Health Board or Trust Director of Nursing (1)
Health Board or Trust Director of Finance (1)
Health Board Director of Therapies & Health Science (1)
Health Board or Trust Chair Audit Committee Chair (1)
Health Board or Trust Board Secretary (1)
Health Board Director of Primary Care and Mental Health
Welsh Government (2)
Health Board Associate Medical Director – Primary Care
GP Advisor
In attendance:
NWSSP – WRPS Head of Finance
NWSSP - WRPS Head of Safety and Learning
WRPS Operations Team
WRPS Safety and Learning Team

2.03 Other individuals may be involved at the discretion of the Chairman (e.g. representatives from NSAGs as appropriate). The WRPC shall appoint a vice chairman from the agreed membership. The vice-chair shall deputise for the Chair in their absence for any reason.

2.04 In the event that a member of the WRPC is unable to attend a meeting he/she is required to seek a suitable person to attend on their behalf.

3. Dealing with Members' interests during meetings

3.01 The Chair, advised by the Committee Secretariat, must ensure that the WRPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must demonstrate, through their actions, that their contribution to the WRPC's decision making is based upon the best interests of the NHS in Wales.

3.02 Where individual members identify an interest in relation to any aspect of

business set out in the meeting agenda, that member must declare an interest at the start of the meeting. Members should seek advice from the Chair, through the Committee Secretariat before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the minutes. It is responsibility of the chair, on behalf of the Committee, to determine the action to be taken in response to the declaration of interest, this can include excluding the member, where they have a direct or indirect financial interest or participating fully in the discussion but taking no part in the WRPC decision.

4. Quorum

4.01 A quorum shall be the Chairman or Vice Chair and at least 4 other representatives, 2 of which must be officer members of shared services and 2 of which must be NHS Trust or LHB representatives.
Repeated non-attendance will be reported to the NWSSP Committee.

5. Frequency of Meetings

5.01 Meetings will be held at least 8 times per year, with additional meetings held if considered necessary.

6. Authority

6.01 The Accountable Officer for NWSSP is authorised to carry out any activity within the terms of reference and the scheme of delegation. In the normal course of WRPC business items included on the agenda are subject to discussion and decisions based on consensus. Decisions made by the Accountable Officer against that recommended by the WRPC will be reported to the NWSSP Committee and the Velindre NHS Trust Audit Committee for Shared Services.

6.02 The WRPC may, establish subgroups or task and finish groups as appropriate to address specific issues and to carry out on its behalf specific aspects of business.

7. Responsibilities of the WRPC

7.01 It is important that there is clarity between the role of the WRPC and that of the NWSSP Committee. The NWSSP Committee will have overall responsibility for overseeing the governance arrangements within WRPS and in support of this function the minutes of the WRPC will be forwarded for information and assurance including the highlighting of matters of significance.

7.02 The role of the WRPC is to:

a) Receive assurance on the management of delegations for areas of responsibility detailed within this Terms of Reference and to report regularly to the on performance;
b) Undertake actions reserved specifically for the WRPC;
c) To provide advice and guidance to the NWSSP Accountable Officer on claims reimbursement decisions; and
d) To support and promote a learning culture within NHS Wales.
e)

8. WRPS areas of responsibility

8.01 The main areas of responsibility for which WRPS will be held to account by the WRPC are:

- To present key financial and performance information.
- To develop an effective and efficient process including technical notes for the receipt of claims and reimbursement of monies to NHS Wales.
- To ensure that there are effective processes for the forecasting of resource requirements over the short and medium term and that there is sufficient liquidity to meet obligations.
- To ensure that the transactions of the WRPS are fully recorded and that financial accounts are produced in accordance with the timetable set by the Welsh Government.
- To undertake regular assessments of the arrangements for the management of Concerns and Claims by NHS Wales.
- To undertake regular assessments of the arrangements for the management of GMPI claims by NHS Wales.
- To undertake the assessments of high-risk clinical areas as required by Chief Executives of NHS Wales Bodies.
- To develop processes for learning from events and cascading information to all NHS Wales Bodies including undertaking detailed reviews of claims and identifying trends arising from claims.
- To undertake project work as required by the WRPC.
- To develop a process for the scrutiny of claims and Redress cases presented to each WRPC to provide assurance across NHS Wales that appropriate action has been taken to reduce the risk of recurrence. This process should have regard for the number and complexity of claims being presented to ensure that sufficient consideration is given to issues arising.
- To develop an effective and efficient process for handling and responding to enquiries in relation to indemnity and reimbursement matters.
-

9. WRPC reserved matters

- To approve the reimbursement of claims and Redress cases and impose

penalties in accordance with the Reimbursement Procedures

- To enact the risk sharing arrangements (not currently applicable to GMPI and Redress) as agreed by the NWSSP
- To receive and consider the annual statements of account
- To receive and consider the annual assessment reports and to approve recommendations for any necessary action.
- To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
- To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
- To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
- To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All-Wales basis.
- To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

10. Support and promote a learning culture across NHS Wales

10.1 The members of the WRPC will have collective responsibility for ensuring that the learning from events is formally considered and that a culture of improvement across NHS Wales is fostered. This will include providing advice and guidance at each meeting and where necessary taking action to address weaknesses identified, either at an individual organisational level or at a more strategic level.

11. Reporting Arrangements

11.01 Minutes shall be taken at each meeting and circulated to all members of the WRPC and to the NWSSP Committee for information.

11.02 Risk sharing arrangements will be agreed by the NWSSP Committee.

11.03 Regular financial reports on the risk sharing forecasting will be considered by the Shared Services Committee and provide to Welsh Government as and when required.

11.04 Annual presentations will be made to the groups identified by the WRPC (e.g. Chief Executives, Directors of Finance, Directors of Nursing and Medical Directors).

12. Audit Arrangements

12.01The WRPS will be subject to audit by both internal and external auditors. The external auditors of Velindre University NHS Trust will ensure that there is

overall audit coverage of claims management across the NHS in Wales.

13. Associated documents

- All Wales Policy on Indemnity and Insurance
- Scope of the Risk Pooling Arrangements
- WRPS Reimbursement Procedures

3. Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership - Terms of Reference

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for . Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

*"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or **utilise Velindre's Committee arrangements** to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend, should there be anything on the agenda which has implications for the (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

This document goes on to outline the Terms of Reference for **(b)**, above.

2. INTRODUCTION

2.1 Velindre University NHS Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference, as detailed in the NHS Wales Audit Committee Handbook, June 2012.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:

    - NWSSP's ability to achieve its objectives;
    - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;
    - The reliability, integrity, safety, and security of the information collected and used by the organisation;
    - The efficiency, effectiveness, and economic use of resources; and
    - The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit, and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity, via monitoring of NWSSP's Audit Action Plan;
- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, External Audit Opinion, or other appropriate independent assurances), prior to endorsement by the SSPC;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above

disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Counter Fraud Authority.

4.3 In carrying out this work, the Audit Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

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

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace)

internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records, or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

4.7 The Audit Committee is authorised by the SSPC to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the SSPC's procurement, budgetary and other requirements.

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

4.9 The Audit Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist, without the presence of officials, on at least one occasion each year.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre Trust Board. The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager

NWSSP Assistant Director of Corporate Services
NWSSP Corporate Services Manager
Representative of Velindre University NHS Trust
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors will attend as required by the Committee Chair

By invitation The Committee Chair may invite:

- any other Partnership officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary	As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Assistant Director of Corporate Services and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role;
- Ensure that Committee agenda and supporting papers are issued 5 working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

6.1 At least two members must be present to ensure the quorum of the Audit Committee, one of whom should be the Audit Committee Chair or Vice Chair.

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

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

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual work plans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC and the Accountable Officer on its work in support of the Annual

Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of

governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Audit Committee's self-assessment and evaluation.

8.3 The Velindre Trust Board and SSPC may also require the Audit Committee Chair to report upon the Audit Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Audit Committee's assurance role relates to a joint or shared responsibility.

8.4 The NWSSP Assistant Director of Corporate Services and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *(as per section on Committee meetings)*
- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press, and other observers
-

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre Trust Board.

Annexe 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. Evidence Based Procurement Board (EBPB)
2. Welsh Energy Group (WEG) and Welsh Energy Operational Group (WEOG)

1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP) (August 2018)

1. Aims and Objectives

The Board shall be known as the 'Evidence Based Procurement Board' (EBPB) and will consist of professionals from across various disciplines within NHS Wales and appropriate research bodies, making recommendations and guidance for implementation by the Welsh NHS**.**

The EBPB advises, promotes, develops and implements value and evidence-based procurement of medical technologies for NHS Wales. The group will assist with rationalisation and standardisation in line with Prudent healthcare principles, underpinned with the "*Once for Wales*" philosophy, and will assess whether NHS Wales should discard devices/technologies if they are deemed inappropriate or wasteful.

The EBPB will produce advice and guidance to support planning and decision making in Local Health Boards and Trusts.

The EBPB shall provide advice, guidance and recommendations to the Shared Services Committee and the WG Efficiency Healthcare Value & Improvement Group.

The EBPB will support NHS Wales core values through the assessment of quality and safety elements of medical technologies; using this to provide high value evidence-based care whilst reducing harm. In addition, through the rationalisation and standardisation programme, the EBPB will enable reduced variation and waste. It also specifically supports the 2018 report "*A Healthier Wales: our Plan for Health and Social Care*" principles of "Higher value" (better outcomes, better experience at reduced cost, less variation, and no harm) and "Evidence driven" (the use of research, knowledge and information to understand what works).

In line with the emphasis of "Value" in "*A Healthier Wales*", the EBPB will play a key role in assisting the delivery of the Value Based Health Care agenda across the NHS in Wales.

It is acknowledged that there will be some areas that will be of mutual interest to Health Technology Wales (HTW) and these will be addressed through discussion with appropriate representatives.

2. MEMBERSHIP

Membership will be endorsed by Welsh Government and made up of senior

professionals from NHS Wales and academia. The EBPB will consist of both voting and non-voting members. Membership is as follows;

- Chair - Medical Director/Assistant MD
- NWSSP Director (SRO)
- Finance Director
- Health Economist
- Director of SMTL
- Health Technology Wales
- Procurement Services
- Deputy Executive Nurse Director
- Secondary Care Clinician
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician
- Value Based Care/National Lead VBP
- Academic Clinician
- Academia
- NWSSP MD

Non-voting members may be invited to attend as and when appropriate;

- Individuals co-opted for advice on specialist category areas, including Clinical networks and clinicians locally.
- Nominated experts from Evidence Research Group

Secretariat

- NHS Wales Shared Services Partnership – Procurement Services
- NHS Wales staff may request to attend as observers by writing in advance to the Chair.

Deputies

In the event of a voting member not being in attendance, an agreed named deputy should attend. The EBPB will approve deputies for all voting members of the group, (Chair excluded). A Vice Chair will be appointed in accordance with *Point 4.*

3. OFFICERS

The Chair will normally be a Medical Director/ Assistant Medical Director, appointed by the EBPB and approved by Welsh Government whose term of office shall normally be between 1-5 years. They will be eligible for reappointment for an additional term of office, but the total period cannot exceed 10 years.
A Vice-Chair will be elected from the voting members. The Vice Chair or in their

absence, another voting member may preside over meetings in the absence of the Chair.

4. MEETINGS

The EBPB will meet a minimum of 4 times per year, and roles and responsibilities of members should be readily available to any relevant party on request.

5. DECLARATION OF INTEREST

Members MUST declare, in advance any financial and/or personal interests, to any related matter that is subject of consideration. Any declarations made and/or actions taken will be noted in the minutes.

6. VOTING

Any issues/questions should be resolved by consensus. Only voting members will have voting rights. Deputies will be eligible to vote. The Chair will not normally vote on matters however in the case of equality of votes, the Chair or person presiding as Chair will have the casting vote. Members with a conflict of interest in a specific Topic, including members who have had a significant role in the preparation of the submissions being considered, will not cast a vote for that Topic.

7. QUORUM

Quorum will be 50% of voting members.

8. VALIDITY OF PROCEEDINGS/MEMBERSHIP VACANCIES

Validity of proceedings of the EBPB is not affected by a vacancy or defect in the appointment of a member of deputy. Membership of the EBPB shall end if;

- Members resign by giving notice in writing to the Chair of the EBPB
- Absenteeism from 3 consecutive ordinary meetings; unless the EBPB is satisfied that absence is due to reasonable cause
- Ceases to belong to the body they represent
- Term of office expires

9. EVIDENCE REVIEW GROUP (ERG)

The ERG is a standing committee which reports to the EBPB. Staff from SMTL and ProcS form the core membership who will undertake the day-to-day workload for the ERG.

The ERG will also include experts in Health Economics and Human Factors from

Swansea University as and when required.

The ERG will liaise with other researchers and analysts as and when required, including partnering with HTW staff.

Expert Membership - The ERG will recruit expert members as and when required to provide clinical and domain-specific advice and expertise. Expert members may include Clinical experts from NHS Wales and Welsh Government National Special Advisory Groups (NSAGs).

10. POWERS OF THE EBPB

- The EBPB may require the Evidence Review Group (ERG) to convene meetings of expert advisors.
- The work and meetings of the ERG and expert advisors should be reported to the EBPB.
- The ERG should operate in an advisory role to the EBPB.
- The EBPB may seek independent advice as and when appropriate.
- The EBPB may commission external bodies to evaluate evidence in relation to products.
- The EBPB and ERG will incur the minimum necessary expenditure to enable their work to be carried out. These expenses will be considered and administered by NWSSP Shared Services Procurement Services.
- Nominated experts from the ERG may be required to attend meetings of the EBPB.

11. GOVERNANCE AND ACCOUNTABILITY

The EBPB is accountable to the NWSSP committee and will utilise NWSSP's governance structures.

12. ROLES AND RESPONSIBILITIES

- Support the rationalisation and standardisation agenda in line with prudent Healthcare principles.
- Review evaluations and evidence assessments of medical technologies.
- Develop a work programme determined by Health Boards/Trusts, Welsh Risk Pool, and other stakeholders.
- Provide advice to stakeholders regarding new or innovative products for use across NHS Wales in consultation with HTW.
- Liaise with Academia on the EBPB work programme, including product development initiatives where appropriate.
- Participate in horizon scanning with other agencies such as HTW and advise on the potential impact for the NHS.

- Provide advice on clinical pathways/treatments where devices and consumables are part of the clinical process, complimenting and supporting the work of NICE.
- Receive for consideration into the work programme topics referred by WG and other key stakeholders. This will include liaison with HTW's Front Door Group.
- Liaise and engage with professional peers.
- Produce an Annual report for review by NHS Wales and .
- Consider NICE guidance and Do Not Do recommendations when developing the work programme.
- Develop mechanisms to audit adoption of the EBPB advice.

13. GROUP STRUCTURE & METHODS

A separate document is available detailing the structure and working methodology of the EBPB and other structures.

Welsh Energy Group (WEG)
Welsh Energy Operational Group (WEOG)
Terms of Reference

Scope

The energy requirements of the NHS in Wales have a combined value in excess of £134m per annum. The overall portfolio comprises of over five hundred sites each requiring a supply of Gas, Electricity, Fuel Oils and/or Biomass Fuel.

Given the exceptional energy prices and volatility in the energy markets, an All Wales Directors of Finance (AWDoFs) Task & Finish Group was established in 2023 to progress a review, consider options and make recommendations in regard to the governance of energy procurement for NHS Wales. The outcome of this was the recommendation for the following groups to be formed:

- Wales Energy Group (WEG) - with delegated authority to agree national purchasing decisions & report to the NHS Wales (SSPC)

- Wales Energy Operational Group (WEOG) as a sub-group to the WEG – for operational management issues

This document's purpose is to define the Terms of Reference (ToR) for both of the above groups.

WEG

The WEG shall establish a strategy for the procurement of gas and electricity which will define basket choices from the Crown Commercial Services (CCS) framework options available to NHS Wales. The strategy shall have the aim of balancing risk limitation with cost certainty to the NHS Wales energy budget. Group members will be provided with monthly energy market analysis from CCS, in order to develop expertise of group members and aid informed decision making. The group will meet quarterly – with the option to increase frequency as market volatility dictates. The WEG shall also act as the All-Wales Programme Review Board regarding the renewal, extension and ratification of Gas and Electricity contracts made on an All-Wales Basis.

WEOG

The WEOG shall establish a common model to supplier management and best working practices across all NHS Wales utility contracts. Group members will be provided with monthly energy market analysis and insight from CCS, in order to keep members well-informed of market conditions. The group will meet monthly – with the option to increase or decrease the frequency if required.

Structure

WEG

The group will consist of Directors of Finance representatives from each of the Health Boards, Special Health Authorities, NWSSP and Trusts, or their deputies who will act with the delegated authority of their respective organisation to contribute to the collective decisions of the Group. The group will also include representation from NWSSP Procurement Services and NWSSP Finance.

WEOG

The group will consist of representatives from each of the Health Boards, Special Health Authorities, NWSSP and Trusts, made up of colleagues from various departments such as (but not limited to) Estates, Facilities and Finance. Representatives should have the delegated authority of their respective organisations to contribute to the decisions relevant to the scope of the Group. The group will also include representation from NWSSP Procurement Services.

Membership

WEG

It is suggested that the Group consist of the following members as a minimum;

- Chair of the Group
- Vice Chair of the Group
- Health Board/ Special Health Authority /NWSSP/ Trust Directors of Finance representatives or deputies with the delegated authority of their respective organisation to contribute to the decisions of the Group
- Representative(s) from NWSSP Procurement Services and NWSSP Finance.

The Group shall Co-opt an Account Manager or Market Analyst of the framework provider (CCS) for each meeting of the WEG to provide market intelligence.

It may be necessary for separate Task & Finish group(s) to be established in order to undertake specifically defined programmes of work with clear objectives and timescales. In such instances, the WEG will determine the remit and membership of such groups and the resultant groups will report progress and deliverables to the WEG and WEOG where appropriate.

Quorum – The minimum group representation required to make any decision shall be the Chair of the Group (or the Vice Chair), the Head of Sourcing from NWSSP Procurement Services (or a deputy nominated by the same) and sufficient additional members so that there are no less than seven member organisations represented at the meeting.

WEOG

It is suggested that the Group consist of the following members as a minimum;

- Chair of the Group
- Vice Chair of the Group
- Organisation representatives from various departments such as (but not limited to) Estates, Facilities, and Finance as appropriate
- Representative(s) from NWSSP Procurement Services and NWSSP Finance.

The Group shall Co-opt an Account Manager of the framework provider (CCS) for each meeting of the WEOG to provide market intelligence and discuss matters arising in relation to the Gas and Electricity contracts. Additionally, the group shall Co-opt a commodity supplier representative on a bi-monthly basis to facilitate account management discussions.

It may be necessary for separate Task & Finish group(s) to be established in order to undertake specifically defined programmes of work with clear objectives and timescales. In such instances, the WEG will determine the remit and membership of such groups and the resultant groups will report progress and deliverables to the WEOG and WEG where appropriate.

Quorum – The minimum group representation required to make any decision shall be the Chair of the Group (or the Vice Chair), the Head of Sourcing from NWSSP Procurement Services (or a deputy nominated by the same) and sufficient additional members so that there are no less than seven member organisations represented at the meeting.

Role of the Groups

WEG

- To ensure a consistent approach to the procurement / sourcing of Gas and Electricity throughout all aspects of the NHS in Wales.
- To input into the development of a strategic procurement model for Gas and Electricity contracts within NHS Wales.
- To provide a platform for the framework provider to share utility market intelligence with all Health Boards, Special Health Authorities, NWSSP and Trusts within NHS Wales.
- To develop, agree and manage the Purchasing Strategy for the All-Wales Gas and Electricity contracts having received market intelligence and actual price/contract performance, and agree in a timely manner national purchasing decisions (i.e. basket choice).
- To monitor contract performance with the WEOG representative/s providing an update of performance of the Gas and Electricity contracts.
- To monitor NHS Wales Gas and Electricity forecasts as provided by the supplier and supply regular financial forecasts to all member NHS organisations.
- To nominate NHS Wales member(s) as required for participation in the suppliers

External Risk Management (ERM) group
- To ensure that the Terms of Reference for the WEG/WEOG are reviewed each year .

WEOG

- To ensure a consistent approach to the contract management of the supply of all utilities (including but not limited to Gas, Electricity, Fuel Oils, and Biomass) throughout all aspects of the NHS in Wales.
- To allow all parties to discuss their respective levels of satisfaction in respect of those Services provided via all Contracts managed by the WEOG and to agree any action necessary to address areas of dissatisfaction.
- To monitor and discuss the performance of supplier(s) against the terms of the All-Wales Utilities contracts and (where necessary) agree a strategy for enforcing said contractual terms, including (but not limited to) the use of performance improvement notices, financial penalties and termination of contracts.
- To support the role of the Local Estates and Energy leads by enabling a collaborative approach to contract management.
- To agree and monitor Key Performance Indicators for All Wales Utilities contracts.
- To consider any changes required to the supply of utilities in line with national policies and strategies as they change and develop.
- To provide an update of performance of Gas and Electricity contracts to WEG, by nominated person/s.
- To nominate NHS Wales member(s) as required for participation in the suppliers Operational Improvement Group (OPIG)
- To ensure that the Terms of Reference for the WEG/WEOG are reviewed annually

Market Analysis

WEG

The framework provider will provide a market overview prior to the development of a Purchasing Strategy by WEG. The framework provider will not influence the development of the strategy and decisions will be verbally agreed by NHS Wales WEG attendees.

The Purchasing Strategy will decide basket(s) for NHS Wales to join, and should multiple baskets be selected, define meter level criteria for basket participation.

The framework provider shall provide monthly/quarterly/annual market and basket analysis as required by NHS Wales, which will be distributed to the WEG and WEOG by NWSSP Procurement Services.

WEOG

The framework provider shall provide monthly/quarterly/annual market and basket

analysis as required by NHS Wales, which will be distributed to the WEG and WEOG by NWSSP PS.

Authority and Accountability

NWSSP Procurement Services has the authority to conduct market engagement activity, on behalf of all Health Boards, Special Health Authorities, NWSSP and Trusts, in NHS Wales, from the governance divested in NHS Wales Shared Services Partnership.

The WEG is under the authority of NHS Wales and therefore will be required to submit an update/highlight report to each meeting of the NHS Wales as instructed.

WEG

All decisions made by the WEG should ideally be via the consensus of all member organisations in attendance at the relevant WEG meeting. In the event that consensus cannot be reached, a decision will be made by means of a vote whereby each member organisation will have a single equal vote and a decision based on the view of the majority. NWSSP Procurement Services will have no vote. In the event of a tied result, the Chair of the Group will have the casting vote.

The WEG is a sub-Committee of the . The All-Wales Directors of Finance Group will be responsible for nominating a Chair and Vice Chair for the WEG from within NHS Wales once every two years or as necessitated due to the resignation of the previous Chair. The will be responsible for appointing the Chair and Vice Chair. Individuals will not be restricted from undertaking these roles for longer than two years provided that the approve, and All-Wales Directors of Finance Group is in favour of their continued tenure

WEOG

All decisions made by the WEOG should ideally be via the consensus of all member organisations in attendance at the relevant WEOG meeting. In the event that consensus cannot be reached, a decision will be made by means of a vote whereby each member organisation will have a single equal vote and a decision based on the view of the majority. NWSSP Procurement Services will have no vote. In the event of a tied result, the Chair of the Group will have the casting vote.

The WEG will be responsible for appointing a Chair for the WEOG from within NHS Wales once every two years or as necessitated due to the resignation of the previous Chair. The WEG will also appoint a Vice Chair. Individuals will not be restricted from undertaking these roles for longer than two years provided that the WEG is in favour of their continued tenure.

The WEOG shall also have the authority to agree the award and renewal of supply agreements for other utilities contracts (Fuel Oils and/or Biomass) on behalf of the

Health Boards, Special Health Authorities, NWSSP and Trusts, in NHS Wales.

Performance Monitoring and Financial Forecasting

The framework provider shall be required to produce quarterly reports outlining the overall performance of trading on behalf of NHS Wales. This will include analysis of the traded periods in comparison to the average market price for each tradable period and information provided by the Department for Energy Security and Net-Zero. This report shall evidence the overall pricing activity carried out in relation to the pure energy components of each contract only. Whilst the Group will acknowledge the impact of transmission, transportation, and other industry pass through costs, no accountability will be borne by the group in this respect. This report will be provided at each quarterly meeting of the WEG and will be distributed onwards to WEOG members by NWSSP Procurement Services.

The framework provider shall also be required to produce an annual report each financial year providing a forecast of out-turn costs for each NHS Wales organisation for that financial year. By request, they will also be required to provide forecasts of utilities costs for future years as may be required to meet IMTP planning requirements.

Frequency of meetings

The WEG shall meet on a quarterly basis as a minimum. The Group will, at its discretion, agree intermediate meetings if these are deemed to be warranted. The WEOG shall initially meet on a monthly basis and at its discretion, may amend the frequency of the meetings and agree intermediate meetings if required.

Content of meetings

Each of the WEG meetings will consist of the following activities.

- Brief internal pre meeting to enable discussion for NHS members prior to main meeting forum (The framework provider will not be at the pre meeting) .

- Approve the minutes of the previous WEG meeting and review agreed actions.
- Review of the energy market activity, trends and factors which influence commodity pricing (to be provided by the framework provider).
- WEG member to provide feedback from the suppliers External Risk Management (ERM)
- Review of the performance of the WEG Purchasing(baskets) as executed by the framework provider
- Review of Gas and Electricity supplier(s) performance, including any agreed KPIs and improvement actions – with summary to be provided by nominated person/s from WEOG.
- Framework provider's report of any change to pass-through costs to enable member organisations to project total energy costs.
- Updates on specific projects and activity of any separate Task & Finish group(s).

Each of the WEOG meetings will consist of the following activities.

- Brief pre internal meeting to enable discussion for NHS members prior to main meeting forum with framework provider and supplier(s) present. (The framework provider will not be at the pre meeting)
- Approve the minutes of the previous WEOG meeting and review agreed actions.
- Review of framework providers summary market report on those factors currently affecting utility pricing.
- Supplier risk (framework provider to highlight any risk of note)
- Review of supplier performance, including any agreed KPIs and improvement actions.
- Supplier's presentation of any information requested by the Group, for example billing, Complaints etc
- Framework provider's report of any change to pass-through costs to enable member organisations to project total energy costs.
- Any potential new/deleted sites affecting volumes to be flagged
- Updates on specific projects and activity of any separate Task & Finish group(s).
- WEOG member to provide feedback on the CCS Operational Improvement Group

While it is acknowledged that the WEOG will focus on Gas and Electricity contracts, the Group's meeting agenda will also include review of other Utility contracts, such as Fuel Oils and Biomass, at least once per annum. The inclusion of such contracts as part of the agenda will be notified to the Group in advance. This will enable additional personnel as may be required to be co-opted into the Group for those specific meetings where other Utility contracts will be discussed.

Annexe 5

Process for the Selection, Appointment and Termination of the Chair of the SSPC

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

The (SSPC) has the responsibility for appointing the Chair of the SSPC. Whist the appointment is not a Cabinet Secretary appointment the process takes account of the appointment principles outlined in the Governance Code on Public Appointments (revised October 2025), as published by the Cabinet Office and updated January 2026 that sets out the regulatory framework for public appointments.

MAIN BODY

In line with the Governance Code on Public Appointments to Public Bodies (revised October 2025) the principles of public appointments are summarised below:

A. Ministerial responsibility - The ultimate responsibility for appointments and thus the selection of those appointed rests with Ministers who are accountable to Parliament for their decisions and actions. Welsh ministers are accountable to Senedd Cymru, Welsh Parliament.

B. Selflessness - Ministers when making appointments should act solely in terms of the public interest.

C. Integrity - Ministers when making appointments, and all others involved in the appointment process, must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

D. Merit - All public appointments should be governed by the principle of appointment on merit. This means providing Ministers with a choice of high-quality candidates, drawn from a strong, diverse field, whose skills, experiences and qualities have been judged to meet the needs of the public body or statutory office in question.

E. Openness - Processes for making public appointments should be open and transparent.

F. **Diversity** - Public appointments should reflect the diversity of the society in which we live, and appointments should be made taking account of the need to appoint boards which include a balance of skills and backgrounds.

G. **Assurance** - There should be established assurance processes with appropriate checks and balances. The Commissioner for Public Appointments has an important role in providing independent assurance that public appointments are made in accordance with these Principles and this Governance Code.

H. **Fairness** - Selection processes should be fair, impartial and each candidate must be assessed against the same criteria for the role in question.

I. **Public service** - All public appointments should be seen as an opportunity to ensure that exceptional people from across the United Kingdom are given the chance to serve the public and utilise their skills and expertise to drive progress.

The essential features of the process will include the following:

- A panel must be set up to oversee the appointments process;
- The panel must be chaired by an independent assessor;
- An agreed selection process, selection criteria and publicity strategy for a successful appointment;
- A panel report must be prepared, signed by the chair of the appointment panel; and
- The appointment of the successful candidate must be publicised.

It is important that all public appointees uphold the standards of conduct set out in the Committee on Standards in Public Life's Seven Principles of Public Life. The panel must satisfy itself that all candidates for appointment can meet these standards and have no conflicts of interest that would call into question their ability to perform the role.

The selection panel will comprise of the following members:

- Independent Assessor (Panel Chair)
- SSPC representative (Vice-chair)
- Velindre University NHS Trust Chair (as NWSSP host)
- Welsh Government representative

The appointment process is managed by the NWSSP Director of People and Organisational Development.

A suite of supporting documentation has been developed to support the process.

The job **advertisement.** Published via on-line fora in keeping with best practice for public appointments.

The candidate application **form**. The content and format very closely mirrors the application form currently used by the Welsh Government for Public Appointments.

A **briefing pack** for candidates. This includes details of the role profile and person specification.

Governance and Risk Issues

Whilst the appointment is not a Cabinet Secretary appointment, the planned process will take account of the appointment principles outlined in the Governance Code on Public Appointments to Public Bodies (revised October 2025) and sets out the regulatory framework for public appointments.

The selection process will be repeated following each maximum term of office for the Chair of the SSPC, or when the Chair resigns, or following removal of the Chair by termination.

Reappointment and Tenure

The SSPC SOs form part of the Velindre University NHS Trust Standing Orders, which must take account of the provisions of the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

Suspension and Termination

Should the circumstances laid down in the draft regulations at 9.(1), 9.(3), 9.(5) or 10.(1) emerge, and the removal (i.e. suspension or termination) of the Chair is deemed necessary, the Committee will agree the reasons for the decision to do so and formally submit these reasons to a panel constituted as that described for the selection process above.

The panel will then make a recommendation to Velindre University NHS Trust to suspend or remove the Chair. Velindre University NHS Trust will then take the necessary action and subsequently provide the Welsh Ministers with the reasons agreed as per section 9.(2) (termination) or 10.(2) (suspension) of the Regulations.

TRUST BOARD		
Equalities Policies Review		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	Claire Budgen, Organisational Development Specialist	
PRESENTED BY	Sarah Green, Executive Director of Workforce and Organisational Development	
REPORT SPONSOR	I, Sarah Green, Executive Director of Workforce and Organisational Development, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	28/09/2026	Executive Management Board
	10/11/2026	People, Engagement and Culture Committee
	The People, Engagement and Culture Committee endorsed three policies for onward submission to Trust Board. The Committee approved one guidance note and one procedure.	
ONWARD SCRUTINY ROUTE		
PURPOSE OF THE REPORT	FOR APPROVAL	
EXECUTIVE SUMMARY	Five separate policies and guidance documents were reviewed at the People, Engagement and Culture Committee. The opportunity was taken to link them within a policy pack to enable staff clear signposting and understanding of the interplay between the documents as part of creating an inclusive organisation. The Supporting Staff with Special Needs Guidance and the Interpreters Procedure were approved at the Committee stage. The three policies seek final approval by Trust Board. Legal changes to the definition of sex within the Equalities Act have been reflected in the wording of the Supporting Transgender Staff Policy. A clause relating to Respite Care has been altered within the Supporting Staff who are Carers Policy.	

ACTION / DECISION	Approval
ADDITIONAL RESOURCES	

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

- Outstanding for quality, safety, and experience
- A sustainable organisation that plays its part in creating a better future for people across the globe

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

- A Prosperous Wales
- A More Equal Wales

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

[Delete as appropriate and then remove this paragraph]

- Equitable
- Effective

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

Status: QIA not required - not a strategic decision

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

Status: Yes - please outline what, if any, actions were taken as a result

All three EQIAs highlighted the need for clear communication, supported by line manager training and for documents to be available in Welsh and English. In addition, the Supporting Transgender Staff Policy stated the need for Line Managers to check that suitable facilities are in place for their team members.

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Equality and Diversity Policy
	Appendix 2	Supporting Transgender Staff Policy
	Appendix 3	Supporting Staff who are Carers Policy

1. SITUATION

1.1 Three policies are attached for approval:

- Equality and Diversity Policy
- Supporting Transgender Staff Policy
- Supporting Staff who are Carers Policy

2. BACKGROUND

2.1 These documents set the framework for creating an inclusive workplace.

2.2 For the first time, these policies and additional guidance have been linked into a policy pack. The introduction to the Equality and Diversity Policy explains *'This Equality and Diversity Policy provide the overarching framework for promoting fairness, dignity, respect and inclusion for all staff, patients, service users, volunteers and stakeholders. The policy sits at the centre of a cohesive Equality and Diversity Policy Pack and should be read together with the relevant operational sub-policies and guidance documents*.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 The majority of changes have been in formatting and presentation. Key to this is the addition of the umbrella statement in the introduction of each of the documents explaining how they link within an overarching framework for promoting fairness, dignity, respect and inclusion.

3.1.2 In terms of material changes to the contents:

The Supporting Transgender Staff has Policy been updated to reflect the definition of Sex as being biological sex. This has meant changes to the wording regarding the use of toilets and changing rooms.

The Supporting Staff who are Carers Policy previously had a clause regarding the Trust supporting respite care. There was no budget identified for this, so the clause has been changed to signposting staff to external resources.

3.2 FINANCIAL IMPLICATIONS

3.2.1 Not applicable.

3.3 LEGAL IMPLICATIONS

3.3.1 These policies relate to the Equalities Act 2010. In May 2026, a court judgement clarified that for the purposes of the Equalities Act, sex should be defined as biological sex. Subsequent guidance has been issued on how to apply this in practice. This development has been reflected in the Supporting Transgender Staff Policy.

3.4 PEOPLE IMPLICATIONS

3.4.1 These policies are instrumental in shaping an inclusive culture with fairness, dignity and respect.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 Policies will be available in Welsh and English once approved.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

06 - People and Organisational Development (POD)

Operational Risks

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 Approve the policies.

Ref: WF05

Equality and Diversity Policy

Executive Sponsor & Function:	Executive Director of OD and Workforce
Document Author:	Equality, Diversity & Inclusion Manager
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	September 2026
Outcome of Equality Impace Assessment:	Continue to promote and monitor Equality, Diversity and Inclusion training across the Trust. Policy translation to Welsh. Ensure all new and revised policies, service developments and organisational changes are supported by Equality Impact Assessments. Monitor workforce equality data, staff survey feedback and staff network

	feedback to identify and address any inequalities or barriers.
Review Date:	September 2029
Version:	

CONTENTS

1. Introduction / Purpose 4
2. Policy Statement 4
3. Objectives 4
4. Principles 5
5. Scope / Area Of Application 5
6. Legislation And Nhs Requirements 6
7. Roles And Responsibilities 6
8. Procedure / Main Body 7
9. Resources 9
10. Training 9
11. Implementation And Policy Compliance 9
12. Health And Care Standards 10
13. Integrated Impact Assessment 10
14. Environmental Impact 10
15. Audit 10
16. Review 11
17. Non-Conformance 11
18. Getting Help 11
19. References And Related Documents 11
Appendix 1: Protected Characteristics And The Equality Act 2010 13
Appendix 2: Equality Communication 14
Appendix 3: Responsibilities 15

1. INTRODUCTION / PURPOSE

This Equality and Diversity Policy provides the overarching framework for promoting fairness, dignity, respect and inclusion for all staff, patients, service users, volunteers and stakeholders. The policy sits at the centre of a cohesive Equality and Diversity Policy Pack and should be read together with the relevant operational sub-policies and guidance documents.

The purpose of this policy is to ensure equality and fairness throughout Velindre University NHS Trust and to support compliance with the Equality Act 2010, the Public Sector Equality Duty, National Terms and Conditions of Service for NHS employees and good practice guidance. The policy specifically relates to workforce issues and supports an inclusive working environment where equality of opportunity is actively advanced, barriers are removed and reasonable adjustments are made where required.

The policy also supports the principles of the Well-being of Future Generations (Wales) Act 2015 by contributing to a more equal, cohesive and inclusive organisation.

2. POLICY STATEMENT

Velindre University NHS Trust aims to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and foster good relations between people who share a protected characteristic and those who do not.

The Trust recognises that individuals may experience discrimination or disadvantage as a result of one or more intersecting protected characteristics. This will be taken into account in the implementation of this policy, decision-making and employment practices.

The Trust is committed to making reasonable adjustments to ensure equitable access to employment, development opportunities and the working environment for staff who require them. The Trust is also committed to ensuring that workplace communication, information and services are accessible and inclusive, including compliance with Welsh Language Standards and accessible communication requirements.

3. OBJECTIVES

- Promote equality, diversity, inclusion, fairness, dignity and respect across the Trust.
- Support compliance with equality, human rights, Welsh Language and NHS Wales requirements.

- Ensure equality considerations are embedded in employment policies, practices, decision-making and service developments.
- Support staff to achieve their full potential within a safe, inclusive and supportive working environment.
- Promote accessible and inclusive communication and engagement.
- Ensure concerns about unfair treatment, discrimination, harassment, bullying or hate-related behaviour can be raised through appropriate routes.
- Support the development, monitoring and delivery of the Trust Strategic Equality Plan.

4. PRINCIPLES

Velindre University NHS Trust will seek to employ a workforce that is representative of all sections of society within the communities it serves. The Trust is committed to equality of opportunity for all employees and prospective employees, regardless of protected characteristic, and to eliminating discrimination, harassment and victimisation in all aspects of employment.

The Trust aims to ensure that every employee feels respected, valued and able to be their authentic self, giving their best within a safe, inclusive and supportive working environment. Employees will be supported and encouraged to develop their full potential, and the talents, skills and experience of the workforce will be fully utilised to maximise the effectiveness of the organisation.

The Trust recognises and values individual difference and will not tolerate intimidation, bullying, harassment or hate-related behaviour. Staff will be supported where they feel they are being unfairly treated and encouraged to report concerns using appropriate and safe reporting routes.

5. SCOPE / AREA OF APPLICATION

This policy applies to all employees of Velindre University NHS Trust, including those employed on a permanent, temporary, fixed-term, bank, agency or honorary basis, as well as volunteers, including those working within hosted organisations.

The policy also applies to job applicants, potential employees, students, trainees, apprentices and secondees undertaking work or placements within the Trust. It applies to all stages of employment, including recruitment and selection, employment, training and development, promotion and termination of employment.

The principles of this policy apply to behaviour in the workplace and to work-related activities, including training, events, meetings and online or digital working environments.

6. LEGISLATION AND NHS REQUIREMENTS

- This policy complies with relevant legislative and NHS requirements, including:
  - Equality Act 2010 and Public Sector Equality Duty.
  - National Terms and Conditions of Service, Agenda for Change, Equality and Diversity Statement.
  - Human Rights Act 1998.
  - Well-being of Future Generations (Wales) Act 2015.
  - Welsh Language (Wales) Measure 2011 and associated Welsh Language Standards.
  - NHS Wales equality and human rights requirements and guidance.

7. ROLES AND RESPONSIBILITIES

Clear responsibilities for equality, diversity and inclusion apply at all levels of the organisation. All staff and managers are responsible for promoting equality, preventing discrimination and fostering an inclusive working environment.

Role	Responsibilities
Board members	Set strategic direction, review performance and ensure good governance, with equality, diversity and human rights considered in policies, strategies and service developments.
Senior managers	Oversee the design, delivery, quality and effectiveness of organisational functions, demonstrate inclusive leadership and ensure equality is embedded in recruitment, workforce management, decision-making and service delivery.
Managers	Implement this policy within their areas, embed equality considerations into people management and day-to-day behaviours, promote inclusive teams and ensure concerns are addressed appropriately.
Equality Manager	Raise awareness, provide advice and build capacity regarding equality duties and support employees and managers to meet their responsibilities.
Workforce and OD officers	Build equality considerations into employment policies, procedures and people practices.
Communications officers	Ensure information is available and accessible to employees, service users and wider communities, taking account of protected characteristics, Welsh

	Language Standards and accessible communication requirements.
Workforce information officers	Support the collection and reporting of equality characteristics and workforce information to monitor the effect of Trust policies and practices.
Frontline employees	Treat colleagues, service users and the public with dignity and respect, and meet the needs of people from protected groups in line with Trust values and policies.
Trade union representatives	Contribute to the equality agenda and support members who have concerns about equality, fairness or inclusion.

8. PROCEDURE / MAIN BODY

8.1 EQUALITY POLICY PACK

This policy is the umbrella policy for the Equality and Diversity Policy Pack. Dedicated sub-policies provide more detailed operational guidance. Staff and managers should consider the main policy and related sub-policies together to support a holistic and intersectional approach to workforce support.

Other equality-related policies and guidance include Supporting Staff with Specific Needs, Supporting Transgender Staff Policy, Supporting Staff who are Carers Policy and the Procedure for Delivering Interpreting Services.

8.2 PROTECTED CHARACTERISTICS

The Equality Act 2010 identifies nine protected characteristics. These are:

- Age
- Gender reassignment
- Sex
- Disability
- Pregnancy and maternity
- Sexual orientation
- Race, including ethnic or national origin, colour or nationality
- Religion or belief, including lack of belief
- Marriage and civil partnership

The duty applies to marriage and civil partnership only in respect of the requirement to have due regard to eliminating discrimination.

8.3 STRATEGIC EQUALITY PLAN AND MONITORING

The Trust will seek to achieve equality and fairness through its Strategic Equality Plan. The Trust will make every effort to improve the collection of staff equality data so that the Strategic Equality Plan remains appropriate and current.

Progress towards the Strategic Equality Plan and information contained in the Workforce Profile will be discussed through relevant governance routes. Where any shortfall or cause for concern is identified, further analysis will be undertaken and appropriate action plans agreed and monitored. This may include positive action where lawful and appropriate.

8.4 EMPLOYMENT PRACTICES AND EQUALITY IMPACT ASSESSMENT

The Trust will regularly review its employment practices and procedures to ensure fairness, compliance with law and good practice. All new and existing policies, service changes and developments will be impact assessed using the Trust Equality Impact Assessment tool to support compliance with legislation and good practice.

Recruitment processes will seek to ensure that all potential and actual applicants have equality of opportunity when applying for posts and following appointment. Equality principles will also apply to wider employment practices, including training, development, promotion, flexible working considerations and retire and return arrangements.

8.5 REASONABLE ADJUSTMENTS AND ACCESSIBILITY

Specific arrangements may be required to accommodate particular groups. These may include reasonable adjustments to facilities, catering, the workplace, working arrangements or communication methods. The Trust is committed to making reasonable adjustments where required to support equitable access to work, development opportunities and the working environment.

Full account will be taken of the Welsh Language Standards, the Trust Bilingual Skills Strategy and the promotion of the Welsh language. Workplace communication, information and services should be accessible and inclusive.

8.6 RAISING CONCERNS

Where an individual feels they have been treated unfairly from an equality perspective, they should raise the matter with their manager in the first instance where appropriate. Where the issue relates to treatment by another person, it may be addressed through

the Trust Dignity at Work procedure, Grievance Policy, Speaking Up Safely arrangements or other relevant Trust policies.

If the individual feels stressed by the situation, they should refer to the Management of Stress Policy. If the issue relates to an application for employment, the individual may raise the concern with the appointing officer and, where not resolved, through the complaints process. The Trust will endeavour to deal with concerns promptly, fairly and sensitively.

8.7 ENGAGEMENT AND COMMUNICATION

Employee engagement will be promoted through staff networks, equality champions and other mechanisms that support involvement, voice and inclusion. The Trust will make every effort to keep employees informed of equality-related news, initiatives and developments, and to encourage discussion of relevant issues.

Further engagement may be undertaken through the NHS Wales Annual Staff Survey, staff networks, newsletters, intranet communication, formal engagement events, feedback mechanisms and other accessible routes.

9. RESOURCES

Implementation of this policy is supported through existing Trust governance, Workforce and OD, Equality, Diversity and Inclusion, Communications, management and staff engagement structures. Resource requirements may include staff time, training provision, communication resources, equality impact assessment activity, workforce data monitoring and reasonable adjustments where required.

10. TRAINING

Equality and Diversity training forms part of the Trust core skills training requirements. Employees are required to undertake the Treat Me Fairly e-learning package and/or classroom Equality Training sessions on a three-yearly basis. This may be supplemented by more detailed or specific training by request, or to support specific initiatives.

Training will be delivered to managers through e-learning, formal training programmes and informal discussion of specific equality issues such as equality impact assessment. Management development and organisational development programmes will include equality, diversity, inclusion and human rights elements wherever possible, supporting inclusive leadership, fair decision-making and compliance with legal and NHS Wales requirements.

11. IMPLEMENTATION AND POLICY COMPLIANCE

The principles of this policy will underpin all policies, practices and decision-making within Velindre University NHS Trust. Equality in the workplace is good management practice and supports the delivery of fair, inclusive and effective services.

Managers are responsible for implementing this policy within their areas of responsibility and ensuring equality considerations are embedded in decision-making, people management practices, service delivery and day-to-day behaviours.

12. HEALTH AND CARE STANDARDS

This policy supports safe, inclusive, respectful and fair working environments. It contributes to quality, safety, dignity, voice, learning, improvement, workforce wellbeing, equality of opportunity and good governance by embedding equality considerations into employment practices, policy development and service delivery.

13. INTEGRATED IMPACT ASSESSMENT

This policy has been impact assessed and has not been found to be discriminatory in accordance with the Equality Act 2010 and the Human Rights Act. The Equality Impact Assessment process considered the potential impact of this policy on all protected characteristics and identified no adverse impact. Where potential impacts are identified in future reviews, appropriate mitigating actions will be identified and implemented.

14. ENVIRONMENTAL IMPACT

No specific environmental impact has been identified within this policy. Where changes to communication, engagement, training materials or working arrangements are considered, environmental considerations should be taken into account where relevant and proportionate.

15. AUDIT

The policy will be monitored on an annual basis, including through workforce data, Equality Impact Assessments, staff engagement feedback and governance reporting arrangements. Audit and review activity should consider whether the policy remains current, accessible, understood and consistently applied.

16. REVIEW

This policy will be formally reviewed on a three-yearly basis, or earlier where required to reflect changes in legislation, NHS Wales requirements, organisational priorities or learning arising from monitoring, audit or review activity.

17. NON-CONFORMANCE

Failure to comply with this Equality and Diversity Policy, including behaviour that constitutes discrimination, harassment, victimisation or failure to uphold equality responsibilities, will be regarded as misconduct and may lead to disciplinary action in accordance with the Trust Disciplinary Policy and procedures. Appropriate action will be taken in line with the seriousness of the breach and may include informal action, formal disciplinary proceedings or other management action as appropriate.

18. GETTING HELP

For interpretation, advice or support in relation to this policy, staff and managers should contact their line manager, Workforce and OD, the Equality Manager or other appropriate Trust support routes. Concerns should be raised through the relevant Trust policy or reporting process, depending on the nature of the issue.

19. REFERENCES AND RELATED DOCUMENTS

- Equality Act 2010.
- Public Sector Equality Duty.
- Human Rights Act 1998.
- Well-being of Future Generations (Wales) Act 2015.
- Welsh Language (Wales) Measure 2011 and associated Welsh Language Standards.
- National Terms and Conditions of Service, Agenda for Change, Equality and Diversity Statement.

- NHS Wales equality and human rights requirements and guidance.
- Velindre University NHS Trust Strategic Equality Plan.
- Supporting Staff with Specific Needs.
- Supporting Transgender Staff Policy WF46.
- Supporting Staff who are Carers Policy WF40.
- Procedure for Delivering Interpreting Services WF55.
- Dignity at Work procedure, Grievance Policy, Speaking Up Safely arrangements, Management of Stress Policy and Disciplinary Policy.

APPENDIX 1: PROTECTED CHARACTERISTICS AND THE EQUALITY ACT 2010

The Equality Act 2010 brought together and replaced previous anti-discrimination laws with a single Act. It simplified and strengthened the law, removed inconsistencies and made it easier for people to understand and comply with it. The Act includes the Public Sector Equality Duty, replacing the separate duties on race, disability and gender equality.

The general duty requires public bodies, when exercising their functions, to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and foster good relations between people who share a protected characteristic and those who do not.

Advancing equality of opportunity involves removing or minimising disadvantages experienced by people due to protected characteristics, taking steps to meet different needs and encouraging participation where participation is disproportionately low. Fostering good relations involves tackling prejudice and promoting understanding.

APPENDIX 2: EQUALITY COMMUNICATION

Equality communication applies to service users as well as employees. Given the size and importance of the equality agenda, particularly in relation to the Public Sector Equality Duty and accessible communication requirements, the Trust will support a two-way, inclusive and accessible communication approach.

The key aims are to communicate equality, diversity and human rights activity and messages to employees, the Trust, the public, seldom-heard and underrepresented groups, public sector and third sector partners and other key stakeholders; enable two-way communication and meaningful engagement; and support training and awareness through accessible information, resources and toolkits.

- Monthly equality newsletters, Trust communications, intranet news and links to significant equality calendar dates.
- Equality and accessible healthcare web pages, internally and externally.
- Formal engagement and consultation events, including targeted engagement where appropriate.
- Development and support of staff networks and stakeholder groups.
- Media and digital communications, including social media and press releases.
- Awareness and marketing events for equality programmes.
- Surveys, questionnaires, suggestion boxes and digital feedback routes.
- Links with patient experience, concerns, complaints and partnership working.
- Equality and accessibility information within training and development activity.
- Ongoing exploration of innovative communication routes to improve reach, engagement and accessibility.

The Trust communication strategy should be underpinned by equality considerations, with regular communication with the Communications Team. Accessible formats should be considered fundamental to inclusive communication.

APPENDIX 3: RESPONSIBILITIES

It is important for all employees of Velindre University NHS Trust to be aware of the Public Sector Equality Duty so that it is considered in their work where relevant. Responsibilities include strategic leadership, inclusive management practice, advice and support, accessible communication, workforce monitoring, respectful frontline behaviour and trade union contribution to the equality agenda.

Ref: WF46

SUPPORTING TRANSGENDER STAFF POLICY

Executive Sponsor & Function	Executive Director of OD and Workforce
Document Author:	Equality, Diversity & Inclusion Manager
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	September 2026
Equality Impact Assessment Outcome:	Translation of whole policy to Welsh. Managers to check facilities in their area are suitable for all staff. Offer transgender staff support and remain clear that harassment/discrimination towards trans staff will not be tolerated.
Review Date:	September 2029
Version:	

Contents

1. Policy Statement 4
2. Purpose 4
3. Background/Context 5
4. Scope 5
5. Aims and Objectives 6
6. Roles and Responsibilities 6
7. Recruitment and Selection 7
8. Disclosure and Barring Service (DBS) 8
9. Record Keeping 9
10. Employment References 10
11. Birth Certificates 11
12. Work Permits 11
13. National Insurance 11
14. Pensions 12
15. Professional Registrations 12
16. Managing Staff Going Through the Transition 12
17. First Meeting 13
18. Real Life Experience/Change in Social Gender 14
19. Uniform/Dress Code 14
20. Informing Colleagues 15
21. Use of Changing/Shower Facilities and Toilets 15
22. Public Facing Roles 16
23. Time Off Work 17
24. Responsibilities 18
25. Further Information 19
26. References 19

Appendix 1: Gender Terminology 21

Appendix 2 - Additional Legislation Information 24

This document is part of our Equality & Diversity Policy Pack

This document is a specialised sub-policy of the Trust's overarching Equality & Diversity Policy. It provides targeted guidance on supporting transitioning and trans colleagues but does not duplicate the fundamental protections against discrimination outlined in the main Equality & Diversity policy [WF05].

Together, these documents set out the Trust's commitment to eliminating discrimination, advancing equality of opportunity, fostering good relations, and ensuring accessible and inclusive services and workplaces for everyone

Why look wider?

Individual experiences intersect. A trans staff member may also have specific health, or accessibility needs that trigger the Supporting Staff with Specific Needs (Disability) Policy. Always refer back to the main Equality & Diversity policy for overarching confidentiality and dignity at work standards.

Other Policies

Currently our other equalities-related policies are:

- Equality & Diversity Policy [WF05]
- Supporting Staff with Specific Needs (Disability) [Num?]
- Supporting Staff who are Carers Policy [WF40]
- Procedure for Delivering Interpreting Services [WF55]

INTRODUCTION

We want everyone connected to Velindre NHS Trust to feel included, to be themselves, and to achieve their full potential without fear of discrimination. This includes people whose gender identity does not match the sex they were assigned at birth.

For the purpose of this document the term “Trans” is used as an inclusive, umbrella term to support transgender and non-binary staff.

For support in this area, staff have available to them our LGBTQ Staff Network, Union colleagues and ED&I Staff. Our well-being offering also includes confidential support services for any staff seeking additional support.

Disclaimer

The UK Supreme Court ruling (April 2025), clarified that the protected characteristic of "sex" under the Equality Act 2010 refers to biological sex (at birth).

Staff should continue to treat all individuals with dignity and respect and seek advice from the Equality, Diversity & Inclusion Manager if they are unsure how the changes may apply in practice.

1. Policy Statement

The Trust will protect the rights of all staff, volunteers, applicants and members of the public to be treated with fairness, dignity, respect and professionalism. The Trust will ensure that anyone who identifies as transgender (“trans”) whether they may be considering undergoing, currently undergoing or who has undergone gender reassignment or not, will feel valued, respected, and understood and as a result be treated fairly.

2. Purpose

The purpose of this policy is to set out the support that is available to both managers and staff, if a staff member identifies as Transgender, this includes gender identity and expression. The Trust recognises that not all people that identify as transgender wish to undergo medical procedures and this would not prevent them from having the legal protection under the Equality Act 2010 to work free from discrimination.

3. Background/Context

Employers should expect roughly 1 in 150 staff to experience and/or express their gender in ways that do not follow the typical binary man/woman model. Many of these people will not disclose their feelings and may choose not to express them in the workplace because they fear a transphobic reaction from their employers and colleagues.

A transgender or Trans employee is an employee whose gender identity or gender expression differs from the gender assumptions made about them when they were born. For some they may feel that they do not fit into the male or female binary and may therefore identify as *non-binary*.

Some Trans employees will have just started to undergo gender reassignment (transition) to change to the gender role in which they live to better reflect their gender identity. Others will have already completed their gender reassignment (transition) and will have a Trans history. Some Trans employees may still be deciding whether or not to change the gender role they express in the workplace and may express their gender differently on a part-time basis in non-work situations.

Many Trans employees face discrimination before, during and after the process of gender reassignment. Most Transgender employees are not “out” as Trans to their workplace colleagues or managers. Often it is only when an employee is actually changing their workplace gender role as part of the process of gender reassignment (transition) that they will be out about being Trans. Many Trans employees do not feel they can afford to take the risk of being “out” as Trans in the workplace. Half of trans people (51 per cent) have hidden their identity at work for fear of discrimination (Stonewall report – LGBT in Britain Trans Report 2018).

Change often creates anxiety and uncertainty. As with all workplace change, gender transitions affect many people, the individual transitioning, their managers, colleagues, clients/patients and those with whom there may be incidental contact (such as working in the same location or practice area).

4. Scope

The policy applies to currently employed staff, potential employees, agency staff, locums, staff on honorary contracts and volunteers. It also applies in situations where employees are service users. It is expected that staff will afford all individuals equal

fairness, respect, dignity and professionalism, at all times, under the terms of this policy.

5. Aims and Objectives

The guiding principle supporting this policy is to create a fair, inclusive and respectful culture in which staff are protected from discrimination, harassment and victimisation on the grounds of their transgender or non-binary identity in line with the Equality Act 2010 (gender reassignment).

This policy aims to:

- Create an open, inclusive, diverse and supportive working environment

  that meets the needs of all transgender and non-binary staff enabling them to feel safe, valued and supported to achieve their full potential;
- Promote dignity, respect and equality of opportunity for trans and non-binary staff across all stages of employment;
- Provide clear advice, guidance and information to build understanding around transgender and non-binary identities, gender reassignment and transition and inclusive workplace.
- Assist managers in supporting staff who have changed their gender identity before joining the organisation where support is needed or requested.
- Assist managers in supporting staff who may be considering changing or are changing their gender identity whilst employed by the Trust.
- To support Transgender and non-binary staff, their managers, colleagues and all other staff in maintaining a professional working environment that embraces diversity, and promotes fairness and equity for all.
- To ensure that incidents of discrimination, harassment, bullying, violence and or aggression towards transgender and non-binary staff are reported, recorded and managed appropriately.

6. Roles and Responsibilities

Under the Equality Act 2010, it is unlawful to discriminate against, harass or victimise people who have the protected characteristics of gender reassignment. This protection applies to individuals who are proposing to undergo, are undergoing, or have undergone a process (or part of a process) of gender reassignment.

While legal protection is specifically defined under the Equality Act, extending respectful and inclusive practice to all transgender and non-binary people represents

good practice in employment, vocational training, and the provision of goods, facilities and services, and reflects NHS values and organisational commitments to dignity and inclusion.

All references to duties to promote the equality between men and women include Trans-men and Trans-women and the Trust recognises and respects non-binary identities in its employment practices, in line with inclusive workplace standards.

7. Recruitment and Selection

The Trust welcomes applications for employment from transgender and non-binary people, and all applicants can be assured of equal, fair and non-discriminatory treatment throughout the recruitment and selection process. It should not be expected that applicants and interviewees for employment would wish to disclose their gender identity or gender history. It is neither a relevant criterion for selection for a post, nor a question that should be asked at interview or alluded to in the recruitment and interview process.

However, if one of the *very* limited exceptions applies, then an individual could be expected to disclose their trans status and an interviewer would be able to ask an appropriate question. Any statement about the need for disclosure must be accompanied by the explicit reassurance that such information will be treated in strict confidentiality and that disclosure will not preclude eligibility for the post.

There is no obligation for a transgender or non-binary person to disclose their status as a condition of employment. If they choose to disclose, this is not in itself a reason for not offering employment and non-disclosure, or subsequent disclosure are not grounds for dismissal. All decisions must be based around the qualifications and skills offered by individuals.

Individuals involved in the recruitment and selection process who become aware of an applicant's transgender or non-binary status must maintain strict confidentiality in line with the Equality Act 2010, the Gender Recognition Act 2004, and data protection legislation.

Employees at all levels who could learn about an individual's gender reassignment history in the course of their work need to be very clear about the lawful and appropriate handling of this information. This could apply to:

- The information that can be entered into Workforce files where other staff might have access;
- Discussion about an applicant's job interview (recruitment, shortlisting or interview decision)
- The contents of Occupational Health Reports;
- Information that can be passed from one medical professional to another in the course of referral or when discussing a case;
- Information stored in medical records where that data could be accessed by others.

Any such information must be treated with the utmost confidentiality and included only as "special category personal data" under the UK General Data Protection Regulations (UK GDPR) and the Data Protection Act 2018 in any records which must not be available to or accessible by anyone not specifically authorised or agreed with the specific employee to have access.

Generally, it is only appropriate to inform colleagues, or other relevant contacts about an employees' trans status or history where they have *explicitly agreed*. When agreed, the trans employee should decide who is responsible; whether they would prefer to do this, a manager/colleague, or a mixture of these options. The employee should also decide when and how this will happen, including the details of the message and who it will be shared with.

8. Disclosure and Barring Service (DBS)

For those staff requiring a DBS check the process requires applicants to state all previous names and aliases. The last page of the form then has to be completed by the "Registered Body" who checks and verifies the contents and the evidence supplied. This means there can be some anxiety about the implications for transgender and non-binary applicants or staff who have legally changed their name.

The DBS has a confidential checking process for transgender applicants who don't want to reveal details of their previous identify to a potential or existing employer. These applicants are required to contact the DBS direct via email or telephone. Any Transgender or non-binary employee who does not wish to disclose a previous name on the initial disclosure form has a legal duty to follow this special DBS procedure. It is good practice to make this information available to all staff and applicants needing a DBS check.

Transgender applicants – sensitive@dbs.gsi.gov.uk

Telephone 0151 676 1452

Further information is available on the Disclosure and Barring Services website;

https://www.gov.uk/crb-criminal-records-bureau-check/contact-disclosure-and-barring-service

9. Record Keeping

Transgender people can apply to the Gender Recognition Panel under the Gender Recognition Act 2004 to seek full legal recognition. If successful a full Gender Recognition Certificate (GRC) is issued to the applicant unless the person is married or in a civil partnership.

A transgender member of staff is under no obligation to provide a GRC to their employer and has the right to have respect shown for their new name and gender role from the start. Nor should anyone be asked for a GRC or if they hold one; under any circumstances. A passport, driving licence or other recognised identity document is the relevant form of identification for employment purposes. A birth certificate is not routinely required, and where previously held should not be retained unnecessarily.

The manager and Workforce Manager should advise on where records are maintained that need to be changed. Managers and Workforce Managers should ensure that all documents, public references (such as telephone directories, web biographies etc.) and employment details display their affirmed gender. All records that disclose previous gender history should be withdrawn and destroyed as soon as the person legally changes their name and any copies needing to be kept in the person's workforce file have to be treated as "special category personal data under the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 and not disclosed to anyone not specifically authorised to see them.

When documents have been seen and copies taken at the point of starting employment (such as birth certificate) then every effort will be made to replace those with equivalent documents in the new name and gender. The Data Protection Act limits the purposes for which information may be kept. When the information is no longer useful, it must be destroyed. In some instances, it is necessary to retain records relating to an individual's identity at birth, for example, for pension or insurance purposes prior to obtaining gender recognition. However, once a person has obtained a GRC, these must be replaced with new details.

Access to records showing the change of name and any other details associated with the individual's Transgender status (such as records of absence for medical

treatment) must be restricted to staff who need the information to do their work. Such people could include those directly involved in the administration of a process, for example, Occupational Health Physician, or the person who authorises payments into a pension scheme. They do not include colleagues, line managers or third parties.

Once a person has received a GRC, there must be no disclosure of this information. Breaches of confidentiality must be treated in the same serious manner as disclosure of personal details of any other member of staff. It must also be recognised that such disclosure after the receipt of the GRC is a strict liability of a criminal offence.[1]

Trans staff may choose voluntarily to disclose information at a secondary level, e.g. answering a staff survey or asking for support from a line manager. Again, strict confidentiality must be observed as further disclosure must not be made without the express written permission of the individual. This means that such questionnaires must be assessed for impact beforehand to determine how such circumstances are going to be handled in confidence.

It is not an offence to disclose protected information if the person cannot be identified or if they give their consent. Such consent however must not be forced and should be written confirmation of consent from the individual concerned.

10. Employment References

If giving a reference for someone moving to a new job, a reference must be in the name which will be used in the new job and must not disclose any former name.

It may sometimes be necessary for a transgender or non-binary person to disclose a previous identity for a reference from past employers to be obtained. In these cases, strict confidentiality and respect for their dignity must be applied and protected information kept secure.

It is good practice to give references in the name of the person as they were named on the request for reference

[1] A strict liability criminal offence means that someone can be held responsible for the offence without proof of carelessness or fault.

11. Birth Certificates

Someone who has changed their gender and has a GRC will be able to obtain a new birth certificate which will not disclose the fact they have changed gender ('Sex' on the birth certificate).

12. Work Permits

Staff who are working in the Trust on a work permit or student visa are asked to comply with any work permit/visa regulations which may relate specifically to name change or gender reassignment in order that the work permit/visa continues to be valid.

The Trust will provide appropriate support and signposting to relevant guidance where required, recognising that immigration decisions and requirements are determined by UK Visas and Immigration (UKVI). Any discussions or documentation relating to immigration status, name change or gender reassignment will be handled sensitively and in strict confidence, in line with Trust policies, data protection legislation and equality duties.

No member of staff will be required to disclose their transgender status or gender history beyond what is strictly necessary to meet legal right-to-work requirements

13. National Insurance

Staff who change their name will need to inform the local Department of Work and Pensions and will pay National Insurance (NI)I contributions based on their affirmed gender if they choose to provide their GRC.

People will be referred to in their affirmed gender pronouns by HM Revenue and Customs, but they will still have their original birth gender for National Insurance purposes unless and until they choose to provide a GRC.

They are under no obligation to provide a GRC or disclose their transgender status.

14. Pensions

Pension benefits and entitlements are governed by NHS Pension Scheme regulations and relevant pension legislation. Employees who have questions regarding the impact of gender reassignment or a Gender Recognition Certificate on their pension arrangements should be directed to the NHS Pension Scheme or appropriate pension advisers.

Information relating to an individual's transgender status, Gender Recognition Certificate, or pension arrangements must be treated as confidential and handled in accordance with the Gender Recognition Act 2004, data protection legislation and Trust confidentiality requirements.

15. Professional Registrations

Those staff who are professionally registered are advised to contact their professional bodies to find out whether there are any specific requirements in terms of name changes etc. If the employer has to keep evidence of professional status or qualifications, the manager must discuss with the member of staff how to retain such evidence on file so as not to compromise or breach disclosure of protected information.

16. Managing Staff Going Through the Transition

The successful support and management of an employee's gender reassignment depend crucially on taking account of the individual's views on how to proceed. It should be noted that the first contact may be just to "sound out options". Some Trans people evolve over many years and may only "switch" gender after some years of varying gender expression.

When a member of staff considers embarking on gender reassignment, the initial point of contact may vary according to the nature of the workplace and preference of the individual, but could be an immediate line manager, a senior manager, Workforce and Organisational Development Manager, the Trust Equality and Diversity Manager, a Union Representative, a diversity network or a colleague or Occupational Health Department/Staff Psychological Wellbeing Service. All must maintain confidentiality except as agreed otherwise by the individual. It is vital to assure that the Trust will

be supportive and that it does not tolerate discrimination against or harassment of Transgender employees.

Initially, managers (and any other member of staff acting as a point of contact) should be made aware of this Policy, to support the individual fully. A meeting should be arranged between the trans employee and the nominated person to have a more detailed discussion and to agree the process for handling the transition.

The line manager (or nominated contact) and trans employee should agree an action plan together, detailing all the steps that need to be taken before, during and after transition. Trans employees are also encouraged to meet regularly with their manager to discuss how their action plan is progressing and agree any additions or changes needed.

The timescales, activity and communication will be driven and led by the trans employee. If at any point during the discussions they decide to delay their action plan, any information they have already shared will be kept confidential, in line with their wishes.

17. First Meeting

The nominated contact and member of staff should agree an action plan together for managing the transition at work. This, along with any other notes of the meeting, must be kept strictly confidential in the individual's personal file. The action plan should include: -

- Whether the employee is to stay in their current position or if they wish to be redeployed – this will be the choice of the individual. It is inappropriate to redeploy someone who wishes to transition just because you think it is in their best interests. [2]
- The expected timescales of the medical and surgical procedures, if known. This may vary considerably.
- Time off required for medical treatment (if known), this may vary considerably in accordance with the needs of individuals concerned.
- The expected point or phase of change of name, personal details and social gender

[2] A request for redeployment should be considered at any time in order to fully support the member of staff

- Whether the employee wishes to inform their line manager, colleagues and clients themselves, or would prefer this to be done for them and whether training or briefing of colleagues will be necessary or desirable.
- The amendments that will need to be made to records and systems
- Whether a transgender employee is adequately covered by existing policy on issues such as confidentiality, harassment and insurance and, if not, how these will be amended
- A procedure for adhering to any dress code. Having a mentor can help in relation to advice on appearance, style etc.
- Occupational Health may be involved where appropriate**, and** only with the consent of the employee**,** to provide advice or support where health-related considerations are relevant.

After a person has successfully transitioned into their affirmed gender role, it would not be appropriate to keep these records within the personal file and they must be destroyed. It may also be useful to involve Occupational Health at this point if they are not already involved.

18. Real Life Experience/Change in Social Gender

Staff undergoing treatment will receive specialist medical advice and diagnosis. They will usually be expected to undertake a “real life experience” in which they begin to live and work in the affirmed gender role. At this point, they may have records changed to reflect this such as driving licence or passport. Treatment packages are tailored to the individual and may vary greatly in terms of chronology, time span and choices made, but may include transition to the gender role, hormones and/or surgery.

This change in social gender, whilst usually taking place before hormone therapy, but can be during or after hormone therapy and will often occur years before the final surgical procedure, which for some members of staff will never take place. These issues must be discussed fully with the member of staff.

19. Uniform/Dress Code

Any dress code forms part of the contract of employment. The Trust currently adheres to the All-Wales Uniform and Dress Code Policy. Some flexibility must be allowed to accommodate the change of gender role, but the Transgender or non-binary person

is otherwise required to adhere to the All-Wales Uniform and Dress Code Policy, dressing appropriately for the affirmed gender from the date of transition.

Where clothing or uniform is provided by the Trust, new clothing will be provided consistent with the change in gender on the same basis as replacement clothing/uniform is provided to accommodate a change in size.

20. Informing Colleagues

Generally, it is only appropriate to inform colleagues, or other relevant contacts about an employees' trans status or history where the trans person has explicitly agreed. When agreed, the trans employee should decide who is responsible; whether they would prefer to do this, a manager/colleague, or a mixture of these options. The employee should also decide when and how this will happen, including the details of the message and who it will be shared with.

The Trust must not inform colleagues, clients or the public that an employee is intending to undergo or is undergoing or has undergone gender reassignment without the employee's explicit written agreement. If there is a change of name planned, all staff must refer to the transgender person by their new name and use pronouns appropriate to their affirmed gender.

Colleagues should be given general information about transgender issues (available via Equality and Diversity training sessions) and specific information to help people to understand the needs of the person involved.

It is never appropriate to inform colleagues, clients and the public that an employee has in the past undergone gender reassignment. This is a private matter since gender reassignment will have no bearing on that person's ability to do their job. Careful consideration should be made on a case-by-case basis in relation to the extent of the formal disclosure of this information and should be agreed with the individual.

21. Use of Changing/Shower Facilities and Toilets

The Trust will seek, wherever reasonably practicable, to provide suitable and sufficient facilities that protect the privacy, dignity and wellbeing of all staff. The use of changing, shower and toilet facilities will form part of the discussion process with the employee undergoing gender reassignment. Managers should discuss with the

employee any concerns relating to privacy, dignity, safety and wellbeing, and consider what facilities are available within the workplace.

The Trust recognises that, following the UK Supreme Court judgment (2026), the terms "sex", "man" and "woman" in the Equality Act (2010) refer to biological sex. Any arrangements relating to single-sex facilities must therefore comply with current legal requirements.

Where available, consideration should be given to the use of lockable self-contained or private facilities where this supports the privacy and dignity of the employee concerned, or any other staff members. Where changing or shower facilities are open plan, managers must consider whether additional privacy measures can reasonably be provided, such as individual cubicles, screened areas or curtained spaces.

Arrangements should be reviewed as required throughout the transition process. Any concerns or practical difficulties relating to facility use should be discussed with Workforce and addressed on a case-by-case basis.

No employee should be subjected to harassment, bullying or less favourable treatment because they are transgender or undergoing gender reassignment.

22. Public Facing Roles

A member of staff's gender transition may be unavoidably visible to the public especially in the early stages of gender transition. Some staff may elect to move to another role during their transition; however, they must not be pressured to do so, and they will not be required to do so.

A person's appearance, gender expression, or the possibility of negative reactions from members of the public must not be used as a barrier to recruitment, retention or progression in public-facing roles.

Where staff work in public-facing roles, managers must provide active, visible support, listen to how the individual feels, and respond promptly to any concerns about safety, dignity or wellbeing. Any inappropriate behaviour, harassment or abuse from members of the public must be managed in line with Trust policies, and must not be tolerated.

Managers should be willing to explore equitable solutions. Colleagues may also benefit from advice on how to contribute. The Trust will provide training for staff and

has an ongoing program of equality awareness events that will support staff's development and understanding.

23. Time Off Work

Trans staff who choose to undergo medical and surgical procedures related to gender reassignment may require time off from work. The employee may wish to take a period of leave at the time of the transition and return to work in their affirmed gender. Such absence is covered by Section 16 of the Equality Act 2010 which states that an employer must not treat a person absent because of gender reassignment less favourably than they would treat:-

- absence due to sickness or injury
- absence for some other reason if it is not reasonable to do so.

The legislation does not specify a minimum or maximum time that employers should allow for treatment. If, however, the Transgender employee is absent for a long period, retirement on medical grounds may be considered in the same way as for any other person who is medically unable to work. The Trust's policy on managing Attendance at Work and time off for Medical and Dentist appointments must be referred to for guidance.

The length and amount of time off will vary according to individual need, therefore trans employees will be given reasonable time off to attend appointments were possible. The individual transitioning will have the right to privacy of appointments. Managers should try to be as flexible as possible to meet reasonable requests for changes in shifts or working hours within the needs of the service and should refer to the Flexible Working Policy.

Managers may need to be aware of the possibility of side effects from medication, which may adversely affect work performance. The application of disciplinary action/dismissal from employment in accordance with capability procedures is not appropriate in these circumstances and advice should be sought from Occupational Health where appropriate.

The individual may also suffer from longer term depression if their reassignment does not go smoothly for reasons that may or may not relate to work. In this case, it should be dealt with under arrangements for reasonable adjustments for disability, rather than as gender reassignment absence. The employee and line manager will meet to discuss the possibility of the employee who is undergoing gender reassignment working reduced hours, having reduced duties or the possibility of relocation. It is

important that a Transgender person is never removed from a public facing role because they are Transgender – unless they have specifically requested to be moved.

Managers should not seek to impose a change of duties on the individual, but must seek assistance, including advice from Occupational Health and Workforce and Organisational Development before decisions are made in respect of any adjustments, redeployment, or the need for termination of employment.

Gender reassignment is not a “sickness” and absence or adjustments related to it must be managed by the manager with dignity, fairness and the aim of supporting a successful outcome for the employee and the Trust.

24. Responsibilities

Trans people have the same right as everyone else to work in an environment free from harassment, bullying, discrimination or behaviour that creates feelings of unease or distress.

All employees

- Responsible for ensuring that the requirements of this policy are adhered to at all times and are expected to treat transgender and non-binary person with dignity and respect.
- Report any instances of discrimination, harassment and/or bullying.

Line managers

- Responsible for ensuring that this Policy is applied, as necessary, when recruiting staff and for staff they are accountable for.
- Monitor the working environment to ensure that this right is upheld.

Trans employees

- Transgender and non-binary staff are not responsible for managing the reactions or attitudes of others; they are encouraged to raise concerns or request support from their line manager, Workforce & Organisational Development, or other appropriate support routes.

Any concerns of staff which are not able to be resolved at a local level i.e. through discussions with the Line Manager and the individuals concerned must be brought to the attention of the relevant Workforce Manager, who will attempt to negotiate an acceptable outcome with the parties.

The Trust Employee Assistance Programmes can be accessed to provide a confidential support service. They can signpost to additional services and provide short term counselling for any employee affected by issues related to gender identity, transition, workplace relationships or wellbeing.

25. Further Information

Further information, advice, guidance and support is available from the following:

Gender Identity Research and Education Society (GIRES) http://www.gires.org.uk/

Equality and Human Rights Commission – www.equalityhumanrights.com

A-GENDER – http://www.agender.org.uk - the employee support network for Transgender and intersex staff in all parts of the civil service and associated government agencies across the UK

UNISON guide on the rights of Trans workers, “Bargaining for Transgender Workers’ Rights” http://www.unison.org.uk

The Gender Trust is a registered charity which specifically helps adults who are transgender, gender dysphoric or transgender. www.gendertrust.org.uk

Interconnected UK is an education, advocacy, campaigning and support organisation working on behalf of intersex people. https://www.interconnecteduk.net

Stonewall Cymru – for advice on LGBT issues. https://www.stonewall.org.uk/

26. References

This policy was written with reference to:

GIRES 2011 Guidelines for employers - Legal protection and good practice for gender variant, transgender and transgender people in the workplace - Author Terry Reed with acknowledgements to Christl Hughes and Heather Salmon.

Workplace and Gender Reassignment - A Guide for Staff and Managers . A: Gender

Appendix 1: Gender Terminology

Term	Definition
Sex	A legal and biological classification, typically recorded at birth as male or female, based on biological characteristics. For the purposes of the Equality Act 2010, “sex” refers to biological sex as interpreted by current case law.
Intersex	Intersex describes a person whose biological sex is ambiguous. There are many genetic, hormonal or anatomical variations which make a person’s sex ambiguous. Parents and medical professionals usually assign intersex infants a sex and perform surgical operations to confirm the infant’s body to that assignment. This practice has become increasingly controversial and is being used less often.
Gender identity	Gender identity is understood to refer to each person’s deeply felt internal and individual experience of gender, may or may not correspond with the sex assigned at birth, including the personal sense of the body(which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.
Gender Dysphoria	Gender Dysphoria is a recognised medical condition in which the distress caused by a mismatch between biological sex (birth assigned sex) and the gender a person feel them self to be, causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Non-binary	Non-binary describes any gender identity which does not fit the male and female binary. Those with non-binary genders can feel that they: • Have an androgynous (both masculine and feminine) gender identity.

- Have an identity between male and female, such as intergender.
- Have a neutral or unrecognized gender identity, such as agender.
- Have a gender identity which varies over time, known as genderfluid.

Non-binary people may also identify as transgender. The label genderqueer has a lot of overlap with non-binary. Non-binary is often seen as the preferred term, as "queer" may be used as a transphobic insult.

Transgender / Trans / Trans*	This is an umbrella term used to describe a whole range pf people whose gender identity and/or gender expression differ in some way from the gender assumptions made about them at birth and the consequent biological sex assigned to them. This applies not only to those who identify as transgender or intersex but to anyone who feels that the gender assigned to them at birth incompletely or does not at all describe their own gender identity.
Transition	A trans woman is someone who was registered as a male child and later undertakes the “transition” to presenting as a woman because she wants to be regarded and treated as the woman she feels inside. Similarly, a trans man is someone who was born with female anatomy and undertakes the transition to present to the world as a man. Altering one’s gender is not a one-step procedure: it is a complex process that occurs over a long period of time. Transition includes some or all of the following cultural, legal and medical adjustments, telling one’s family, friends and/or co-workers, changing one’s name and/or sex on legal documents, hormone therapy and possibly (though not always) some form of surgical gender affirmation.
Gender reassignment	Under the Equality Act 2010, a person has the protected characteristic of gender reassignment if they are proposing

	to undergo, are undergoing or have undergone a process (or part of a process) for the purpose of reassigning their gender by changing physiological or other attributes of gender. This is a deeply personal process that may involve medical interventions but does not have to.
Transphobia	A fear and dislike of transgender people which can lead to hatred resulting in verbal or physical attacks or abuse
Gender Expression	External manifestation of one's gender identity, usually expressed through "masculine", "feminine", or gender variant behaviour, mannerisms, clothing, haircut, voice or body characteristics. Typically, transgender people seek to make their gender expression match their gender identity, rather than their birth-assigned sex.
Sexual orientation	Describes an individual's enduring physical, romantic, emotional and/or spiritual attraction to another person. Gender identity and sexual orientation are not the same. Transgender people may be heterosexual, asexual, lesbian, gay or bisexual. For example – a man who becomes a woman and is attracted to other women would be identified as a lesbian.

Appendix 2 - Additional Legislation Information

EQUALITY ACT 2010

The Equality Act protects an individual under the protected characteristic of gender reassignment from the point at which the individual:

- makes their intention to seek gender reassignment known to someone;
- proposes to undergo gender reassignment, even if they take no further steps or decide to stop later;
- starts or continues to dress, behave or live (full time or part time) in the gender they identify with;
- undergo treatment related to gender reassignment; or
- has received gender recognition under the Gender recognition Act 2004.
- Recent Supreme Court decisions clarified that in the Equality Act, "sex", "man" and "woman" are referring to their biological identity (i.e. as they were observed at birth)

DATA PROTECTION LEGISLATION

Information relating to a person's transgender status, gender history or gender reassignment constitutes special category personal data under the **UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018.**

Such information must only be:

- Collected where lawful and necessary;
- Processed for specific, legitimate purposes;
- Accessed strictly on a need-to-know basis; and
- Handled with the highest level of confidentiality, whether or not the individual has legal gender recognition.

The Human Rights Act 1998

This Act applies equally to the treatment of all Trans* people. The following article of the Human Rights Act are of particular relevance:

Article 14 Prohibition of Discrimination

The enjoyment of the rights and freedoms ser forth in this Convention shall be secured without discrimination on any grounds such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

The Gender Recognition Act 2004

The Gender Recognition Act 2004 enables eligible individuals to apply for a Gender Recognition Certificate (GRC), which provides legal recognition of their affirmed gender.

A person does not need to hold a GRC to be protected under the Equality Act 2010. Protection from discrimination because of gender reassignment applies regardless of whether a person has obtained a GRC, undergone medical treatment, or intends to do so.

The Trust recognises that information relating to a person's transgender status or application for a GRC may be protected under Section 22 of the Gender Recognition Act 2004. Unauthorised disclosure of such information by a person who has obtained it in an official capacity may constitute a criminal offence. Managers and staff must therefore treat such information as strictly confidential and only disclose it where there is a lawful basis to do so.

The Trust will handle all information relating to an individual's transgender status in accordance with data protection legislation, confidentiality requirements and the Gender Recognition Act 2004.

Ref: WF40

Supporting Staff Who are Carers Policy

Executive Sponsor & Function:	Executive Director of Workforce and OD
Document Author:	Equality & Diversity Manager
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	September 2026
Equality Impact Assessment Outcome:	Ensure the policy is easily accessible via the Trust intranet and SharePoint, including accessible formats where required. Translation the whole policy to Welsh. Raise awareness of the support available to staff with caring responsibilities, including flexible working, special leave and wellbeing services. Ensure managers are aware of their responsibilities and apply the policy

	consistently and fairly to support staff with caring responsibilities.
Review Date:	September 2029
Version:	3

CONTENTS

1. Introduction 4
2. Policy Aim 4
3. Legislation 5
4. Definition of who is a Carer 7
5. Support Initiatives 7
5.1 Employee Assistance Programme (EAP) 7
5.2 Respite Care 8
5.3 Wellbeing Support 8
5.4 Stress Management, Training and Initiatives 9
6. Supporting Policies 9
6.1 Emergency carer and dependant leave 9
6.2 How to get 'planned time off' 10
6.3 Unpaid Leave 10
6.4 Manager’s responsibilities 11
6.5 Employee’s responsibilities 11
6.6 Requests for support 12
6.7 Telephone access during working hours 12
6.8 Helpful ideas and Organisations 12

1. Introduction

This policy is part of the Trust's Equality and Diversity Policy Pack and should be read alongside the overarching Equality and Diversity Policy and other related workforce policies.

Velindre University NHS Trust is committed to improving the working lives of its staff, supporting them in maintaining a healthy work life balance. This is achieved via the introduction and implementation of a range of initiatives, to support staff – including bank/agency staff and volunteers.

The Trust recognises as the social environment changes, more people are taking on caring responsibilities. The Trust also recognises that it has a duty of care to ensure that it provides adequate support, which will enable staff to maintain a healthy physical and mental wellbeing. This Policy will identify the various area of support, on either a short-term or long-term basis, and it will provide a framework which is flexible to the needs of both the employee, as well as the needs of the service, providing Managers with the tools they need to fully support their staff.

Currently, more than three million people – one in seven of the workforce – juggle the responsibilities of caring and paid employment. Recent reports and statistics from organisations such as Carers UK demonstrate that staff may, at any stage of their career, face differing caring responsibilities.

2. Policy Aim

The aim of this policy is to provide information and support, which will have a positive impact around areas such as recruitment and retention, sickness absence and organisational performance. The caring responsibilities, which staff have outside of the workplace, is an essential function and Velindre University NHS Trust therefore does not just have a legal, but also a moral, obligation to ensure that any caring responsibilities which an employee has, does not jeopardise that member of staff's future career prospects.

The policy provides links to the Trust's Flexible Working Policy and Procedure where staff can make a request to change their working patterns, to support their caring responsibilities. The following principles apply:

the request will be looked at on an individual basis, although a consistent approach will be taken when considering requests. As identified in the Velindre University NHS Trust Flexible Working Policy, once a change has been agreed, it will be subject to a review.

This is to the benefit of both the member of staff and the Manager, as it will allow for any amendments to the request or identify any alternative solutions.

any solution will be tailored to the Trust and the individual's needs at any given time and therefore solutions for different scenarios and Divisions of the organisation will, by their very nature, be different. Managers will be required to provide a reasonable explanation for the decision which has been reached.

an agreement made on a short-term basis (less than six weeks), may not be sustainable on a long-term basis and there is no guarantee that it will be deemed suitable should the need become long term. Therefore, alternative solutions should be sought by both parties.

3. Legislation

Main Legislative/Policy Developments affecting Carers in Wales since 1995

Development	Key change for Carers* highlights selected provisions and does not aim to summarise all aspects of the development indicated
Carers (Recognition and Services) Act (1995)	Introduced the concept of a Carers Assessment
Employment Relations Act (1999)	Gave employees the right to 'reasonable time off' to deal with emergencies
Changes to Invalid Care Allowance (now known as Carers Allowance) (2000)	Amendment to the Social Security and Benefits Act 1992, which included extending carers' benefits to people aged 65 and over
Employment Act (2002)	Gave employed parents of disabled children, under the age of 18, the right to request flexible working arrangements
Children Act (2004)	Required local authorities to lead on joined up service delivery through multi agency Children's Trusts. Strong emphasis on supporting families and carers, described as 'the most critical influence on children's lives'
Carers (Equal Opportunities) Act (2004)	Placed a statutory duty on local authorities to inform Carers of their rights and to consider Carers' wishes in relation to education, training and employment when conducting Carers Assessments

Work and Families Act (2006)	Extended the right to request flexible working arrangements to all recognised Carers in employment from April 2007
Pensions Act (2007)	Recognised carers' situations and reduced the number of qualifying years needed for a full, basic state pension and introduced the new Carers Credit for those caring 20+ hours a week for someone who is severely disabled
Sharon Coleman –v- Attridge Law and Steve Law Case	Case Law established around discrimination 'by association'. Sharon Coleman was denied flexible working conditions at her employers, which were available to other staff, to allow her to care for her disabled son
Equality Act 2010	As a result of the Sharon Coleman case, the Equality Act extends protection, not just in relation to employment, but also across the provision of goods and services. The Act also aims to extend the Carers ruling of 'discrimination through association to disability' across other 'protected characteristics' of Sex, Gender Reassignment, Disability and Age For the first time, Carers will be protected from direct discrimination (and harassment) because of their association with people who are protected from discrimination themselves
Social Services and Well-being (Wales) Act 2014	This Act is the law that gives people who need care—and unpaid carers who need support—greater voice, choice and control, while requiring services in Wales to focus on well-being, prevention, early help and working together.
The Carer's Leave Act 2023	This gives employees in England, Wales and Scotland the right to take up to one week of unpaid leave each year to provide or arrange care for a dependant with a long-term care need.
WG Strategy for Unpaid Carers (Wales)	This sets out the Welsh Government's national priorities for recognising and supporting unpaid carers of all ages. It focuses on improving carer

	identification, access to information and advice, support for health and wellbeing, and help to balance caring with work, education or daily life. The Strategy is delivered through annual Delivery Plans, such as the 2025–2026 plan, which outline practical actions across health boards, local authorities and partner organisations to ensure consistent, meaningful support for carers throughout Wales

4. Definition of who is a Carer

A carer is defined as someone who looks after a dependant. This could be a partner, child, parent or person who lives in the same household, but not an employee, tenant or lodger, who cannot manage without help due to sickness, frailty or disability. The carer's role is unpaid, unlike that of a care worker or foster carer for example. Someone can be a carer on a short- or long-term basis.

Short-term caring responsibilities generally arise unexpectedly and last for a brief period. Long-term caring responsibilities involve ongoing, regular support for a dependant with longer-lasting health or care needs

A carer may or may not live in the same household of the person they are caring for and may share the caring responsibility with others in the family or a professional.

A dependant may also be someone who relies on the carer for assistance, either as a primary carer or as the only person who can help in an emergency. This includes partners or relatives living with the family. A member of staff's family may extend beyond the common understanding of a family, and these responsibilities need to be catered for. This may be linked to culture for example and therefore careful consideration should be given to broader family commitments.

5. Support Initiatives

Velindre University NHS Trust HAS introduced several initiatives to support staff. These include:

5.1 Employee Assistance Programme (EAP)

The Employee Assistance Programme is a dedicated confidential information and counselling support service for all staff providing confidential assistance with any work, personal or family issues. Any time, any day, you can contact an EAP professional for support, including telephone information, fact sheets, information packs and short-term counselling. The service is available 24 hours a day, seven days a week. Support is available in relation to, but not limited to:

Personal Issues	Financial Issues – Debt Management
Job Stress	Trauma
Relationship Issues (e.g. marital)	Esteem/ Confidence
Balancing work and family (e.g. eldercare, childcare, parenting issues)	Retirement concerns
Bullying/ Harassment	Work environmental issues
Anxiety/Depression	Life Changes
Substance Abuse	Family Problems
Legal Issues	Family violence
Bereavement, Separation and Loss	Loneliness

5.2 Respite Care

Velindre NHS Trust recognises the additional emotional and financial burden facing members of staff that have additional caring responsibilities. This can be caring for parents, siblings or disabled family members, including children.

It is advised that staff contact their local Social Services Department for help in arranging respite care. Please note that respite care can be given outside of the family member's geographical area, if demand is high.

5.3 Wellbeing Support

The Trust aims to support staff who are experiencing a long-term condition, long-term sickness, returning to work after illness or injury, or who may be at risk of sickness absence, by offering support via the VUNHST Staff and Teams Psychology and Wellbeing Service to help staff manage symptoms, reduce stress, and maintain their overall health.

The VUNHST service is complemented by the wider wellbeing pathways available through Occupational Health, external Employee Assistance Programme and national employee programmes as well as Trust initiatives designed to promote a healthier working environment.

If you are looking for support with work or cancer related issues impacting you or your team at work, please contact the Clinical Psychology for Staff and Teams Service. Please note that this is not an emergency or urgent service**. If someone's life is in**

danger, please ring 999. If someone is not in immediate danger, and would benefit from urgent mental health support, please ring NHS 111 and choose Option 2.

5.4 Stress Management, Training and Initiatives

Stress is one of the key barriers for staff who are carers. It is difficult to find time to 'switch off'. The overall impact of stress can be detrimental to all parties, from the carers themselves to the person they are caring for, any other dependants they may have, as well as the organisation needing to deal with time off work, for example. It is therefore crucial that the Trust supports each member of staff to its best ability and one of the key areas is recognising the signs of stress and putting workable solutions in place.

6. Supporting Policies

All Wales Special Leave Policy - Provides the NHS Wales framework for emergency leave, time off for dependants, and domestic emergencies.

All Wales Flexible Working Policy - Sets out how staff can request temporary or permanent changes to working patterns to support caring responsibilities.

All Wales Managing Attendance at Work Policy - Describes how staff attendance is supported, including wellbeing considerations and the management of health-related absences.

All Wales Adoption Policy - Covers leave and pay entitlements for employees adopting a child, including pre-adoption meetings and post-placement support.

All Wales Parental Leave - Provides statutory and contractual rights to unpaid parental leave for employees with caring responsibilities for a child up to age 18.

Velindre University NHS Trust Flexible Working Policy (Local Implementation) – Details the Trust's own processes for submitting, reviewing, and approving flexible working requests.

Velindre University NHS Trust Special Leave Policy (Local Implementation) Provides local guidance for managers and staff on emergency leave and short-notice caring responsibilities.

6.1 Emergency carer and dependant leave

This provision enables employees to take action, which may be necessary, to deal with an unexpected or sudden problem concerning a dependant and to make necessary long-term arrangements e.g.:

- to make longer term care arrangements for a dependant who is ill or injured.
- if a dependant falls ill or has been injured or assaulted.
- to deal with an unexpected disruption or breakdown of care arrangements for a dependant.
- to deal with an unexpected incident involving a child during school hours.

It should be noted that this does not include any situations, which are pre-planned or where the employee has prior knowledge of the arrangements. In these instances, special leave will not apply, and the expectations will be for the employee to make alternative arrangements, such as requesting annual leave or unpaid leave.

Usually, no more than three days may be granted per episode, unless there are extenuating circumstances or no more than 6 days in any rolling twelve month period, as there are other types of leave, such as annual leave, flexi leave (if the organisation operates a flexi system), parental leave or unpaid leave (if applicable) may be taken for longer periods. As an alternative, or in addition to the above, “home working” may be an option in some circumstances.

The aim of carer’s leave is to provide a suitable response to an employee whose normal care arrangements breakdown at short notice or who finds that they have to care for a child or dependant who suddenly becomes ill. Carer’s leave may also be granted to enable the employee to make alternative arrangements, so that they can cope with long term care challenges.

Please note that carer’s leave is at the manager’s discretion and authorisation is required. Managers will need to explain any reason for refusal. If a member of staff is unhappy with the decision they can follow the Appeal process, which is outlined in Velindre Trust’s Respect and Resolution Policy.

6.2 How to get 'planned time off'

Our special leave policy is only for emergency (unforeseen) and paid time but lots of staff with caring needs are to support dependents with planned appointment the legal position attached gives an option for unpaid time off for planned appointments this is another option for staff and details the notice needed.

6.3 Unpaid Leave

When all paid forms of leave have been utilised, in exceptional circumstances and with the approval of their manager, staff who are carers are aware of the work life balance options available to them, which include:

part-time working

temporary reduced hours

compressed hours

term time working

More information on these options and other options can be found in the Trust Flexible Working Policy, including the form required and the procedure to follow for making requests.

6.4 Manager's responsibilities

The manager needs to look at all options and seek, wherever possible and reasonable, to accommodate a long or short-term caring need. Each case needs to be reviewed on an individual basis.

Managers must be consistent and adhere to the Trust's Equality Policy and Flexible Working Policy ensuring that, where possible, individual needs are met.

explicitly ensure that all decisions comply with the Equality Act 2010, meaning decisions must be fair, transparent and must not directly or indirectly discriminate against any employee.

balance the needs of the service with those of the individual employee.

be flexible in identifying options if the original request cannot be met including, where possible, looking at alternative ways in which responsibilities and tasks can be undertaken.

confirm any agreement in writing, as set out in the Trust's Flexible Working Policy.

where a particular need cannot be accommodated and alternatives have been sought, the Line Manager needs to provide clear and justifiable reasons as to why this is the case.

ensure that any arrangements agreed do not have any unreasonable or negative impact on other members of staff within the team or the Division.

6.5 Employee's responsibilities

Employees have an important role in helping to identify and agree suitable arrangements that support their caring responsibilities. Employees must:

encourage early conversations with their Line Manager about any caring responsibilities that may impact their work, so that possible solutions can be explored in good time.

provide reasonable notice, where possible, of a request to change their working pattern or take time away from work due to caring responsibilities. The Trust recognises that this may not always be possible and will seek to support the employee wherever it can.

provide clear reasons for the request, including an indication of the timescales or expected duration, as outlined within the Trust's Flexible Working Policy.

be flexible in identifying options, including suggesting alternative ways in which duties or working patterns could be adjusted or managed.

maintain regular communication with their Line Manager, recognising that good communication is essential to the success of any agreed arrangement.

be prepared to consider alternative options, particularly where the original request cannot reasonably be accommodated due to service needs.

6.6 Requests for support

Any member of staff who has caring responsibilities may need further support at times. As well as the initiatives covered in this policy, staff can also contact their GP to access counselling services. Any member of staff who becomes a carer is advised to inform their GP, so that they can be supported where needed.

6.7 Telephone access during working hours

Velindre University NHS Trust will provide reasonable access to a telephone if required to enable the employee to check on the person that they are caring for or to arrange appointments, if necessary. This is in relation to urgent carer needs.

It would be seen as best practice that any requests to use the telephone, including an indication of frequency of requirement, must be agreed in advance with the manager and not negatively impact on service requirements. Any abuse of this could result in the use of a telephone being withdrawn.

6.8 Helpful ideas and Organisations

Below is a list of the main organisations, which can provide help and assistance. However, there will be many local facilities in your area that can also help.

Contact your local Social Services Department which will have a list of local organisations, as well as being able to provide you with an up-to-date list of local care homes and respite facilities.

It is also important that all carers ask for a “Carer’s Assessment”, including young carers. Your Social Services Department will carry out the assessment.

These organisations can help with form filling and benefits advice, as well as advise you of your rights around employment and training.

Carers Wales
Age Cymru
Care & Repair Cymru
Adferiad
Kids Cancer Charity
Carers Trust Wales
All Wales Forum of Parents & Carers
Alzheimer's Society
Learning Disability Wales
Multiple Sclerosis Society
Contact a Family Wales
Care for Carers
Parkinson's UK/Cymru
The Stroke Association
SNAP Cymru
Citizen's Advice Bureau
Working Families
Community Legal Services

TRUST BOARD		
Domestic Abuse Workplace Policy		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	SUE PRICE, SENIOR PEOPLE & OD BUSINESS PARTNER	
PRESENTED BY	Sarah Green, Executive Director of People and OD	
REPORT SPONSOR	I, **Sarah Green, Executive Director of People and OD**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	24/08/2026	EMB
	10/11/2026	People, Culture and Engagement Committee
	EMB happy to support this revised Trust policy. People, Culture and Engagement Committee happy to support revised policy subject to minor changes on clarity of who the policy applies to, and the document control dates, which have been addressed within the policy.	
ONWARD SCRUTINY ROUTE	Trust Board is the final scrutiny before publishing to the intranet.	
PURPOSE OF THE REPORT	ENDORSE FOR APPROVAL	
	Revised and updated people policy to be endorsed for approval.	
EXECUTIVE SUMMARY	The Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure was due for review in line with the Trust's policy review schedule. The policy has been reviewed and updated and was endorsed by the People Policy Review and Development Group in August 2026. The revised document includes a change in scope and title, as outlined within this paper, to ensure clearer alignment with the NHS Wales Anti-Sexual Harassment Policy and the All-Wales Disciplinary Policy. Subject to approval, the policy and procedure will progress through the remaining governance process before being published on the Trust intranet/SharePoint. The revised policy was endorsed for approval by EMB in August 2026 and PCE in November 2026.	

ACTION / DECISION	Trust Board is asked to **ENDORSE FOR APPROVAL.**
ADDITIONAL RESOURCES	None.

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

- Outstanding for quality, safety, and experience
- A sustainable organisation that plays its part in creating a better future for people across the globe

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

- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Wales of more Cohesive Communities
- A Wales of Vibrant Culture and Thriving Welsh Language
- A globally responsible Wales

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

- Safe
- Timely
- Equitable
- Efficient
- Effective

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

Status: QIA completed - document provided as an appendix to this report

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

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

APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Report
	Appendix 2	EQIA

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

The Domestic Abuse Workplace Policy and Procedure has been reviewed and revised in accordance with the Trust's policy review and governance arrangements. The revised documents were considered and endorsed by the People Policy Review and Development Group, the Executive Management Board and the People, Culture and Engagement Committee for approval. There was no feedback on change from the People Policy Review Group or EMB. PCE requested clarification that the policy does not apply to patients and donors and the policy has now been amended to provide clarity in this regard. The version control cover sheet has also been updated in response to feedback from PCE. Subject to approval from Board, the policy and procedure will be published on the intranet/SharePoint for use by staff and managers.

2. BACKGROUND

The policy and procedure were previously titled the Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure. Following review, the title and scope have been revised to provide a clearer focus on domestic abuse, including violence and sexual violence occurring within a domestic abuse context.

Workplace sexual harassment and sexual misconduct are now addressed through the All Wales Anti-Sexual Harassment Policy. Violent misconduct outside a domestic abuse context is addressed through the All-Wales Disciplinary Policy. These matters have therefore been removed from the scope of the revised Domestic Abuse Workplace Policy and Procedure to avoid duplication and provide clearer routes for managing concerns.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

The policy and procedure provide a clear framework to help staff and managers understand when the policy applies; their respective roles and responsibilities; the support available to colleagues experiencing domestic abuse; and how concerns, disclosures and allegations should be managed.

The principal changes are:

- extending the scope from employees to include bank workers, agency workers and volunteers;
- refocusing the policy on domestic abuse, including violence and sexual violence within a domestic abuse context;
- clarifying the possible indicators and impacts of domestic abuse, including changes in appearance, conduct concerns, coercive control and controlling behaviour;

- using more person-centred and neutral language, including replacing general references to “victims” with “employees experiencing domestic abuse” and using “alleged” where allegations have not been determined;
- strengthening signposting to the Trust Wellbeing Service and other sources of support; and
- updating references to associated policies and external support organisations.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None

3.3 LEGAL IMPLICATIONS

3.3.1 None

3.4 PEOPLE IMPLICATIONS

3.4.1 None

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

06 - People and Organisational Development (POD)

Operational Risks

3.6.2 None

Risk Number	Risk title	Risk lead	Current score

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 Endorse for approval

Ref: WF54

DOMESTIC ABUSE
WORKPLACE POLICY AND PROCEDURE

Executive Sponsor & Function	Executive Director of Organisational Development and Workforce
Document Author:	Senior People & Organisational Development Business Partner
Approved by:	Workforce and OD Committee
Approval Date:	TBC
Date of Equality Impact Assessment:	July 2026
Equality Impact Assessment Outcome:	No negative impact on any protected characteristics
Review Date:	September 2029
Version:	Version 2

CONTENT PAGE

		Page Number
1.	Introduction	**4**
2.	Policy Statement	**4**
3.	Scope	**5**
4.	Definition	**5**
5	Confidentiality and privacy rights of employees versus safeguarding responsibilities	**5**
6.	The impact of domestic abuse	**6**
7.	Reporting Concerns	**7**
8.	Support for Employees	**7**
9.	Support for Perpetrators	**7**
10.	Support Provided by Managers	**8**
11.	Equality	**9**
12.	Training	**9**
13.	Resources	**9**
14.	Implementation and Distribution	**9**
15.	Relevant Policies, Legislation and Information	**10**
16.	Appendices 1 – 4	**11-18**

1. Introduction

Velindre University NHS Trust is committed to support and improve the health and wellbeing of our employees. The Trust recognises that violence, domestic abuse and sexual violence are crimes which adversely affect the health of individuals, their families and communities. Identifying abuse at an early stage can be an effective measure in preventing an escalation in severity and frequency and can assist to ensure that appropriate and timely support is provided. Taking a responsive and enabling approach is therefore fundamental in encouraging employees who are experiencing violence, threats, intimidation and other forms of abuse to disclose.

The Trust has a responsibility to provide all employees with a safe and effective working environment. For some employees, the workplace is a safe haven and the only place that offers routes to safety. This policy and procedure represents a commitment to take all reasonable steps possible to combat the reality and impact of violence, domestic abuse and sexual violence, on those being abused and to challenge the behaviour of perpetrators.

2. Policy statement

The purpose of the policy is to ensure that both employee experiencing domestic abuse and perpetrators of domestic abuse including violence or sexual violence within a domestic abuse context, are aware of the support that is available within the Trust. It also provides guidance to line managers when supporting employees affected by this matter.

Sexual harassment, sexual misconduct and sexual violence occurring between colleagues or in connection with work duties will be addressed in accordance with the NHS Wales Anti-Sexual Harassment Policy (WF61). Violence occurring between colleagues or in connection with work duties will be addressed in accordance with the NHS Wales Disciplinary Policy (WF02).

It is important to note that domestic abuse including violence or sexual violence within a domestic abuse context, is not condoned under any circumstance by the Trust and all employees must adhere to the standards of professional behaviour and Trust Values.

The aim of this policy is to educate and provide resources for managers and employees, which will enable them to identify indicators of abuse, to sensitively “ask” the right questions and take the most appropriate “actions” to support the employee.

All employees of the Trust have a duty of care if they:

- Have concerns or suspicion about possible abuse or violence, including sexual violence against an employee and/or their family;
- Witness an employee being abused; or
- Receive a disclosure abuse or violence including sexual violence about an employee

In such instances the employee should report and discuss the matter with their manager or the employee’s manager (if this is known) or the People and OD Department.

3. Scope

The policy applies to all employees, bank workers, agency staff and volunteers of Velindre NHS Trust, including hosted organisations. It does not apply to patients or donors, for which the Trust has separate safeguarding processes in place.

This policy and procedure will apply equally everyone who seeks support, advice or assistance for domestic abuse, including violence or sexual violence in a domestic abuse context.

4. Definition and categories of domestic abuse, violence and sexual violence

Where the term 'domestic abuse' is used throughout this policy, it also encompasses violence or sexual violence within a domestic abuse context. The policy is worded this way to differentiate it from violent misconduct or sexual misconduct that are covered by alternative policies as detailed in Section 2.

Domestic Abuse is defined under Part 1 of the Domestic Abuse Act 2021 as: *an incident or pattern of incidents of controlling, coercive behaviour, threatening behaviour, violence or abuse between those aged 16 years or over who are or have been intimate partners or are family members, regardless of gender and sexuality.*

This includes includes:

- Female genital Mutilation (FGM);
- Forced marriage;
- “Honour” based abuse;
- sexual violence, exploitation, stalking and harassment **where these arise within a domestic abuse, family or intimate partner context**.

The impact of domestic abuse can range from loss of esteem to loss of life (see ***Appendix 1*** for details on the various types of domestic abuse).

Domestic abuse happens in all communities, regardless of gender, age, disability, gender reassignment, race, religion or belief, sexual orientation, marriage or civil partnership and pregnancy or maternity. When dealing with domestic abuse it is important to recognise differences between all protected characteristics. It follows that different approaches and resources are needed when addressing violence and/or abuse with different groups.

5. Confidentiality and privacy rights of employees versus safeguarding responsibilities

The Social Services and Well-being Act (Wales) 2014 introduced a duty to report to the Local Authority, if someone suspects an adult and / or child to be at risk of abuse or neglect. The Trust acknowledges its safeguarding responsibilities. In all cases

where domestic abuse is identified in the workplace and it is known that there are children in the family, the legislative duty to report safeguarding concerns under this Act will be followed. Reference will also be made to the Wales Safeguarding Procedures 2019 and the Trust's Safeguarding & Public Protection Policy. The Domestic Abuse Act 2021 recognise children who see, hear or experience the effects of the abuse are employee experiencing domestic abuse in their own right.

Employees who disclose that they are an employee experiencing domestic abuse can be assured that the information they provide is confidential and will not be shared with other colleagues without their permission. There are however, some circumstances in which confidentiality cannot be assured, to ensure compliance with the above Act. This may occur when there are concerns regarding children, vulnerable adults or where the Trust is required to protect the safety of their employee. In these circumstances, the employee will be informed as to the reasons why confidentiality cannot be maintained. As far as possible, information will only be shared on a need-to-know basis.

Confidentiality cannot be assured for employees who disclose that they are a perpetrator of violence, domestic abuse and/or sexual violence.

6. The impact of domestic abuse

6.1 The impact of domestic abuse in the workplace

It should be noted that there may be incidents which occur in the workplace or specifically affect the work of an employee. Possible signs of domestic abuse include:

- Changes in behaviour, including uncharacteristic depression, anxiety, distraction or problems with concentration;
- Changes in the quality or standards of work for no apparent reason;
- Arriving late or leaving early;
- Poor attendance or high presenteeism without an explanation;
- Needing regular time off for appointments;
- Inappropriate or excessive clothing;
- Changes in appearance.

6.2 The impact of domestic abuse on work colleagues

Domestic abuse also affects people close to the employee experiencing domestic abuse and this can include work colleagues. Some effects may include:

- Being followed to or from work;
- Being subject to questioning about the employee experiencing domestic abuse's contact details or locations;
- Covering for other workers during absence from work;
- Trying to deal with the abuse and fear for their own safety;
- Being unaware of the abuse or not knowing how to help.

The Trust acknowledges that some employees may experience vicarious trauma as a result of supporting employees who are employee experiencing domestic abuse. It is important that senior managers of the Trust are aware of this risk, as the organisation has a responsibility to limit the impact on the workforce. To limit the potential impact, all Trust employees have access to advice and support via the "Employee Assistance Programme" (See ***Appendix 4***).

6.3 The impact of domestic abuse on the Trust

Some effects may include:

- Negative impact on productivity, performance and morale;
- Increase sickness absence;
- Staff turnover, as employees may have to leave work or move away to escape the domestic abuse;
- Conduct concerns.

7 Reporting concerns

The Trust expects all employees to report their concerns if they suspect a colleague is experiencing or perpetrating abuse. Employees should, in confidence, speak to their manager or a member of the People and OD Team about their concerns, in the first instance. They can also speak in confidence to the Trust's Safeguarding Lead (See contact details in ***Appendix 4***).

If an employee feels that they cannot or do not wish to discuss the matter with their manager or the People and OD Team, they may use the confidential Crime Stoppers, reporting line on 0800 111 4444. This is a 24 hour hotline that allows anyone to report any concern they may have where they suspect criminal activity may have taken place. The hotline can be used anonymously.

8 Support for employees

There are a number of ways in which employees experiencing domestic abuse can be supported by the Trust i.e.:

- Through offering practical support;
- Signposting employees to the Trust's Wellbeing Service;
- Signposting employees to "**Vivup**" the Trust's Employee Assistance Programme (EAP) (***Appendix 4 for details***), which provides 24/7 confidential support including counselling services, information, guidance and referrals on any personal or family issue;
- Signposting to the **Live Fear-free** helpline on 0808 80 10 800;
- Raising awareness generally of the issues and in particular amongst managers;
- Providing training opportunities to managers and employees;
- Taking a clear anti-abuse / violence stance against perpetrators.

It is essential that all employees feel able to disclose this personal information and are encouraged to discuss it with their manager. If an employee feels unable to raise the matter of domestic abuse with their manager, support can also be sought via the People and OD Department.

9 Support for perpetrators

Domestic abuse perpetrated by employees will not be condoned under any circumstance, nor will it be treated as a purely private matter. Employees should be aware that domestic abuse is a serious matter which can lead to a criminal conviction. Conduct outside of work may lead to disciplinary action being taken against an employee. Such conduct may undermine the confidence and trust the organisation has in them. Such incidents will be managed in accordance with the relevant Trust policy.

The Trust recognises that it has a role in encouraging and supporting perpetrators to address violent and abusive behaviour of all kinds. If an employee discloses perpetrating violence and or abuse, the police should be informed as well as the employee's manager (if they are not aware of the disclosure) and a senior member of the People and OD Department, so that the disciplinary or other internal procedures can be considered. The employee will be provided with information about the Trust's EAP services and other support available to them (***Appendix 4***). Support will be offered in a compassionate, non-judgmental approach.

This procedure can be applicable in cases where an employee has:

- Behaved in a way that has harmed or threatened their partner, family member or an individual within or not within a relationship;
- Possibly committed a criminal offence against their partner; family member or an individual within or not within a relationship;
- Had an allegation of domestic abuse made against them;
- Presented concerns about their behaviour within an intimate or external relationship.

The Trust will ensure:

- The allegation(s) are dealt with fairly and in a way that is transparent and provides support for the employee, who is the subject of the allegation or disclosure;
- All employees will receive appropriate support, guidance and information;
- The investigation process will be sufficiently independent and managed in a timely manner.

The employee will be:

- Treated fairly, consistently and honestly;
- Helped to understand the concerns expressed and processes involved;
- Kept informed of the progress and outcome of any investigation and the implications for any disciplinary process.

9.1 Employee experiencing domestic abuse and perpetrators who are employed by the Trust

In cases where both the employee alleging domestic abuse and alleged perpetrator of domestic abuse work for the Trust, appropriate action will be taken. In addition to considering disciplinary action against the alleged perpetrator, action may need to be taken to ensure that the employee alleging domestic abuse and alleged perpetrator do not come into contact in the workplace.

Action may also need to be taken to minimise the potential for the alleged perpetrator to use their position or work resources to find out details about the whereabouts of the employee alleging domestic abuse. This may include a change of duties or withdrawing the alleged perpetrator's access to certain computer programs. Further advice can be sought from the People and OD Department.

10 Support provided by managers

Domestic abuse is unlikely to be disclosed easily by employee experiencing domestic abuse or the perpetrators. There are a number of steps that can be taken to address the workplace effects of domestic abuse, including how to recognise the problem, respond and provide appropriate advice and support.

There are also a number of steps that managers can take to address the effects of domestic abuse. In many cases it is about being aware and signposting the employee to organisations that provide specialist support. ***Appendix 2*** sets out "**Ten steps for managers to address the effects of domestic abuse**".

10.1 Facilitating a conversation about domestic abuse

If a manager suspects that an employee is experiencing domestic abuse they should facilitate a conversation to discuss this and to identify/implement appropriate support for them.

Shying away from the subject can perpetuate fear of stigma and increase feelings of anxiety. Often employees will not feel confident in speaking up, so by making the first move to begin a conversation, can be a very important step in providing much needed support and advice.

Appendix 3 contains a "**Manager's guide to asking difficult questions**".

10.2 Support available to employees

10.2.1 Paid Special Leave

Managers may consider offering a broad range of support to employees experiencing domestic abuse. Employees may need time off work to access legal or financial advice, to arrange child care or alternative accommodation and to seek medical advice. Managers should be flexible when supporting an employee who is experiencing domestic abuse and treat each instance sensitively and individually.

Employees should not be expected to provide proof of their circumstances. Generally, up to 3 days paid leave may be granted for each required leave period, with up to 10 days paid leave pro rata, in any rolling 12 month period.

Other types of leave may also be taken to extend the period of absence e.g. annual leave, flexi-time or time off in lieu, to attend relevant appointments.

10.2.2 Other support available

Managers may also consider;

- agreeing temporary or permanent changes to working times and patterns using existing procedures i.e. flexible working;
- Changing specific duties, for example to avoid potential contact with the perpetrator in a patient / donor / customer facing role or a workplace situation;
- Implementing measures to ensure a safe working environment, for example blocking emails / screening telephone calls; alerting reception / security if the perpetrator is known to come to the workplace; and ensuring arrangements are in place for safely travelling to and from work;
- Redeploying or relocating, at the employee's request and with their consent;
- Advising colleagues on a need-to-know basis and agree a response if the perpetrator contacts the workplace;
- Providing a photograph of the perpetrator to management, security staff and reception. This may also be extended to colleagues on a need-to-know basis;
- Reviewing the security of personal information held, such as temporary or new address and bank details.

The manager must respect the right of an employee to make their own decisions about their preferred course of action, at every stage. It is recognised that an employee may need some time to decide what to do and may try different options during this process.

11 Equality

The Trust is committed to ensuring that as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

12 Training

All employees of the Trust are required to undertake domestic abuse and coercive control mandatory training. The training supports and underpins the content of this policy.

13 Resources

The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

14 Implementation and Distribution

This policy will be maintained and updated by the People and OD Department. The policy will be available to employees via the Trust Intranet Site. Where employees do not have access to the intranet their manager must ensure that they have access to a paper or electronic copy of this policy.

15 Relevant Trust Policies, Legislation and Information

- Disciplinary Policy
- NHS Wales Flexible Working Policy
- Respect and Resolution Policy
- Guidance on Industrial Injury and Work Related Claims
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust
- Professional Registration Policy
- Special Leave Policy
- Standards of Behaviour Framework Policy
- NHS Wales Anti-Sexual Harassment Policy
- Trust's Safeguarding & Public Protection Policy
- Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Social Services Wellbeing (Wales) Act and Domestic Abuse Act 2021

Types of Domestic Abuse

- **Emotional and Psychological Abuse**

Emotional or psychological abuse can be either verbal or non-verbal. This kind of abuse chips away at the confidence and independence of the employee experiencing domestic abuse to make them compliant and limit their ability to leave their abuser. Emotional abuse can include verbal abuse such as yelling, name-calling, blaming and shaming, isolation, intimidation, threats of violence and controlling behaviour.

- **Physical Abuse**

A wide range of different behaviour can come under the heading of physical abuse and can include punching, slapping, hitting, biting, pinching, kicking, pulling hair out, pushing, shoving, burning and strangling.

- **Sexual Abuse**

Rape and sexual abuse is common in abusive relationships, due to the employee experiencing domestic abuse's refusal or consent being ignored. Any situation where someone is forced to take part in unwanted, unsafe or degrading sexual activity is sexual abuse.

- **Economic and Financial Abuse**

Economic or financial abuse limits the employee experiencing domestic abuse ability to get help. The abuser controls finances; withholds money or credit cards; makes someone unreasonably account for the money they spend; exploits assets; withholds basic necessities; prevents someone from working or sabotages the employee experiencing domestic abuse job and deliberately runs up debts.

- **Coercive and controlling behaviour**

Coercive and controlling behaviour is a pattern of acts designed to make an employee experiencing domestic abuse subordinate and dependent by isolating them from sources of support, exploiting their resources and capabilities, restricting their independence and regulating their everyday behaviour.
Examples may include:

- Monitoring phone calls, emails, social media activity or whereabouts.
- Restricting contact with family, friends or colleagues.
- Dictating what a person can wear, where they can go or who they can speak to.
- Threatening harm to the individual, children, family members or pets.
- Repeated intimidation, humiliation, degradation or manipulation.
- Preventing access to healthcare, support services or employment.
- Using technology to track, harass or monitor an individual.

Coercive and controlling behaviour may occur alongside physical, sexual, emotional or financial abuse and can have a significant impact on an individual's safety, wellbeing and ability to seek help.

Ten Steps for Managers to Address the Effects of Domestic Abuse

There are a number of steps that managers can take to address the effects of violence, domestic abuse and sexual violence. In many cases it is about being aware and signposting to the relevant organisations that can provide specialist support. Below are ten steps that can be taken by managers:

- **Recognise the Problem**

1. Look for sudden changes in behaviour and/or changes in the quality of work performance for unexplained reasons despite a previously strong record.

2. Look for changes in the way the employee dresses, for example excessive clothing on hot days, changes in the amount of make-up worn.

- **Respond**

3. Believe an employee if they disclose experiencing domestic abuse. **Do Not** ask for proof.

4. Reassure the employee that the Trust has an understanding of how the domestic abuse may affect their work performance and the support that can be offered.

- **Provide Support**

5. Contact Digital Services to divert or block phone calls and email messages and look to change a phone extension if an employee is receiving harassing calls.

6. Agree with the employee what to tell colleagues and how they should respond if their ex/partner or perpetrator of the domestic abuse telephones or visits the workplace.

7. Ensure the employee does not work alone or in an isolated area and check that they have arrangements for getting safely to and from work.

8. Keep a record of any incidents of abuse experienced in the workplace, including persistent telephone calls, emails or visits to the workplace.

9. Provide employees with access to supportive literature i.e. leaflets and posters. Ensure these are placed in discrete locations e.g. putting up posters on the backs of toilet doors. Also ensure that all employees are made aware of the services and support which can be provided by the Trust's Employee Assistance Programme (***Appendix 4***).

- **Refer to the Appropriate Help**

10. Have a list of the support services offered in your area that is easily accessible and refer staff to appropriate organisations that deal with domestic abuse (***Appendix 4***).

Appendix 3

Managers Guidance to Asking Difficult Questions

If you suspect that an employee is experiencing domestic abuse you should facilitate a conversation to discuss this and identify/implement appropriate support. Shying away from the subject can perpetuate fear of stigma and increase feelings of anxiety.

Remember an employee may not feel confident in speaking up, so making the first move to begin a conversation can be very important to ensuring that they provide appropriate support and advice.

You should ask the employee indirect questions, to help establish a relationship and develop empathy. Below are some examples of questions that could be used:

- How are you doing at the moment?
- Are there any issues you would like to discuss with me?
- I have noticed recently that you are not yourself. Is anything the matter?
- Are there any problems or reasons that may be contributing to your frequent sickness absence / under-performance at work / presenteeism at work?
- Is everything alright at home?
- What support do you think might help?
- What would you like to happen?
- How can I help?

Avoid blaming the employee experiencing domestic abuse

It is important that you are able to provide a **non-judgemental** and **supportive** environment. Respecting boundaries and privacy is essential.

Even if you disagree with the decisions being made regarding an employee's relationship or actions they wish to take, it is important to understand that an employee experiencing domestic abuse may make a number of attempts to leave their situation before they are finally able to do so. Your role is not to deal with the abuse itself but to make it clear that the employee will be supported and outline what help and support is available to them.

Domestic Abuse Internal and External Contracts

Internal Contacts

If you are experiencing domestic abuse the following support is available via the Trust. You can contact:

- **Manager**
  You can speak to your manager, in confidence who can provide you with and sign- post you to appropriate sources of advice and support.

- **People and OD Department**
  You can contact the People and OD Department and arrange to speak to a member of the team, in confidence. They will be able to provide you with and sign post you to appropriate sources of advice and support.
  Email: Velindre.WorkforceandOD@wales.nhs.uk

- **Trust Safeguarding Lead**
  You can speak to the Trust's Safeguarding Lead, in confidence. The Lead will be able to provide you with advice, support.
  Email: Fiona.Davies5@wales.nhs.uk

External Contacts

If you are experiencing domestic abuse there are a number of external organisations in Wales that can help you by providing advice and practical guidance on domestic abuse:

- **Live Fear Free Helpline**
  The LiveFearFree helpline is a free, confidential helpline run by Welsh Women's Aid. It offers confidential advice, support and information to employees experiencing domestic abuse, and can help with
  referrals to women's refuges for women fleeing domestic violence. Services are available in Welsh, English and other languages.

  Opening Hours: 24 hours a day – 7 days a week

  Telephone: 0808 8010 800

Text: 07860077333

Email: info@livefearfreehelpline.wales

Visit the https://livefearfree.gov.wales website.

- **Vale Domestic Abuse services**

  Vale Domestic Abuse services is a registered charity which provides support for women and children within the Vale of Glamorgan who have experienced or are experiencing domestic abuse.

  Opening Hours: 9.30 am – 4.30 pm Monday to Friday

  Telephone: 01446 744755

  Email: info@valedas.org

  Visit the http://www.valedas.org website

- **Bawso**

  Bawso is an all Wales voluntary organisation, providing specialist services to employees experiencing domestic abuse and BME people affected or at risk of by domestic abuse and all forms of violence including; female genital mutilation, forced marriage, honour based violence and human trafficking.

  Opening Hours: 24 Hour helpline

  Telephone: 029 20644 633 or ***24 hour helpline*** on 0800 731 8147

  Email: referrals@bawso.org.uk

  Visit the http://www.bawso.org.uk/ website

- **Childline**

  Childline is a confidential helpline for children and young people experiencing or witnessing abuse run by the NSPCC. The helpline is open 24/7. Calls are free and will not appear on BT or cable phone bills. Calls to the helpline are free from most mobile networks (3, BT Mobile, Fresh, O2, Everything Everywhere, Virgin, Vodafone).

  Opening Hours: 24 hours a day – 7 days a week

  Telephone: 0800 11 11

  Visit the Childline website

- **Civil Legal Advice**

The Civil Legal Advice helpline is a free legal advice service available in England and Wales. This helpline can provide free advice on housing, family and other issues if you are eligible to receive legal aid. The helpline can provide contact details of solicitors in your area who may be able to help you.

Opening Hours: Monday to Friday, 9am to 8pm / Saturday, 9am to 12:30pm

Telephone: 0345 345 4 345

Visit the Civil Legal Advice Website

Dyn Wales Helpline

Safer Wales provides confidential support and help for gay, bisexual, transgender and hetrosexual men affected by domestic abuse, to assist them to find the best available services in their local area. This includes practical and effective support and advocacy as well as information on safety planning, signposting to services across Wales, advice and emotional support.

Opening Hours: Helpline open Monday to Friday 10.00 am to 4.00 pm

Telephone: 0808 8010321

Visit the https://www.saferwales.com/en/about-us website

- **Employee Assistance Programme – Vivup**

  Vivup provides confidential and free support including counselling services, information, guidance and referrals on any personal or family issue to our employee and their family members. Services available 24/7. There is a dedicated Domestic Abuse section.

  Opening Hours: 24 hours a day – 7 days a week

  Telephone: 0330 380 0658

  Visit
  https://vivup.yourcareeap.co.uk/UK/EAP-Products.awp?P1=oA==&P2=xBcuZQ==&P3=2

  You will be prompted to create an account to log in and you will need to say you work for Velindre University NHS Trust

- **Llamau**

  Llamau provide support to children, young people and women who are homeless, sofa surfing, in an abuse relationship or at risk of becoming homeless.

  Opening Hours: 24 hours a day – 7 days a week

  Telephone: 02920 239585 (24/7)

Visit the https://www.llamau.org.uk/ website

- **Men's Advice Line**

  The Men's Advice Line offers information and support to male employees experiencing domestic abuse, as well as to their friends and family. The helpline is run by the charity Respect) Calls are free from landlines and from mobiles using the O2, Everything Everywhere (EE), Three (3), Virgin, and Vodafone networks). Calls will not appear on BT landline phone bills.

  A telephone interpreting service is available upon request.

  Opening Hours: Monday to Friday 10am to 1pm and 2pm to 5pm.

  Telephone: 0808 801 0327

  Email: info@mensadviceline.org.uk

  Visit the Men's Advice Line website

- **Rise Cardiff**

  A partnership delivered by Cardiff Women's Aid, Llamau and BAWSO to provide support and advice to women and men experiencing, violence, domestic abuse and sexual violence.

  Opening Hours: 24 hours a day – 7 days a week

  Telephone: 02920 460566

  Visit the https://rise-cardiff.cymru website

- **Stonewall Cymru**

  Stonewall Cymru provides advice and support on a range of issue to lesbian, gay, bisexual and transgender employees experiencing domestic abuse and survivors of domestic abuse in wales.

  Telephone: 02920 23 7744

  Email: Cymru@stonewallcymru.org.uk

  Visit the https://www.stonewall.org.uk/about-us/nations/stonewall-wales website

- **The Survivors Trust**

The Survivors Trust (TST) is a UK-wide national umbrella agency for 130 specialist organisations to provide support in respect of the impact of rape, sexual violence and childhood sexual abuse.

National Helpline: 0808 801 0818

Visit the https://thesurvivorstrust.org website

- **New Pathways**

  Providing a similar resource to The Survivors Trust (above)

  Email: enquiries@newpathways.org.uk

  Visit the: www.newpathways.org.uk website

- **Women's Aid – Cardiff**

  Employ expert and professional staff to provide employees experiencing domestic abuse with safety planning, advocacy, advice and emotional support.

  Opening Hours: 9.00 am – 5.00 pm Monday to Friday

  Telephone: 02920 460566

  Visit the https://www.cardiffwomensaid.org.uk/ website

- **Women's Aid – Newport**

  It is an organisation run by women, serving women in the community, who are suffering from domestic abuse. They have two refuges in Newport. They also have outreach and aftercare workers that support women in the community. Additionally, they run a number of programmes which empower women in making decisions in their life.

  Opening Hours: 9.00 am – 4.30 pm

  Telephone: 01633 840 258

  Visit the http://www.nptwomensaid.org.uk/ website

TRUST BOARD		
Business Continuity and Emergency Planning Policy (PP06), Version 4.0		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	Chief Operating Officer	
PRESENTED BY	Chief Operating Officer	
REPORT SPONSOR	I, **Anne Carey, Chief Operating Officer**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	28/09/2026	Executive Management Board
	12/11/2026	Performance & Finance Committee
	The Policy was endorsed by the SME Task & Finish Group and subsequently approved by the Chair of the VUNHST Business Continuity and Emergency Preparedness Group under Chair's action. It was then formally endorsed by the Executive Management Board (EMB) and subsequently reported to the VUNHST Business Continuity and Emergency Preparedness Group for information and noting, and was reported to the Performance and Finance Committee for noting and onwards submission to Trust Board.	
ONWARD SCRUTINY ROUTE	No further scrutiny route required	
PURPOSE OF THE REPORT	FOR APPROVAL	
	To present the revised Business Continuity and Emergency Planning Policy (PP06), Version 4.0, to the Trust Board for approval. The policy has reached its scheduled review point and has been updated to reflect current organisational roles, governance arrangements and relevant emergency preparedness and business continuity requirements.	
EXECUTIVE SUMMARY	This paper presents the revised Business Continuity and Emergency Planning Policy (PP06), Version 4.0, for approval. This revised policy updates the Trust's established framework for business continuity management and emergency preparedness, resilience and response.	

	It sets out the scope, governance, accountabilities and minimum requirements intended to support the continued delivery and recovery of priority services and products during disruptive incidents, so far as is reasonably practicable. The policy applies across relevant Trust functions, services and premises. It also describes expectations relating to hosted organisations, supply chains and contractors where these support the delivery of priority services. The policy is aligned with the Civil Contingencies Act 2004, relevant NHS emergency preparedness, resilience and response requirements, and BS ISO 22301:2019. It applies the Plan-Do-Check-Act model to support review, learning and continual improvement. The principal revisions update organisational roles, governance arrangements and relevant framework references. The overall intent of the policy remains unchanged. It continues to require a risk-based approach supported by current Business Impact Assessments, coherent and accessible plans, clear escalation arrangements, regular review, training and exercising, and defined Strategic (Gold) and Tactical (Silver) on-call arrangements. Approval of the policy provides the governance framework for business continuity and emergency planning. Operational assurance will continue to depend on effective divisional implementation, including the maintenance, testing and exercising of supporting plans. Compliance and areas requiring improvement will be monitored through the Trust's business continuity and emergency preparedness governance arrangements.
ACTION / DECISION	The Trust Board is asked to: 1. **APPROVE** the revised Business Continuity and Emergency Planning Policy (PP06), Version 4.0; and 2. **NOTE** the responsibilities and governance arrangements described within the Policy.
ADDITIONAL RESOURCES	N/A – Policy will be attached as a separate appendix.
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:	

- Outstanding for quality, safety, and experience
- A sustainable organisation that plays its part in creating a better future for people across the globe

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

- A Resilient Wales
- A globally responsible Wales

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

- Safe
- Timely
- Efficient
- Effective

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

Status: QIA not required - not a strategic decision

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

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

	Appendix no.	Appendix title
APPENDICES	Appendix 1	Business Continuity and Emergency Planning Policy (PP06), Version 4.0

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

1.1 The Trust Board is asked to consider whether the revised policy provides an appropriate governance and accountability framework for Business Continuity and Emergency Preparedness across the Trust.

1.2 In particular, the Committee is asked to note:

- The Policy establishes clear strategic, tactical and operational responsibilities
- Divisions are required to maintain current Business Impact Assessments and supporting continuity plans
- Plans must identify priority activities, recovery requirements, dependencies and escalation arrangements
- Relevant plans action cards must remain accessible during digital or power disruption
- Plans are required to be reviewed, tested and exercised, with learning incorporated following exercises and live incidents
- Implementation will be monitored through the established Business Continuity and Emergency Preparedness governance arrangements
- Approval of the Policy does not in itself provide assurance that every local plan is complete and fully tested. This assurance will be obtained through ongoing monitoring, exercising and reporting

2. BACKGROUND

2.1 The Trust provides specialist services through Velindre Cancer Centre and the Welsh Blood Service, and hosts Health Technology Wales and NHS Wales Shared Services Partnership. The Policy recognises that the ability to continue delivering products and services during disruption is a key priority.

It applies across all relevant staff, functions and premises, with expectations for hosted organisations to maintain local procedures. Its scope also includes supply chains and contractors associated with core service delivery. The framework is informed by BS ISO 22301:2019, the Civil Contingencies Act 2004, and relevant NHS and Welsh Government emergency preparedness, resilience and response guidance.

2.2 The Chief Executive Officer owns the Policy and is accountable for emergency preparedness. The Chief Operating Officer is the delegated Accountable Emergency Officer for business continuity management and emergency preparedness, resilience and response. Each Division is required to nominate a Business Continuity and Emergency

Planning Lead to support implementation, monitoring, business impact assessment, plan development, testing, training and multi-agency engagement.

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 The Policy adopts a risk-based approach to business continuity management. It requires coherent and accessible plans, robust escalation arrangements, regular review, and testing and exercising at an agreed frequency. Hard copies of relevant plans and action cards are to remain accessible in the event of digital or power failure.

The Business Continuity Management System follows the Plan, Do, Check and Act model. Services are expected to identify prioritised activities through Business Impact Assessments, including the Maximum Tolerable Period of Disruption, Recovery Time Objectives and dependencies such as people, premises, equipment, information technology and external stakeholders.

The framework supports preparedness through clearly allocated strategic, tactical and operational responsibilities, on-call arrangements and continual improvement following exercises, management review and live incidents. The Policy records that its equality relevance has been screened and that no potential negative impact was identified.

3.1.2 The revised Policy provides a Trust-wide framework for maintaining priority services during disruption and clarifies accountability, divisional responsibilities and governance. It embeds statutory and standards-based requirements, promotes regular review, training and exercising, and requires plans to remain coherent, accessible and responsive to organisational or operational change.

3.2 FINANCIAL IMPLICATIONS

3.2.1 No additional financial approval is sought through this paper. Implementation will be managed through exiting corporate and divisional resources. Any material resource requirements identified through implementation will be escalated through the appropriate governance and financial planning route.

3.3 LEGAL IMPLICATIONS

3.3.1 The Policy supports the Trust's arrangements for meeting relevant duties and requirements under the Civil Contingencies Act 2004 and NHS Emergency Preparedness, Resilience and Response arrangements. Effective compliance depends on effective implementation, maintenance, review and exercising of the supporting plans.

3.4 PEOPLE IMPLICATIONS

3.4.1 Implementation requires nominated leads, appropriate staff awareness and training, participation in exercises and clarity regarding on-call and incident management responsibilities. These requirements will be managed through existing operational and workforce arrangements.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 No specific adverse Welsh language impact has been identified. Communications during an incident must continue to reflect statutory Welsh language requirements wherever reasonably practicable.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

08 - Governance

3.6.2 **Operational Risks**

Approval of the policy strengthens the Trust's control framework for managing disruption. Residual risk remains where local Business Impact Assessment or continuity plans are incomplete, out of date, inaccessible or insufficiently exercised. These risks will be monitored through the Trist's Business Continuity and Emergency Preparedness governance arrangements and escalated through the relevant operational and corporate risk processes where necessary.

3.1.1 Approving the policy creates no new strategic risk.

4. RECOMMENDATIONS FOR ACTION / DECISION

The Trust Board is asked to:

- **APPROVE** the Business Continuity and Emergency Planning Policy (PP06), Version 4.0 and;
- **NOTE** that assurance on implementation, exercising and identified gaps will continue to be monitored through the established governance arrangements

Ref: PP 06

Velindre University NHS Trust

Business Continuity and Emergency Planning Policy

Executive Sponsor & Function:	Chief Operating Officer
Document Author:	Head of Validation & Risk Management
Approved by:	Trust Board
Approval Date:	27 July 2023
Date of Equality Impact Assessment:	24 July 2023
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2026
Version:	**4.0**

Velindre University NHS Trust

Business Continuity and Emergency Planning Policy

CONTENTS

1	**Introduction**	**3**
2	**Definitions**	**3**
3	**Scope of Policy**	**3**
4	**Aims & Objectives**	**4**
5	**Responsibilities**	**4**
6	**Business Continuity Management System (BCMS) Lifecycle**	**6**
7	**Equality Impact Assessment**	**7**
8	**Governance**	**8**
9	**Main relevant Legislation and Standards**	**8**

1. Introduction

1.1 The Velindre University NHS Trust (VUNHST) Business Continuity and Emergency Planning Policy provide the framework within which the Trust Business Continuity Management System (BCMS) is established to ensure that the organisation can continue to deliver the core services and products in the event of any disruptive incidents so far as is reasonably practicable.

VUNHST provides specialist services to the people of Wales. The operational delivery of products and services is managed through Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

1.2 The Trust hosts the following organisations on behalf of other bodies:

- Health Technology Wales (HTW)
- NHS Wales Shared Services Partnership (NWSSP)

Further information on the above organisations is available by clicking on the following link: https:/velindre.nhs.wales

1.3 The capability of the Trust to continue delivery of its products and services during a disruptive incident or emergency remains a key priority and the Trust is required to ensure it has in place appropriate, acceptable, and effective arrangements and plans to protect its products and services.

1.4 The Policy provides the strategic framework and sets out the scope and governance of the Business Continuity and Emergency Planning arrangements within the Trust.

1.5 The VUNHST Business Continuity and Emergency planning system is based upon the industry wide guidance and specifically that contained in the International Organisation for Standardisation ISO Security and resilience – Business Continuity Management Systems – requirements.

1.6 The Trust will comply with its duties under the Civil Contingencies Act 2004, and associated NHS Emergency Preparedness, Resilience and Response requirements, so business continuity and emergency planning arrangements are embedded, maintained and kept under review across the organisation.

2. Definitions

2.1 A glossary of terms is available from your Divisional Business Continuity and Emergency Planning leads.

3. Scope of Policy

3.1 The scope of this Policy covers all staff, functions and premises that are required to deliver and maintain services to the public and service users. The Trust are committed to embedding a culture that will ensure staff and management are engaged and proactively manage business continuity within the organisation.

3.2 This Policy extends its application to the Trust Hosted Organisations, with the expectation that hosted services have their own local procedures embedded within their services.

3.3 Furthermore, this Policy extends to ensure supply chains and contractors associated to the delivery of core services have appropriate contingency arrangements in place to enable resilience to be achieved and avoid potential points of failure.

4. Aim and Objectives

4.1 The aim of the Policy is to ensure that the core services and functions provided by the Trust are protected so far as is reasonably practicable, through the application and management of robust business continuity arrangements.

4.2 The Trust will adopt a risk-based approach to its BCMS, ensuring business continuity plans are in place and are coherent and accessible to support response to an incident. Where possible the Trust will endeavour to adopt a standard approach across the Trust, however there may be instances where specific divisional or departmental plans and approaches are required. In these circumstances, divisional / departmental procedures will be developed, implemented, tested, and exercised to provide assurance of business continuity and emergency planning arrangements to support delivery of core products and services.

4.3 Ensures robust escalation arrangements within the Trust that are embedded across all employees and stakeholders through awareness communications enabling a Trust wide preparedness and capability to respond to a disruptive incident 24 hours a day, 7 days a week.

4.4 The reputation and integrity of the Trust for the benefit of the public and service users is always protected.

4.5 Business Continuity and Emergency Plans will be regularly reviewed for accuracy and available to provide guidance and support during disruptive incidents and a response structure to those responsible for managing a crisis. Hard copy plans will be accessible in the event of Digital or Power failure.

4.6 The Trust will ensure that there is a Strategic (Gold) and Tactical (Silver) On-Call arrangement in place to support the capability to respond to any incident, emergency, or crisis where a contingency has not been already identified.

5. Responsibilities

Strategic (Gold)

5.1 The Trust Chief Executive owns the Business Continuity and Emergency Planning Policy.

5.2 The Chief Executive is accountable and responsible for ensuring the Trust is prepared for emergency situations including Business Continuity incidents. This role is identified by the NHS EPRR Framework and Core Standards 2015 as the **Accountable Emergency Officer (AEO).**

5.3 The Chief Executive can delegate the responsibility of AEO to an appropriate Trust Officer.

5.4 The VUNHST Chief Operating Officer is the delegated AEO for BCM and EPRR for the

Trust. They will have executive authority and responsibility for ensuring that the Trust complies with legal and Policy requirements. They will provide assurance to the Board that strategies, systems, training, policies, and procedures are in place to ensure an appropriate response for the Trust in the event of an incident. Additionally, to promote continual improvement of the VUNHST BCMS.

5.5 The AEO will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain public protection and maximise the NHS response.

5.6 The AEO will provide assurance to the Board that the Trust is meeting its obligations with respect to EPRR and relevant statutory duties under the Civil Contingencies Act 2004 (CCA) and the NHS Act 2006 (as amended). This will include assurance that the Trust has allocated sufficient experienced and qualified resources to meet these requirements.

5.7 The AEO, in consultation with the nominated Business Continuity leads and General Managers/ Service Leads will identify the appropriate external stakeholders and interested parties who may need to be aware of the Trust Business Continuity and Emergency Planning arrangements.

5.8 The AEO in conjunction with Divisional leads will ensure the completion and timely submission of the Health Emergency Planning Annual Report.

Tactical / Operational (Silver/Bronze)

5.9 Each Division shall nominate a Business Continuity and Emergency Planning Lead who will be responsible for the development and delivery of the Trust BCM arrangements under the direction of the AEO. The lead in conjunction with the respective Heads of Departments within each Division will:

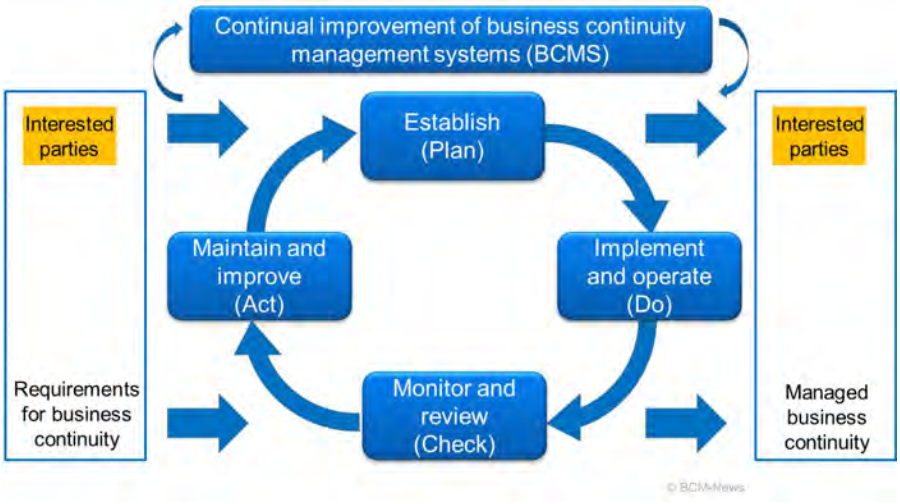
- Review and develop the BCMS in line with industry's best practice and the needs of the Trust.
- Monitor standards and compliance with the system.
- Undertake a Business Impact Assessment (BIA) for their service areas within each Division to ensure service prioritised activities are identified. The BIA will confirm the Maximum Tolerable Period of Disruption (MTPD) i.e., the length of time that services can tolerate a disruption, the Recovery Time Objective (RTO) i.e., the point in time following an incident at which each of the key services would need to be resumed and, finally, quantify the resource and dependencies required to maintain the essential activities including people, premises, equipment, IT, and other stakeholders.
- Develop, review and test Divisional Business Continuity Management Plans and Procedures on an annual basis or as determined appropriate for their service area based on available guidance. (Where possible, the Trust will endeavour to avoid duplication of effort to ensure a standard approach is taken to Business Continuity and Emergency Planning).
- Undertake a Training Needs Analysis for Business Continuity within their service area.
- Attend relevant Trust Business Continuity & Emergency Preparedness groups as required.
- Provide training, support and guidance to managers ensuring that staff and other appropriate, relevant stakeholders such as contractors and suppliers will be made aware of the Trust's BCM arrangements as defined by the AEO and service managers.

- Engagement with any relevant audit and review requirements.
- Continued multi agency working and engagement.
- Contribute and engage in the Welsh Government and the health Emergency Preparedness Resilience and Response network including the requirement to submit a Health Emergency Planning Annual Report.

6. Business Continuity Management System (BCMS) Lifecycle

The Trust and its Divisions will adopt the cycle of activity illustrated in Figure 1.

Figure 1- Plan Do, Check and Act Model



6.1 Plan (Establish)

Establish business continuity Policy, outlining the scope/ understanding of the BCMS i.e. objectives, targets, controls, processes and procedures relevant to improving business continuity to deliver results that align the organisation's overall policies and objectives.

The scope of BCMS links the potential impact of a disruptive event on the organisation's activities, functions, services, supply chain and relationships with external stakeholders. Do (Implement and Operate).

6.2 Do (Implement and Operate)

Implement and operate this Business Continuity Policy, controls, processes and procedures. All staff will be required to read and understand the Business Continuity Plans relevant to their areas, along with those that can affect all areas i.e. Fire, Severe Weather, Power Outage etc.

Hard copies of Business Continuity Plans and any associated local or divisional action cards will be filed within agreed folders and locations to enable staff quick and easy access during a disruptive event. All staff will be aware of the locations of these folders.

The VUNHST Incident Response Plan (IRP) provides further guidance on varying levels of incident response the Trust may be required to respond to and can be found on the Trust Intranet and within the senior management/leadership and executive on-call packs.

6.1 **Check (Monitor and review)**

Monitor, review and exercise/ test performances against Business Continuity Policy and objectives, report any results to management for review, and determine and authorise actions for remediation and improvement.

6.2 **Act (Maintain and improve)**

Maintain and improve the Business Continuity Policy and Plans by taking corrective action, based on the results of management review, and reappraising the scope of the Policy and corresponding business continuity objectives. Debriefs will be produced following actual disruptive events, and all lessons identified will be reviewed and considered for inclusion within the process.

Note, Business Impact Assessments and Business Continuity Plans shall be updated if:

- There are any changes to the organisation, including major restructures
- Changes to methods of delivery
- Changes to the operating environment (new markets etc.)
- Changes to key staff
- Following recommendations from exercise and testing or debriefs post live incidents

6.3 **Business Continuity & Emergency Preparedness Exercises**

It is a requirement to validate incident response plans through exercises and testing arrangements to ensure they are fit for purpose. Exercise and tests should be carried out at pre-agreed frequency and or to meet the requirements set within relevant legislation or core standards. Exercises will provide opportunities for responding staff to rehearse plans and maintain a level of competence, confidence and aid training.

7. Equality Impact Assessment Statement

7.1 This Policy has been screened for relevance to equality. No potential negative impact has been identified.

8. Governance

8.1 This Policy will be approved by the relevant Board Committee at a minimum of every 3 years subject to changes in legislation, guidelines and Divisional arrangements>

8.2 The Policy has been endorsed by the Trust Business Continuity & Emergency Preparedness Group to ensure alignment with each of the Divisional arrangements.

8.3 The Trust will commit to providing resources as and when required to participate in internal and external delivered exercise, testing and training.

8.4 The relevant Business Continuity and Emergency Preparedness governance group(s) will maintain Terms of Reference confirming membership, meeting frequency and reporting routes. Highlight reports will be submitted to the relevant Executive Management Board and Committee meetings for oversight, as appropriate. The Trust will participate in any internal and external assurance frameworks or reports that relate to Business Continuity

and Emergency Preparedness, Resilience and Response, i.e. Welsh Government Emergency Preparedness Annual Report.

8.5 Disciplinary action under the terms of the Trusts Disciplinary Procedures will be taken against any employee, regardless of status, who shows wilful disregard for the Policy and associated working practices.

9. Main relevant Legislation and Standards

- Civil Contingencies Act 2004
- BS ISO Security and resilience – Business continuity management systems requirements 22301:2019
- BCI Good Practice Guidelines 2018 Global Edition
- NHS & Welsh Government guidance (i.e., NHS Emergency Preparedness Resilience & Response core standard & framework, NHS Business Continuity Guidance)

TRUST BOARD		
TRUST SEAL REPORT: 18 SEPTEMBER 2026 – 18 NOVEMBER 2026		
DATE OF MEETING	26/11/2026	
STATUS	Public	
REPORT AUTHOR	Kyle Page, Business Support Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	DD/MM/YYYY	N/A
	DD/MM/YYYY	
	N/A	
ONWARD SCRUTINY ROUTE	N/A – For Trust Board only	
PURPOSE OF THE REPORT	**FOR ASSURANCE - Level 6 - GREEN (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes)**	
	Board Members are asked to view the content of the report. Further information or queries should be directed to the Director of Corporate Governance (interim).	
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer / Acting Chief Executive Officer at every seal request **(18th September 2026 – 18th November).**	
ACTION / DECISION	The Trust Board is requested to **NOTE for ASSURANCE** the contents of the Trust Board Seal Register included below.	
ADDITIONAL RESOURCES	N/A	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		

• N/A
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):
• N/A
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
• N/A
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Trust Seal Register

KEY CONSIDERATIONS

1. SITUATION

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer / Acting Chief Executive Officer at every seal request **(18th September 2026 – 18th November).**

2. BACKGROUND

2.1 Board members are asked to view the content of the report. Further information or queries should be directed to the interim Director of Corporate Governance.

3. MATTERS FOR CONSIDERATION

3.1 **ASSESSMENT** - Please refer to the Seal Register at Appendix 1.

3.2 FINANCIAL IMPLICATIONS

3.2.1 None.

3.3 LEGAL IMPLICATIONS

3.3.1 None.

3.4 PEOPLE IMPLICATIONS

3.4.1 None.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 None.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

Not Applicable

Operational Risks

None.

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is requested to **DISCUSS** and **NOTE** the contents of the Trust Board Seal Register included below.

4.2

APPENDIX 1 – TRUST SEAL REGISTER

Date	Document Details	Signed
23/09/2026	Deed of Surrender relating to ground floor premises, the Chapel, Whitchurch Hospital, Park Road, Whitchurch, Cardiff, between VUNHST and Trustees for Whitchurch Hospital Bowls Club.	Sara Moseley, Chair / Carl James, CEO
23/09/2026	Lease relating to bowling green at Whitchurch Hospital Bowls Club, Park Road, Whitchurch, Cardiff, between VUNHST and Trustees for Whitchurch Hospital Bowls Club.	Sara Moseley, Chair / Carl James, CEO
23/09/2026	Lease relating to temporary portakabin, Whitchurch Hospital, Park Road, Whitchurch, Cardiff, between VUNHST and the Trustees for Whitchurch Hospital Bowls Club.	Sara Moseley, Chair / Carl James, CEO
01/10/2026	Underlease relating to First Floor Offices at Pembroke House, Ellice Way, Wrexham Technology Park Wrexham, LL13 7YT.	Sara Moseley, Chair / Matthew Bunce, Acting CEO

TRUST BOARD		
TRUST WIDE POLICIES APPROVED UPDATE		
DATE OF MEETING	[26/11/2026]	
STATUS	Public	
REPORT AUTHOR	Kay Barrow, Corporate Governance Manager	
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance	
REPORT SPONSOR	I, **Non Gwilym, Interim Director of Corporate Governance**, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	28/09/2026	Executive Management Board
	12/11/2026	Performance and Finance Committee
ONWARD SCRUTINY ROUTE	N/A	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the trust wide policies and other written control documents and to advise of those that have been approved during the period **October 2026 to November 2026.**	
ACTION / DECISION	The Trust Board is asked to **NOTE for ASSURANCE** the trust wide policies and other written control documents that have been approved during the period **October 2026 to November 2026.**	
ADDITIONAL RESOURCES	**N/A**	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
• Outstanding for quality, safety, and experience		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
• A More Equal Wales		
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:		

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

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

Status: QIA not required - not a strategic decision

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

Status: Yes - please outline what, if any, actions were taken as a result
Each policy will be individually assessed to ensure compliance with EIA requirements.

	Appendix no.	**Appendix title**
APPENDICES	Appendix 1	Key Considerations
	Appendix 2	PP03 Environmental and Climate Resilience Policy
	Appendix 3	PP08 Waste Management Policy
	Appendix 4	PP17 Electric Vehicle Procedure

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive an update on any approved trust wide policies and/or other written control documents.

2. BACKGROUND

2.1 The purpose of this report is for the Trust Board to note for assurance the trust wide policies and other written control documents that have been through the Trust governance process and approved during the period **October 2026 to November 2026.**

3. MATTERS FOR CONSIDERATION

3.1 ASSESSMENT

3.1.1 Since the last report, the following trust wide policies and other written control documents have been **APPROVED**, which has been uploaded to the Trust Intranet and/or Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
2	PP03 Environmental and Climate Resilience Policy	Director of Place, Portfolio and Partnerships	Performance and Finance Committee	12/11/2026
3	PP08 Waste Management Policy	Director of Place, Portfolio and Partnerships	Performance and Finance Committee	12/11/2026
4	PP17 Electric Vehicle Procedure	Director of Place, Portfolio and Partnerships	Performance and Finance Committee	12/11/2026

3.2 FINANCIAL IMPLICATIONS

3.2.1 Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

3.3 LEGAL IMPLICATIONS

3.3.1 Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal.

3.3.2 Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

3.4 PEOPLE IMPLICATIONS

3.4.1 There are no people implications because of the activity outlined in this report.

3.5 WELSH LANGUAGE IMPLICATIONS

3.5.1 All trust wide policies that are published on the Trust's website will be translated into Welsh to comply with the Welsh Language Standards.

3.6 RISKS / REPUTATIONAL IMPLICATIONS

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

08 - Governance

3.6.2 **Operational Risks**

There are no associated operational or reputational risks because of the activity outlined in this report.

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE for ASSURANCE** the trust wide policies and other written control documents that have been approved during the period **October 2026 to November 2026.**

Environmental and Climate Resilience Policy

Policy summary:
This policy outlines Velindre University NHS Trust's commitment to reducing environmental impacts, tackling climate change, and improving climate resilience across all services and sites. It provides a framework for legal compliance, continual improvement, and maintaining an effective Environmental Management System in line with ISO 14001. The policy applies to all staff and supports sustainable management of energy, waste, biodiversity, procurement, transport, and resources.

Policy Title	Environmental and Climate Resilience Policy
Policy Reference	PP 03
Executive Sponsor & Function	Director of Place, Portfolio & Partnerships
Lead FFRESH Area	Sustainability
Document Author	Trust Sustainability Manager
Consultation Group	FFRESH Climate Action Board ISO14001 Management Group WBS Cynefin VCS Cynefin
Approved By	Performance and Finance Committee
Approval Date	12/11/2026
Review Date	November 2029

Equality Impact Assessment	11/04/2022
Status / Version	4

Version	Date	Author	Summary of changes
1	September 2025	Trust Sustainability Manager	Initial draft.
2	April 2026	Trust Sustainability Manager	Updated following consultation with ISO14001 Management Group
3	August 2026	Energy and Environment Officer	Updated after consultation

Contents

1. INTRODUCTION / POLICY STATEMENT 4
2. SCOPE OF POLICY 4
3. AIMS AND OBJECTIVES 4
3.1 Aim 4
3.2 Objectives 5
4. RESPONSIBILITIES 5
4.1 Chief Executive Officer 5
4.2 Director of Place, Portfolio & Partnerships 5
4.3 FFRESH Lead / Policy Lead 5
4.4 Divisional & Hosted Organisation Leads / EMS Teams 5
4.5 Internal EMS Auditors 5
4.6 Climate Action Board 5
4.7 Managers 5
4.8 All Staff 6
4.6 Contractors and External Partners 6
5. DEFINITIONS 6
6. IMPLEMENTATION / POLICY COMPLIANCE 7
7. EQUALITY IMPACT ASSESSMENT 7
8. REFERENCES 7
9. GETTING HELP 7
10. RELATED POLICIES, PROCEDURES AND GUIDANCE 8
11. INFORMATION, INSTRUCTION AND TRAINING 8
14. MAIN RELEVANT LEGISLATION / STANDARDS 8
15. APPENDICES 9
Appendix 1a: Trust Headquarters Environmental Statement 9
Appendix 1b: Velindre Cancer Centre Environmental Statement 10
Appendix 1c: Welsh Blood Service Environmental Statement 11

1. INTRODUCTION / POLICY STATEMENT

Velindre University NHS Trust recognises the critical role it plays in protecting the environment, reducing its contribution to climate change, and ensuring services, estates, and operations are resilient to future climate impacts.

The Trust is committed to:

- Preventing pollution and reducing environmental impacts.
- Reducing carbon emissions in line with Welsh Government targets.
- Building resilience to climate change by future-proofing our services, infrastructure, and supply chains.
- Supporting the transition to a circular economy and sustainable use of resources.
- Enhancing biodiversity and ecosystem health across our estate.

The Trust has successfully maintained certification to BS EN ISO 14001:2015 Environmental Management Systems and is committed to a managed and timely transition to ISO 14001:2026, ensuring continued compliance, continual improvement, and alignment with emerging international best practice in environmental management and climate resilience.

We have successfully maintained certification to BS EN ISO14001:2015 Environmental Management Systems and are committed to continual improvement, compliance with all legal obligations, and transparent reporting of our progress.

This policy supports and integrates with the following key legislation and strategies:

- **Well-being of Future Generations (Wales) Act 2015** – embedding the five ways of working (long-term, prevention, integration, collaboration, involvement).
- **Environment (Wales) Act 2016** – including our Section 6 Biodiversity Duty and sustainable management of natural resources.
- **Climate Change Act 2008** – delivering decarbonisation and adaptation action.
- **Towards Zero Waste Strategy** – supporting Wales' ambition to become a zero-waste nation by 2050.
- **Social Partnership and Public Procurement (Wales) Act 2023** – ensuring procurement delivers environmental, social, and cultural value.

2. SCOPE OF POLICY

This policy applies to:

- All staff, contractors, students, and volunteers within Velindre University NHS Trust, its Divisions, and Hosted Organisations.
- All operations, activities, estates, and services that have an environmental aspect or impact.
- All areas of environmental and climate performance, including energy, water, waste, biodiversity, emissions, procurement, transport, and climate resilience.

Non-compliance with this policy may result in disciplinary action and/or enforcement by regulatory authorities.

3. AIMS AND OBJECTIVES

3.1 Aim

- To maintain and continually improve an Environmental Management System (EMS) compliant with ISO 14001:2015 and the transition requirements of ISO 14001:2026.
- To prevent pollution, reduce environmental impacts, and address climate change.
- To future-proof services, infrastructure, and operations to ensure resilience to climate risks.

3.2 Objectives

The Trust will:

- Maintain ISO 14001 certification and implement a planned transition programme to ISO 14001:2026, in line with accreditation body requirements and transition timescales.
- Embed the waste hierarchy (reduce, reuse, recycle, recover, dispose) and eliminate unnecessary single-use plastics.
- Implement actions to decarbonise operations and reduce Scope 1, 2, and 3 emissions.
- Conduct climate risk and vulnerability assessments to inform planning, capital projects, and service delivery.
- Integrate adaptation and resilience planning into estates development, service delivery, and supply chain management.
- Enhance biodiversity and contribute to nature recovery across all sites.
- Use energy, water, and materials efficiently and responsibly.
- Ensure procurement and contractor management deliver environmental and social value.
- Promote staff training, awareness, and engagement to support environmental and climate action.
- Work collaboratively with partners, regulators, and local communities to deliver shared outcomes.

4. RESPONSIBILITIES

4.1 Chief Executive Officer

- Accountable to the Trust Board and Welsh Government for environmental and climate resilience performance.
- Ensures resources and governance are in place to deliver policy aims.

4.2 Director of Place, Portfolio & Partnerships

- Holds delegated responsibility for environmental and climate resilience matters.
- Provides assurance to the Trust Board and ensures competent advice is available.

4.3 FFRESH Lead / Policy Lead

- Leads corporate management of environmental and climate resilience issues.
- Oversees the EMS, ensures compliance, reporting, and continual improvement.

4.4 Divisional & Hosted Organisation Leads / EMS Teams

- Manage local implementation of the EMS, including climate adaptation and resilience actions.
- Nominate local environmental or sustainability leads and ensure delivery of divisional objectives.

4.5 Internal EMS Auditors

- Undertake audits to verify compliance and identify opportunities for improvement.

4.6 Climate Action Board

- Oversee environmental and climate resilience performance, risk management, and improvement plans.
- Review progress against environmental targets, climate adaptation plans, and audit findings.

4.7 Managers

- Ensure staff are trained and aware of environmental procedures.
- Implement and monitor local actions to reduce environmental impact and improve resilience.

4.8 All Staff

- Comply with environmental and climate procedures.
- Participate in training and awareness activities.
- Report incidents, near misses, and improvement opportunities.

4.6 Contractors and External Partners

- Contractors and external partners must comply with this policy where it applies to their work, follow Trust site rules and cooperate with Trust managers and FFRESH leads.

5. POLICY REQUIREMENTS AND OPERATIONAL PROCEDURE

5.1 General requirements

- All Trust activities must be undertaken in a manner that protects the environment, prevents pollution and minimises adverse environmental impacts.
- Environmental aspects, impacts, risks, opportunities and compliance obligations must be identified, assessed and managed through the Trust's Environmental Management System (EMS).
- The Trust will comply with applicable environmental legislation, regulatory requirements, Welsh Government policy, NHS Wales guidance and other obligations to which it subscribes.
- Environmental considerations, including lifecycle impacts, climate resilience, biodiversity, resource efficiency and carbon reduction, must be incorporated into decision-making, service development, procurement and operational activities.
- Appropriate environmental records, monitoring data, performance reports, risk assessments and audit findings must be maintained and retained in accordance with Trust governance arrangements.

5.2 Operational arrangements

Environmental management will be embedded within day-to-day activities across all Trust sites, services and departments. Departments must identify and manage activities that have the potential to impact the environment and implement appropriate operational controls to reduce environmental risk. Environmental objectives, targets and improvement actions will be managed through the Trust's Environmental Management System and Sustainability Implementation Plans. Environmental performance data, including energy, water, waste, procurement, travel, biodiversity and carbon emissions, will be monitored and reported through established governance arrangements. Significant environmental incidents, complaints, breaches of legal compliance or environmental concerns must be reported promptly through Trust reporting systems and investigated where appropriate. Environmental considerations will be incorporated into planning, procurement, project delivery, maintenance activities and service development to support continual improvement and climate resilience.

4.3 FFRESH Lead / Policy Leads

- Environmental compliance audits, inspections and performance reviews will be undertaken to verify compliance with legal requirements, ISO 14001 requirements and Trust procedures.
- All staff must receive appropriate environmental information, instruction and training relevant to their role, with additional training provided where specialist environmental risks or responsibilities exist.
- Environmental incidents, pollution events, permit breaches, complaints, near misses or other non-conformances must be reported, investigated and corrective actions implemented as required.
- Managers, site leads and nominated environmental representatives must monitor local environmental performance, implement corrective and preventative actions and escalate significant environmental risks through appropriate governance arrangements.
- Environmental objectives, targets and key performance indicators will be reviewed regularly to support

pollution prevention, carbon reduction, climate resilience, biodiversity enhancement and continual improvement.

- Contractors and suppliers undertaking activities on behalf of the Trust must comply with relevant environmental requirements, site rules and contractual obligations

6. DEFINITIONS

Term	Definition
FFRESH	Facilities, Fire, Risk, Estates, Sustainability and Health & Safety.
Environmental Management System (EMS)	A management framework for controlling environmental impacts, fulfilling compliance obligations, and addressing risks and opportunities.
Climate Resilience	The capacity of the Trust's infrastructure, services, and supply chains to anticipate, prepare for, respond to, and recover from climate impacts.

7. IMPLEMENTATION / POLICY COMPLIANCE

The Trust will:

- Operate and maintain an ISO 14001-compliant EMS, including planned transition arrangements to ISO 14001:2026.
- Apply the waste hierarchy and promote a circular economy approach.
- Undertake climate risk assessments to inform planning, investment, and emergency preparedness.
- Integrate adaptation measures into capital projects, infrastructure upgrades, and service design.
- Conduct regular audits, inspections, and Duty of Care checks.
- Investigate incidents and implement corrective and preventive actions.
- Monitor and report progress through the Climate Action Board and Trust Board.

8. EQUALITY IMPACT ASSESSMENT

This policy has been assessed and found not to have a negative impact on any protected groups. It will be reviewed periodically to ensure inclusivity.

9. REFERENCES

BSI (2015). *Environmental Management Systems – Requirements with Guidance for Use (ISO14001:2015)*. London: BSI.
Welsh Government (2010). *Towards Zero Waste: One Wales, One Planet*. Cardiff: WG.
Welsh Government (2015). *Well-being of Future Generations (Wales) Act 2015*. Cardiff: WG.
Welsh Government (2016). *Environment (Wales) Act 2016*. Cardiff: WG.
Welsh Government (2023). *Waste Separation Requirements (Wales) Regulations 2023*. Cardiff: WG.
Welsh Government (2023). *Environmental Protection (Single-use Plastic Products) (Wales) Act 2023*. Cardiff: WG.
Welsh Government (2023). *Social Partnership and Public Procurement (Wales) Act 2023*. Cardiff: WG.

10. GETTING HELP

For support and further information, contact the **Trust Sustainability Manager** or sustainability.velindre@wales.nhs.uk

11. RELATED POLICIES, PROCEDURES AND GUIDANCE

- Waste Management Policy (PP08)
- Risk Management Policy (PP35)
- Health, Safety and Welfare Policy
- Infection Prevention and Control Policies
- Control of Contractors Policy
- Asbestos Policy
- Fire Safety Policy
- Business Continuity Management Policy
- Trust Well-being Objectives

12. INFORMATION, INSTRUCTION AND TRAINING

- All staff must complete mandatory environmental awareness training.
- Managers must ensure new staff complete training during induction.
- Specialist training (e.g. waste handling, spill response, internal auditing, climate risk awareness) will be provided as required.
- Training records will be maintained and monitored through the EMS.

13. MAIN RELEVANT LEGISLATION / STANDARDS

- Environment (Wales) Act 2016
- Well-being of Future Generations (Wales) Act 2015
- Social Partnership and Public Procurement (Wales) Act 2023
- Waste Separation Requirements (Wales) Regulations 2023
- Environmental Protection (Single-use Plastic Products) (Wales) Act 2023
- Climate Change Act 2008
- Environmental Protection Act 1990
- The Waste (England and Wales) Regulations 2011
- Hazardous Waste (England and Wales) Regulations 2005
- Controlled Waste (England and Wales) Regulations 2012
- Environmental Permitting (England and Wales) Regulations 2018
- Air Quality Standards Regulations 2010
- Conservation of Habitats and Species Regulations 2010
- Health and Care Quality Standards 2023
- WHTM 07-01: Safe Management of Healthcare Waste
- WHTM 07-02: Energy and Sustainability
- WHTM 07-03: Car Parking Management
- WHTM 07-04: Water Efficiency
- WHTM 07-07: Sustainable Health and Social Care Buildings

14. APPENDICES

Appendix 1a: Trust Headquarters Environmental Statement

VELINDRE UNIVERSITY NHS TRUST HEADQUARTERS ENVIRONMENTAL POLICY STATEMENT

Velindre University NHS Trust Headquarters is a division within Velindre University NHS Trust. Our activities include providing strategic guidance and support for the practices by which the Trust is governed through administrative support. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N. Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2015, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to persistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard **BS EN ISO 14001:2015**
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions, encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

Appendix 1b: Velindre Cancer Centre Environmental Statement

VELINDRE CANCER CENTRE ENVIRONMENTAL POLICY STATEMENT

Velindre Cancer Centre is a division within Velindre University NHS Trust. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2015, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to persistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard BS EN ISO 14001:2015
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions, encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

Appendix 1c: Welsh Blood Service Environmental Statement

WELSH BLOOD SERVICE ENVIRONMENTAL POLICY STATEMENT

Welsh Blood Service is a division within Velindre University NHS Trust. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2016, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to consistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard BS EN ISO 14001:2015
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions; encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

TRUST WASTE MANAGEMENT POLICY

Policy summary:
This policy outlines how Velindre University NHS Trust will manage waste safely, legally and sustainably across all sites and services. It supports compliance with environmental legislation, WHTM 07-01 and the Trust's Environmental Management System. The policy promotes waste prevention, recycling and circular economy principles while ensuring correct waste segregation and handling.

Policy Title	Trust Waste Management Policy
Policy Reference	PP08
Executive Sponsor & Function	Director of Place, Portfolio & Partnerships
Lead FFRESH Area	Sustainability / Facilities
Document Author	Energy and Environment Officer
Consultation Group	FFRESH Climate Action Board ISO14001 Management Group WBS Cynefin VCS Cynefin
Approved By	Performance and Finance Committee
Approval Date	12/11/2026

Review Date	November 2029
Equality Impact Assessment	06/03/2018
Status / Version	3

Version	Date	Author	Summary of changes
1	September 2025	Trust Sustainability Manager	Initial draft.
2	April 2026	Trust Sustainability Manager	Updated following consultation with ISO14001 Management Group
3	August 2026	Energy and Environment Officer	Updated after consultation

Contents

1. INTRODUCTION / POLICY STATEMENT. 4
2. SCOPE OF POLICY 4
3. AIMS AND OBJECTIVES 4
4. RESPONSIBILITIES 5
4.1 Chief Executive Officer 5
4.2 Director of Place, Portfolio & Partnerships 5
4.3 Trust Sustainability Manager 5
4.4 Site Managers / Service Leads / Department Managers 5
4.5 All Staff 5
4.6 Contractors and External Partners 5
5. POLICY REQUIREMENTS AND OPERATIONAL PROCEDURE 6
5.1 General requirements 6
5.2 Operational arrangements 6
5.3 Specific controls 6
6. RESOURCES 6
6.1 Information, Instruction and Training 6
6.2 Financial Implications 7
6.3 Support Resource. 7
7. DEFINITIONS 7
8. IMPLEMENTATION / POLICY COMPLIANCE 7
9. MAIN RELEVANT LEGISLATION / STANDARDS 7
10. MONITORING, AUDIT AND ASSURANCE 8
11. IMPACT ASSESSMENTS 8
11.1 Equality Impact Assessment 7
11.2 Environmental Impact 7
11.3 Well-being of Future Generations Act 7
12. REFERENCES 8
13. GETTING HELP 9
14. RELATED POLICIES, PROCEDURES AND GUIDANCE 9
15. APPENDICES 9
Appendix 1: Waste Hierarchy 9
Appendix 2: Waste Segregation Charts 10

1. INTRODUCTION / POLICY STATEMENT

Velindre University NHS Trust is committed to delivering high-quality healthcare in a way that protects the environment, safeguards patients, staff, visitors, contractors and communities, and supports sustainable development across the Trust.

This Waste Management Policy sets out how the Trust will manage all waste streams safely, legally and sustainably. It supports compliance with environmental legislation, healthcare waste guidance, the Well-being of Future Generations (Wales) Act 2015, the Environment (Wales) Act 2016 and the Trust Environmental and Climate Resilience Policy (PP03).

The Trust will maintain its Environmental Management System in line with ISO 14001:2015 requirements while preparing for a managed transition to ISO 14001:2026. Waste management arrangements will therefore continue to embed risk-based thinking, lifecycle considerations, compliance obligations, operational controls, performance monitoring and continual improvement.

Waste will be managed in accordance with the waste hierarchy, WHTM 07-01: Safe and sustainable management of healthcare waste, and all relevant legal and Duty of Care requirements.

2. SCOPE OF POLICY

This policy applies to all waste-generating activities, products and services controlled by the Trust.

- All staff, contractors, students, volunteers and any person working on behalf of the Trust.
- All Trust divisions, hosted organisations, departments, clinical areas, offices and estates activities.
- All waste streams generated by the Trust, including healthcare/clinical, domestic, recyclable, hazardous, offensive, confidential, electronic, pharmaceutical, sharps, food, construction and demolition waste.
- Waste activities undertaken by contractors or suppliers on behalf of the Trust, where the Trust retains Duty of Care responsibilities.

Failure to comply with this policy may result in local corrective action, incident reporting, disciplinary action, contractual escalation or regulatory enforcement, depending on the nature of the non-compliance.

3. AIMS AND OBJECTIVES

The aim of this policy is to ensure waste is prevented, reduced, segregated, stored, handled, transported, treated and disposed of safely and sustainably.

- Manage waste safely, efficiently and legally, applying the waste hierarchy and the principles of WHTM 07-01.
- Reduce environmental impacts, carbon emissions and avoidable costs associated with waste generation and disposal.
- Improve waste prevention, reuse, recycling, recovery and landfill diversion performance.
- Provide staff with clear information, instruction and training so that waste is segregated correctly at the point of production.
- Maintain ISO 14001 certification and support transition readiness for ISO 14001:2026 by managing waste-related risks, opportunities, compliance obligations and lifecycle impacts.
- Embed circular economy principles into service delivery, procurement, capital projects, estates activities and contractor arrangements.
- Use audit findings, incident trends, contractor assurance and performance data to drive continual improvement.

4. RESPONSIBILITIES

4.1 Chief Executive Officer

- Accountable to the Trust Board for ensuring effective waste management arrangements are in place.
- Ensures clear accountability, leadership and resources for implementation of this policy.

4.2 Director of Place, Portfolio & Partnerships

- Holds delegated executive responsibility for waste management arrangements across the Trust.
- Provides assurance to the Trust Board and relevant committees on compliance, risks and performance.

4.3 Trust Sustainability Manager

- Provides specialist advice and support on waste management, ISO 14001 compliance and WHTM alignment.
- Maintains the policy and associated guidance in collaboration with operational teams, Infection Prevention and Control, Health and Safety and contractors.
- Oversee waste performance reporting, EMS requirements, contractor Duty of Care documentation, audit findings and improvement actions.
- Supports capital, estates, service change and procurement activities to consider waste prevention, lifecycle impacts and circular economy opportunities.

4.4 Site Managers / Service Leads

Site Managers, Service Leads and Department Managers are responsible for:

- Ensuring staff within their area are aware of and comply with this policy.
- Implementing local arrangements, signage, risk controls, fault reporting and escalation routes where required.
- Monitoring local compliance and addressing inappropriate use, unsafe practice, defects or non-compliance.
- Supporting investigations and corrective actions relating to incidents, damage, misuse or policy breaches.
- Maintain local waste records and documentation where required.
- Coordinate or support local waste audits, segregation checks and action plans.
- Report waste performance, incidents, repeated non-conformances and training needs through agreed routes.

4.5 All Staff

All staff are responsible for:

- Following this policy, associated guidance and any local procedures.
- Completing required training or instruction relevant to their role.
- Reporting incidents, hazards, defects, concerns or non-compliance promptly.
- Using Trust equipment, buildings, systems or services safely and appropriately.
- Segregate waste correctly at the point of production and follow Trust procedures.
- Use the correct containers, labels and storage arrangements.

4.6 Contractors and External Partners

Contractors and external partners must comply with this policy where it applies to their work, follow Trust site rules and cooperate with Trust managers and FFRESH leads.

5. POLICY REQUIREMENTS AND OPERATIONAL PROCEDURE

5.1 General requirements

- All waste must be managed in accordance with the waste hierarchy, relevant environmental legislation, and WHTM 07-01 guidance for healthcare waste.
- Waste must be correctly segregated, labelled, stored, transported and disposed of using approved Trust arrangements and authorised contractors.
- Appropriate records, including Duty of Care documentation, waste transfer notes and consignment notes, must be maintained and retained in accordance with legal and Trust requirements.

5.2 Operational arrangements

Waste must be segregated at the point of production into the correct waste stream using approved containers, bags and receptacles. Departments are responsible for ensuring waste is stored safely and securely until collection. Waste collections will be undertaken by approved and appropriately licensed contractors in accordance with agreed service schedules. Local procedures and signage must be available in all areas generating waste. Managers must ensure that staff understand local waste arrangements and that any waste-related incidents, non-conformances or concerns are reported through the Trust's incident reporting systems. Waste performance, audit findings and improvement actions will be monitored and reported through the Trust's sustainability and governance arrangements.

5.3 Specific controls

- Routine waste segregation inspections and audits will be undertaken to verify compliance with WHTM 07-01, legal requirements and Trust procedures.
- All staff must receive appropriate information, instruction and training relevant to their role, with specialist training provided where specific waste streams require additional competence.
- Waste incidents, spillages, near misses, incorrect segregation, damaged containers or contractor concerns must be reported promptly and investigated where required.
- Site managers and nominated waste leads must monitor local compliance, implement corrective actions and escalate significant risks, repeated non-conformances or assurance concerns through appropriate governance arrangements.

6. RESOURCES

6.1 Information, Instruction and Training

Training requirements will be proportionate to staff role, waste stream and risk. Training content must be consistent with WHTM 07-01, local procedures and Trust governance requirements.

Training area	Requirement
Induction and mandatory awareness	All staff must receive appropriate waste awareness information, including segregation, storage, incident reporting and local arrangements.
Role-specific training	Staff who handle specialist waste streams, including hazardous, pharmaceutical, sharps, radiological or genetically modified material, must receive appropriate role-specific instruction.
Manager responsibilities	Managers must ensure staff are competent and that local training needs are identified, acted upon and recorded.
Records and assurance	Training records will be maintained by the relevant division or service and may be reviewed as part of audits, inspections or EMS assurance activities.

6.2 Financial Implications

The Trust will allocate sufficient resources to meet legal and operational waste management requirements. This may include expenditure on waste collection and disposal services, waste containers and equipment, staff training, contractor assurance activities, audit programmes and initiatives that support waste reduction, recycling and circular economy objectives.

6.3 Support Resource

Specialist advice and support are available from the Trust Sustainability Manager, Estates and Facilities teams, Health and Safety Team, Infection Prevention and Control Team, Procurement Services and appointed waste management contractors. Additional guidance is available through Trust procedures, WHTM 07-01 guidance and the Environmental Management System.

7. DEFINITIONS

Term	Definition
FFRESH	Facilities, Fire, Risk, Estates, Sustainability and Health & Safety.
Duty of Care	The legal responsibility to take all reasonable steps to manage waste safely from production to final treatment or disposal.
Waste hierarchy	The preferred order for waste management: prevention, reduction, reuse, recycling, recovery and disposal.
Segregation	The separation of waste at the point of production into the correct container, bag, bin or receptacle
Compliance obligations	Legal requirements and other requirements that the Trust must or chooses to comply with as part of its Environmental Management System.
Lifecycle consideration	Considering environmental impacts associated with activities, products or services from procurement and use through to disposal or end-of-life management.

8. IMPLEMENTATION / POLICY COMPLIANCE

The Trust will implement this policy through [communication, training, signage, guidance, intranet publication, audits, inspections, contractor controls and governance reporting.

Non-compliance may result in additional training or escalation through relevant governance routes.

9. MAIN RELEVANT LEGISLATION / STANDARDS

- Environmental Protection Act 1990
- Waste (England and Wales) Regulations 2011
- Hazardous Waste (England and Wales) Regulations 2005
- List of Waste (Wales) Regulations 2005
- Landfill (England and Wales) Regulations 2002
- Health and Safety at Work etc. Act 1974
- Environment (Wales) Act 2016
- Well-being of Future Generations (Wales) Act 2015

- Social Partnership and Public Procurement (Wales) Act 2023
- Planning (Wales) Act 2015
- The Waste Separation Requirements (Wales) Regulations 2023, where applicable to Trust waste arrangements
- ISO 14001:2015 Environmental management systems - requirements with guidance for use
- ISO 14001:2026 Environmental management systems - requirements with guidance for use
- WHTM 07-01: Safe and sustainable management of healthcare waste
- Welsh Government Towards Zero Waste strategy

10. MONITORING, AUDIT AND ASSURANCE

Monitoring activity	Lead	Frequency	Assurance route
Policy compliance	Site Managers / Operational Service Leads	Ad hoc	FFRESH / ISO14001 Management Group
Incident, fault or defect review	Trust Sustainability Manager / Energy and Environment Officer	Ad hoc	FFRESH / ISO14001 Management Group
Audit or inspection programme	Trust Sustainability Manager / Energy and Environment Officer	Annually	FFRESH / ISO14001 Management Group
Non-conformity and Corrective Action	Trust Sustainability Manager	Annually	FFRESH / Climate Action Board

11. IMPACT ASSESSMENTS

11.1 Equality Impact Assessment

11.2 Environmental Impact

The policy supports carbon reduction, resource efficiency and biodiversity enhancement in line with the Environment (Wales) Act 2016.

11.3 Well-being of Future Generations Act

- Long-term: supports Wales's goal of zero waste by 2050.
- Prevention: reduces waste at source and avoids pollution.
- Integration: aligns sustainability strategy and decarbonization.
- Collaboration: works with contractors, NHS Wales Shared Services and regulators.
- Involvement: engages staff, patients and communities in waste reduction initiatives.

12. REFERENCES

- BSI. ISO 14001:2015 Environmental management systems - requirements with guidance for use.
- BSI. ISO 14001:2026 Environmental management systems - requirements with guidance for use.

- NHS Wales Shared Services Partnership, Specialist Estates Services. WHTM 07-01: Safe and sustainable management of healthcare waste, 2025.
- Welsh Government. Towards Zero Waste: One Wales, One Planet.
- Welsh Government. Environment (Wales) Act 2016.
- Welsh Government. Well-being of Future Generations (Wales) Act 2015.

13. GETTING HELP

For support or further information, contact:

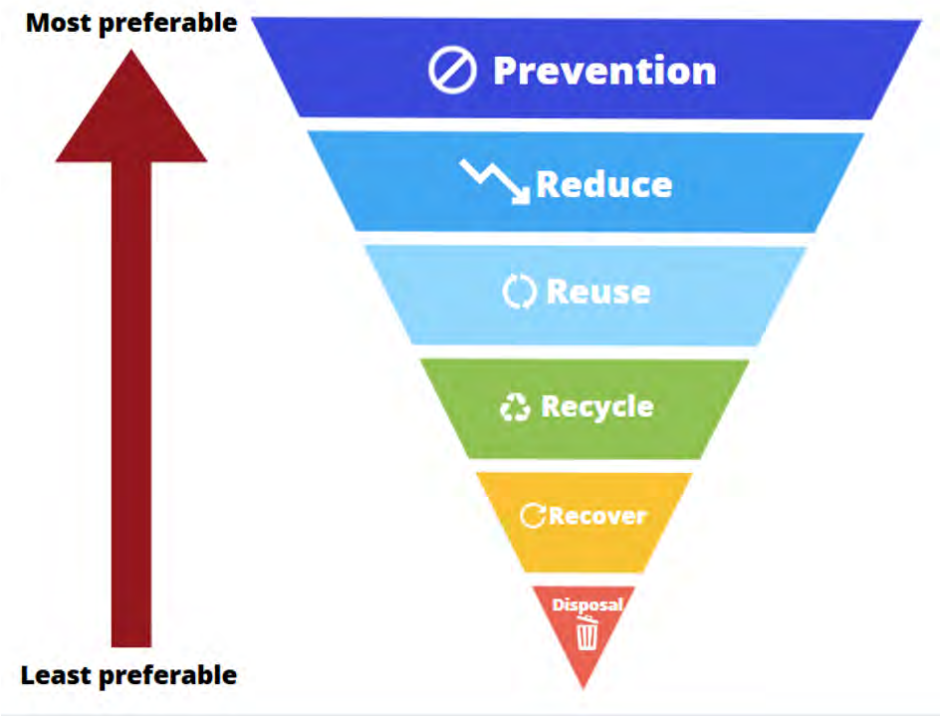
- Policy lead: Rhiannon Freshney – Trust Sustainability Manager
- Team: Sustainability
- Email: sustainability.velindre@wales.nhs.uk

14. RELATED POLICIES, PROCEDURES AND GUIDANCE

- BSI. ISO 14001:2015 Environmental management systems - requirements with guidance for use.
- BSI. ISO 14001:2026 Environmental management systems - requirements with guidance for use.
- NHS Wales Shared Services Partnership, Specialist Estates Services. WHTM 07-01: Safe and sustainable management of healthcare waste, 2025.
- Welsh Government. Towards Zero Waste: One Wales, One Planet.
- Welsh Government. Environment (Wales) Act 2016.
- Welsh Government. Well-being of Future Generations (Wales) Act 2015. .

15. APPENDICES

Appendix 1: Waste Hierarchy



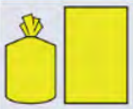
Appendix 2: Waste Segregation Charts

Colour	Description
Yellow	**Waste which requires disposal by incineration** Indicative treatment/disposal required is **incineration** in a suitably permitted or licensed facility.
Orange	**Waste which may be "treated"** Indicative treatment/disposal required is to be "rendered safe" in a suitably permitted or licensed facility, **usually alternative treatment plants (ATPs). However this waste may also be disposed of by incineration.**
Purple	**Cytotoxic and cytostatic waste** Indicative treatment/disposal required is **incineration** in a suitably permitted or licensed facility.
Yellow/black	**Offensive/hygiene waste*** Indicative treatment/disposal required is **landfill** or municipal **incineration/energy from waste** at a suitably permitted or licensed facility.
Red	**Anatomical waste for incineration**[1] Indicative treatment/disposal required is **incineration** in a suitably permitted facility.
Black	**Domestic (municipal) waste** Minimum treatment/disposal required is **landfill**, municipal **incineration/energy from waste** or other municipal **waste treatment process** at a suitably permitted or licensed facility. Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste.
Blue	**Medicinal waste for incineration**[1] Indicative treatment/disposal required is **incineration** in a suitably permitted facility.
white	**Amalgam waste** For **recovery**

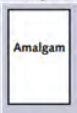
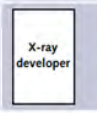
* The use of yellow/black for offensive/hygiene waste was chosen as these colours have historically been universally used for the sanitary/offensive/hygiene waste stream.

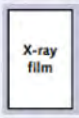
1. The colours "red" and "blue" are new to the colour-coding system in this edition. Care should be taken when ordering red containers to ensure that they can be clearly differentiated from orange. The colour-coding could be agreed as part of a contract specification.

Waste type	Waste receptacle	EWC code(s)[1]	Example description[2,4]	Example hazardous properties[2,4]	Primary transport class & UN number	Waste management requirements[4]	Additional comments
Domestic type waste	Black bag	20 03 01	Mixed municipal waste	None	N/A	Landfill Municipal incineration Energy from waste Other authorised disposal or recovery	Medical practices must not place any hazardous waste in this waste stream. Recycling options should be considered.
Offensive (healthcare)	Yellow and black striped bag	18 01 04 or 18 02 03	Offensive waste from human/animal healthcare	None	N/A	Landfill Municipal incineration Energy from waste Other authorised disposal or recovery	This is restricted to offensive wastes from healthcare and related activities (including autoclaved wastes from laboratories)
Offensive (municipal)		20 01 99	Offensive waste, municipal				This includes municipal hygiene wastes from medical practices
Anatomical waste (chemically preserved)	Red-lidded, rigid yellow container	18 01 06* and 18 01 03* and/or 18 01 02 or 18 02 05* and 18 02 02* and/or 18 02 03	Clinical waste, human/animal anatomical, chemical preserved, for incineration only	H3A or B, H4, H5, H7, H9	Class 6.2 UN 3291	Clinical waste incineration	**Note:** If the waste is not classified as infectious (18 01 03* or 18 02 02*) then: • tissue preserved in chemicals remains clinical waste and the transport requirements may be determined by the chemical preservatives, and • where not preserved in chemicals, tissue would not normally be clinical waste
Anatomical waste (not chemically preserved)		18 01 03* and/or 18 01 02 or 18 02 02* and/or 18 02 03	Clinical waste, human/animal anatomical, not chemically preserved, for incineration only	H9			

Waste type	Waste receptacle	EWC code(s)[1]	Example description[2,4]	Example hazardous properties[2,4]	Primary transport class & UN number	Waste management requirements[4]	Additional comments
Infectious waste contaminated with chemicals		18 01 03* and 18 01 06* and/or 18 01 07 or 18 02 02* and 18 02 05 and/or 18 02 06*	Clinical waste, infectious, containing chemicals from human/animal healthcare, for incineration only	H9, various	Class 6.2 UN 3291	Clinical waste incineration	**Note:** Waste chemicals must not be placed in this waste stream. It is for infectious materials containing or contaminated with chemicals (eg sample vials and used diagnostic kits)
Infectious waste (not containing chemicals or medicinal contamination)	Orange bag or Orange-lidded, rigid yellow container	18 01 03* or 18 02 02*	Clinical waste, infectious, from human/animal healthcare, suitable for alternative treatment	H9	Class 6.2 UN 3291	Alternative treatment or clinical waste incineration	This assumes healthcare offensive and domestic wastes are also segregated separately
Sharps, non-medicinally contaminated	Orange-lidded, yellow sharps box	18 01 03* or 18 02 02*	Clinical waste, sharps, infectious, non-medicinally-contaminated, suitable for alternative treatment	H9	Class 6.2 UN 3291	Alternative treatment or clinical waste incineration	For producers and disposal sites in England and Wales, sharps that are not contaminated with medicinal products only
		20 01 99	Clinical waste, sharps, infectious, non-medicinally contaminated, from non-healthcare activities suitable for alternative treatment				
Sharps, medicinally-contaminated, other than cytotoxic and cytostatic		18 01 03* and 18 01 09 or 18 02 02* and 18 02 08	Clinical waste, mixed sharps and pharmaceutical waste (not cytotoxic and cytostatic), infectious, for incineration only	H9, various[3]	Class 6.2 UN 3291	Clinical waste incineration	**Note:** This may include associated vials, bottles and ampoules of medicine

Waste type	Waste receptacle	EWC code(s)[1]	Example description[2,4]	Example hazardous properties[2,4]	Primary transport class & UN number	Waste management requirements[4]	Additional comments
Sharps, contaminated with cytotoxic and cytostatic medicines	Purple-lidded, yellow sharps box	18 01 03* and 18 01 08* or 18 02 02* and 18 02 07*	Clinical waste, mixed sharps and cytotoxic and cytostatic waste, infectious, for incineration only	H6, H7, H9, H10, H11, etc[3]	Class 6.2 UN 3291	Clinical waste incineration	**Note:** This may include associated vials, bottles and ampoules of cytotoxic and cytostatic medicines
Other infectious waste contaminated with cytotoxic and cytostatic medicines	Purple-lidded, rigid yellow container and sack		Clinical waste, cytotoxic and cytostatic waste, infectious, for incineration only				
Cytotoxic and cytostatic medicines (in original packaging)	Two purple-lidded, rigid yellow containers (one for solid, one for liquid)	18 01 08* or 18 02 07* and/or 20 01 31*	Clinical waste, cytotoxic and cytostatic medicines from animal/human healthcare for incineration only	H6, H7, H10, H11, etc[3] H6 H7 H10 H11	Class 6.1 UN 1851 UN 3248 and/or 3249[5]	Clinical waste incineration	20 01 31* is for separately collected municipal fractions (ie out-patient returns to pharmacies)
Cytotoxic and cytostatic medicines (not in original packaging)	Two purple-lidded, rigid yellow containers (one for solid, one for liquid)				Class 6.1 UN 1851 UN 3248 and/or 3249[5]		

Waste type	Waste receptacle	EWC code(s)[1]	Example description[2,4]	Example hazardous properties[2,4]	Primary transport class & UN number	Waste management requirements[4]	Additional comments
Other medicines (in original packaging)	Two blue-lidded, rigid yellow containers (one for solid, one for liquid)	18 01 09 or 18 02 08 and/or 20 01 32	Clinical waste, medicines (not cytotoxic and cytostatic) from animal/human healthcare, for incineration only	Various[3]	Limited quantity (or if in original packagings for patient use, exempt) – see 'Waste medicines (including amalgam waste)'	Clinical waste incineration	20 01 32 is for separately collected municipal fractions (ie out-patient returns to pharmacies)
Other medicines (not in original packaging)	Two blue-lidded, rigid yellow containers (one for solid, one for liquid)						
Dental amalgam	 Leak-proof rigid container with Hg suppressant	18 01 10*	Dental amalgam and mercury including spent and out-of-date capsules, excess mixed amalgam and contents of amalgam separators	H6, H9	Limited quantity	Recovery	Where teeth containing amalgam are present, H9: Infectious may also apply
Photographic (X-ray) wastes		09 01 04*	X-ray fixer	Various (see SDS)	Various (see SDS)	Recovery or treatment	
		09 01 01*	X-ray developer (water based)	Various (see SDS)	Various (see SDS)	Recovery or treatment	

Waste type	Waste receptacle	EWC code(s)[1]	Example description[2,4]	Example hazardous properties[2,4]	Primary transport class & UN number	Waste management requirements[4]	Additional comments
Photographic (X-ray) wastes (contd)		15 01 04	Lead foil	None	N/A	Recovery	
		09 01 07	X-ray film containing silver	None	N/A	Recovery	
Gypsum and plaster-cast wastes		18 01 04 or 18 02 03	Non-infectious gypsum and plaster waste from healthcare	None	N/A	Gypsum recovery or specialist landfill in separate gypsum cell	See supporting text under 'Gypsum and plaster casts' for advice on the small proportion of this material that may be infectious and clinical waste
Radioactive waste		18 01 03* or 18 02 02* if infectious	Healthcare waste contaminated with radioactive material	Radioactive H9 if infectious	UN number will depend upon isotope. Radioactivity takes precedence for transport class when above the lower threshold	Incineration in hazardous waste incineration facility subject to Radioactive Substances Act (RSA)	

Notes:

The information in this table should be used where the assessment framework in 'Healthcare waste definitions and classifications' has identified that it is applicable to the waste in question.

For non-infectious sharps that are not contaminated with either medicines or body fluids (ie 18 02 01 and 18 01 01), see 'Non-infectious sharps' under 'Step 4'.

1. An "and" indicates that more than one code is needed for this waste stream. An "or" means that the most appropriate code of the two codes joined by the "or" should be selected.
2. The hazardous properties and descriptions given here are examples only. The producer or holder of the waste should not use these without first ensuring they are accurate and appropriate for their waste. Where human/animal healthcare is indicated, the appropriate entry should be selected.
3. A cytotoxic and cytostatic medicine must possess one or more of the hazardous properties H6, H7, H10 or H11. In addition, they may possess a range of other hazardous properties. Other medicines may also possess hazardous properties, for example H3B Flammable, H4 Irritant, H5 Harmful, or H14 Ecotoxic. All relevant hazardous properties should be described and incompatible substances separated.
4. The waste must be disposed of, or recovered, at a suitably authorised facility.
5. The three entries are generic and will not be appropriate for all cytotoxic and cytostatic medicines. Some waste medicines will have to be classified in accordance with the provisions of ADR. In most cases a safety data sheet (SDS) for the medicines should show the appropriate transport classification. If this is not available, advice from a DGSA should be sought.

Electric Vehicle Charging Procedure

Velindre University NHS Trust

Procedure summary
This procedure sets out how Electric Vehicle Chargers are accessed, managed, maintained and monitored across Velindre University NHS Trust sites. It supports safe, fair and accountable use of Trust charging infrastructure for business fleet vehicles and staff personal vehicles, while supporting the Trust's sustainability and decarbonisation objectives.

Policy Title:	Electric Vehicle Charging Procedure
Policy Reference:	PP 17
Executive Sponsor & Function:	Director of Place, Portfolio & Partnerships
Function or Department:	FFRESH
Document Author:	Energy and Environment Officer
Consultation Groups:	FFRESH WBS Transport Finance
Approved by:	Performance and Finance Committee
Approval Date:	12/11/2026
Review Date:	November 2029

Equality Impact Assessment Date:	To be confirmed (awaiting sign off)
Status / Version:	Draft / Version 2.0

Version	Date	Author	Summary of changes
1.0	July 2026	Energy and Environment Officer	Initial draft created using the Trust EV Charging Protocol and FFRESH Procedure Proforma.
2.0	August 2026	Energy and Environment Officer	Edited following comments from FFRESH team.

1. INTRODUCTION

Velindre University NHS Trust (VUNHST) is committed to managing its environmental impact, reducing carbon emissions and supporting sustainable travel choices across its estate. Electric Vehicle (EV) Chargers are provided to support the transition to lower emission transport, complementing the Trust's Sustainability Implementation Plan, Decarbonisation Strategy and duties under the Well-being of Future Generations (Wales) Act 2015.

Vaylens charging infrastructure has been commissioned to support access to Trust EV chargers. The Trust may use associated software and reporting tools to control, monitor and monetise EV charging sessions, enabling transparent access, usage tracking and departmental recharging where applicable.

This procedure formalises the arrangements for access, use, management, payment, monitoring and maintenance of EV Chargers across applicable Trust sites. It replaces informal guidance with a clear Trust-wide procedure framework and should be read alongside any local site arrangements and operational user instructions.

As EV charging is an evolving service across the Trust, this procedure and supporting guidance may be amended following review of occupancy, staff usage, fleet demand, charger utilisation, tariff changes, maintenance learning or site-specific operational requirements.

The Trust will make EV charging facilities available where installed, but availability cannot be guaranteed for staff personal vehicles. Staff remain responsible for ensuring that suitable alternative travel and charging arrangements are available where required.

2. SCOPE OF PROCEDURE

This applies to all VUNHST staff, patients, donors, visitors, contractors and other authorised users who access, use or manage EV charging infrastructure owned by the Trust.

The procedure applies to:

- All EV charging infrastructure owned, managed or operated by the Trust, including chargers designated for business fleet vehicles and chargers available for personal use.
- Trust-owned, leased, pool and fleet electric vehicles using Trust charging facilities.
- Personal electric vehicles belonging to staff, patients, donors, visitors and authorised site users where use of Trust charging facilities is permitted.
- The management and operation of EV charging facilities, including Radio Frequency Identification (RFID) access cards, charging applications, tariffs, payment processes, usage monitoring, maintenance arrangements, fault reporting and local site management procedures.
- All Trust sites where EV charging infrastructure is installed or subsequently introduced.

This procedure sets out the conditions of use for Trust EV charging facilities and the responsibilities of all users. Access to EV charging facilities is provided on a best-endeavors basis and cannot be guaranteed. The Trust reserves the right to prioritise business-critical and fleet vehicles where operationally required.

Use of Trust charging facilities does not constitute an entitlement to a charging space or charging during working hours. Personal vehicle charging must be undertaken in accordance with the charging arrangements, tariffs and restrictions set out within this procedure. Fleet and business vehicles may be subject to separate operational arrangements where charging is required to support service delivery.

Out of the procedure scope is the EV chargers on the new Velindre Cancer Centre site because a final decision on their operation has not been made. The procedure will be updated to include their when nVCC is operational.

3. AIMS AND OBJECTIVES

3.1 Aims

The aim of this procedure is to ensure that Electric Vehicle Charging infrastructure is used safely, fairly, consistently and transparently across Trust sites.

3.2 Objectives

- Support Trust decarbonisation, air quality and sustainable travel objectives.
- Prioritise access for business fleet vehicles where chargers are designated for fleet use.
- Provide a clear process for staff personal use, including payment through the eCharge+ App.
- Ensure charging costs are accurately recorded and recharged to the relevant department where business fleet vehicles are charged.
- Maximise the safe charging of electric vehicles.
- Minimise misuse, damage, parking conflicts and operational disruption.
- Provide clear routes for fault reporting, maintenance, assurance and procedure review.

4. RESPONSIBILITIES

4.1 Chief Executive Officer

The Chief Executive Officer has overall accountability for ensuring that effective governance arrangements are in place for Trust policies and for meeting statutory and strategic sustainability commitments.

4.2 Director of Place, Portfolio & Partnerships

The Director of Place, Portfolio & Partnerships is the Executive Sponsor for this procedure and is responsible for ensuring that appropriate arrangements are in place for the management, funding, operation and assurance of Electric Vehicle Charging infrastructure across the Trust.

4.3 FFRESH

- Maintain this procedure and associated user guidance.
- Manage the Trust-wide process for charger access, tariff review, RFID card administration and fault escalation.
- Monitor charger usage data, including sessions, kWh consumed and fleet recharge information.
- Work with Site Leads, WBS Transport Leads, Finance and Information Governance to ensure appropriate governance, compliance and continuous improvement.
- Ensure departmental recharge costs are reviewed and processed where fleet RFID cards are linked to their vehicles.
- Ensure EV charging infrastructure is maintained, inspected and repaired in accordance with manufacturer requirements, statutory obligations and Trust procedures.
- Reduce risks to people, property, vehicles and Trust assets by promoting safe use of charging equipment, managing defects and faults, and implementing appropriate emergency and isolation procedures where required.

4.4 Site Managers

- Maintaining this procedure and associated user guidance.
- Managing the Trust-wide process for charger access, tariff review, RFID card administration and fault escalation.

- Monitoring charger usage data, including charging sessions, kWh consumed and fleet recharge information.
- Working with Site Leads, WBS Transport Leads, Finance and Information Governance to ensure appropriate governance, compliance and continuous improvement.
- Ensuring departmental recharge costs are reviewed and processed where fleet RFID cards are linked to their vehicles.
- Overseeing the maintenance, servicing and repair of Trust EV charging infrastructure, including liaising with suppliers, contractors and manufacturers to resolve faults and ensure chargers remain operational.
- Coordinating the reporting, investigation and resolution of charger faults, defects and performance issues, and maintaining appropriate records of maintenance activities.
- Managing EV charging facilities at site level and developing a Site EV Charging Statement where required (an example template is provided in Appendix 3).
- Determining local arrangements for charger access, booking systems, charging time limits, fleet vehicle priority and any temporary restrictions.
- Designating EV charging bays for the exclusive use of electric vehicles that are actively connected to and using the charging infrastructure, where required to support operational needs and maximise charger availability.
- Restricting or preventing the use of designated EV charging bays by non-EV vehicles and electric vehicles that are not actively charging, where specified within the Site EV Charging Statement.
- Communicating local EV charging arrangements and any site-specific restrictions to staff, patients, visitors and other authorised users.

4.6 All Users

- Use the correct access method for the vehicle being charged: RFID card for business fleet vehicles and eCharge+ App for personal vehicles.
- Follow all instructions displayed at the charger and within the app.
- Provide and use the correct charging cable for the vehicle and ensure charging equipment is used safely.
- Move the vehicle promptly once charging is complete or when requested by a Site Lead, where safe and practical to do so.
- Report faults, damage, unsafe conditions, lost RFID cards or access issues using the routes set out in this procedure.
- Never use a fleet RFID card for personal charging.

4.7 Contractors and External Partners

- Contractors and external partners may only use Trust charging facilities where authorised by the Trust and must comply with this procedure, local site rules and any contractual requirements.

5. REQUIREMENTS AND OPERATIONAL PROCEDURE

5.1 Charger allocation and prioritisation

Where chargers are installed at Trust sites, one charger or charging bay may be designated for business fleet use only. Fleet-designated bays will be clearly marked and must not be used by staff personal vehicles.

Where local infrastructure follows the current Trust installation model, there are two chargers at each VUNHST site, one charger at each applicable site is designated for business use only and will be clearly marked. Fleet-only chargers will not display will be activated by RFID card only.

Local site arrangements may be introduced to manage fair access, including booking systems, time limits, prioritisation rules, or temporary restrictions during periods of high operational demand.

5.2 Business fleet vehicle charging

1. Each business fleet vehicle will be issued with a unique RFID card where required.
2. The RFID card must be used to activate the charger for the assigned fleet vehicle.
3. Each RFID card will be linked to a specific vehicle registration number and associated department or service.
4. Charging data, including the number of sessions and kWh consumed, will be used to support monitoring and departmental recharging.
5. Fleet RFID cards must remain securely attached to the vehicle keys or stored with the vehicle in accordance with the local fleet arrangement.
6. Fleet RFID cards must not be shared, transferred or used for personal vehicle charging.

5.3 Staff personal vehicle charging

7. Staff must use the eCharge+ App to access chargers made available for personal use.

1. Staff must create and maintain their own eCharge+ account and enter their own payment details before charging.
2. Staff must scan the QR code on the appropriate charger, select the charger and pay for the charging session directly through the app.
3. Staff are responsible for ending the charging session correctly through the app and removing their vehicle when charging is complete.
4. The Trust cannot guarantee that charging will be available for personal vehicles at all times.
5. The eCharge+ App is a third-party platform. Staff use the app at their own discretion and are responsible for reviewing and accepting the provider's terms and conditions, privacy notice and payment arrangements.
6. The Trust is not responsible for the security, management or processing of personal or financial information entered into the eCharge+ App by users. Staff provide payment card details and any other personal information directly to the app provider at their own risk.
7. Any issues relating to app accounts, payment processing, personal payment details or data held within the eCharge+ App should be raised directly with the app provider in accordance with their support arrangements.
8. The Trust accepts no liability for losses arising from the use of third-party payment platforms, except where required by law.

5.4 Charging tariffs and payment

Charging tariffs will be based on the Trust’s average electricity tariff and may change over time in response to electricity costs, operating costs, maintenance costs or changes in charging provider arrangements.

Staff personal charging must be paid for directly by the user through the eCharge+ App. Business fleet charging will be recorded through RFID card usage and recharged to the associated department on a quarterly basis, unless an alternative agreed recharge timetable is approved by Finance.

5.5 Charging equipment and safe use

- Users must provide the correct charging cable for their vehicle.
- The Trust will not provide spare charging cables for personal vehicles.
- Users must not use damaged charging cables, adapters or equipment.
- Cables must be positioned to avoid trip hazards and must not obstruct roads, footways, emergency access routes or pedestrian routes.
- Any damage caused through misuse or incorrect use may be treated as damage to NHS property and may be investigated in line with relevant Trust procedures.
- Users must not use any charging cable, adapter, vehicle charging port or charging equipment that is damaged, defective, overheating, smoking, emitting unusual odours, or showing signs of battery or electrical failure. Charging must not take place where any such condition is present.

- Any concerns regarding fire, smoke, overheating, unusual odours, damage to a vehicle or charging equipment, or any suspected thermal event must be reported immediately and treated as an emergency. Users must follow the relevant site fire and emergency procedures and contact the appropriate emergency response or Estates team in accordance with local arrangements.

5.6 Faults, access issues and damage

Faults, failed charging sessions, RFID card issues, app issues, damaged equipment or unsafe conditions must be reported to the local Site Lead or Site Manager and to sustainability.velindre@wales.nhs.uk as soon as possible.

Urgent safety concerns must be escalated immediately through Estates Computer Aided Facilities Management System (CAFM) or site emergency arrangements. Users must not attempt to repair chargers, open equipment or bypass faults.

Any accident, injury, electric shock, near miss, fire, damage to equipment, vehicle collision or significant charging failure associated with EV charging facilities must be reported in accordance with Trust incident reporting arrangements.

5.7 RFID card administration

RFID cards will be issued to fleet or Trust EV where required. RFID cards must be registered to a vehicle and must not be shared or transferred without approval from the FFRESH team or agreed fleet administrator.

Lost, stolen or damaged RFID cards must be reported promptly. Replacement cards may incur a charge to the relevant department, depending on the circumstances and provider charges.

5.8 Data Management and Information Governance

The Trust may process charger usage data to operate the service, support billing, monitor utilisation, investigate misuse, identify faults and support sustainability reporting. Data may include RFID card identification number, charging session date and time, kWh consumed, cost information and associated department. No staff personal or vehicle information will be retained.

For fleet charging, data may be collated in a controlled spreadsheet or reporting extract showing vehicle information, unique RFID card identification number, number of sessions, units of energy used per session in kWh and associated cost. This information will be used to enable accurate cross-charging to the relevant department and to support operational monitoring.

Any personal data processed through the eCharge+ App will be managed in accordance with the charging provider's privacy notice, terms and conditions, and applicable data protection requirements. The eCharge+ App is a third-party platform and users are responsible for reviewing the provider's privacy arrangements before use. The Trust is not responsible for the collection, storage, processing, security or management of personal or financial information entered into the app by users, and staff use the app and provide payment details at their own risk. Trust-held data will be managed in accordance with Trust Information Governance policies, the UK General Data Protection Regulation (UK GDPR), and any applicable Data Protection Impact Assessment (DPIA).

6. DEFINITIONS

Term	Definition
Electric Vehicle (EV)	A vehicle powered fully or partly by electricity and capable of being charged from an external electricity supply.
RFID card	A Radio Frequency Identification card used to activate a charger for an authorised business fleet vehicle.

eCharge+ App	The mobile application used by staff to access and pay for personal charging sessions.
Fleet-designated charger or bay	A charger or parking space reserved for Trust business fleet vehicles.
Personal charging	Charging of a staff member's own vehicle, paid for by the individual through the app.
kWh	Kilowatt hour, the unit used to measure electricity consumed during a charging session.

7. IMPLEMENTATION / COMPLIANCE

The Trust will implement this procedure through communication with staff, local signage, user guidance displayed at chargers, publication on relevant Trust procedure channels and targeted briefing for fleet, site and departmental leads.

Non-compliance may include, but is not limited to, use of fleet RFID cards for personal charging, parking personal vehicles in fleet-designated bays, failure to pay for personal charging, sharing RFID cards, unsafe use of charging equipment or failure to report damage. Non-compliance may result in access being withdrawn and may be managed under relevant Trust procedures.

8. MONITORING, AUDIT AND ASSURANCE

Monitoring area	Lead	Frequency	Assurance route
Charger utilisation, sessions and kWh data	Sustainability Team	Quarterly	FFRESH
Fleet charging recharges	Sustainability Team, WBS Transpot and Finance	Quarterly	FFRESH
Faults, damage and maintenance issues	Site Leads / Estates	Ongoing	FFRESH
Procedure compliance and misuse trends	Procedure Lead	As required and annually	FFRESH

9. EQUALITY IMPACT ASSESSMENT

This procedure will be subject to an Equality Impact Assessment. The procedure is intended to provide a fair and transparent approach to the use of Trust charging facilities. Local implementation should consider accessibility, parking availability, shift patterns and staff working arrangements to avoid unintended disadvantage.

10. REFERENCES

- VUNHST Sustainability Implementation Plan.
- VUNHST University NHS Trust Decarbonisation Strategy.
- Well-being of Future Generations (Wales) Act 2015.
- Trust Information Governance and Data Protection policies.
- Trust Health and Safety policies and local Estates procedures.

11. GETTING HELP

For support and further information, contact the Sustainability Team: sustainability.velindre@wales.nhs.uk. Operational faults should also be reported to the relevant Site Lead or log a job on the Estates CAFM system.

12. RELATED POLICIES, PROCEDURES AND GUIDANCE

- EV Charging Protocol and Guidance.
- EV SOPs
- Local site parking arrangements and any site-specific booking process.
- Fleet management procedures and driver guidance.
- Health and Safety policies and incident reporting procedures.
- Information Governance and Data Protection policies.

13. INFORMATION, INSTRUCTION AND TRAINING

Staff and fleet users will be provided with appropriate information and instruction through charger signage, user guidance, communications, local briefings and links to provider guidance. Fleet users should be briefed on correct RFID use, safe use of charging equipment and reporting requirements.

Step-by-step guidance for using the chargers, including provider guidance, may be shared with staff and displayed at the chargers. Users are responsible for following the latest instructions displayed on the charger and within the app.

Provider guidance, including the eCharge+ App instructions, should be made available to staff where relevant and kept under review as provider processes or app screens change.

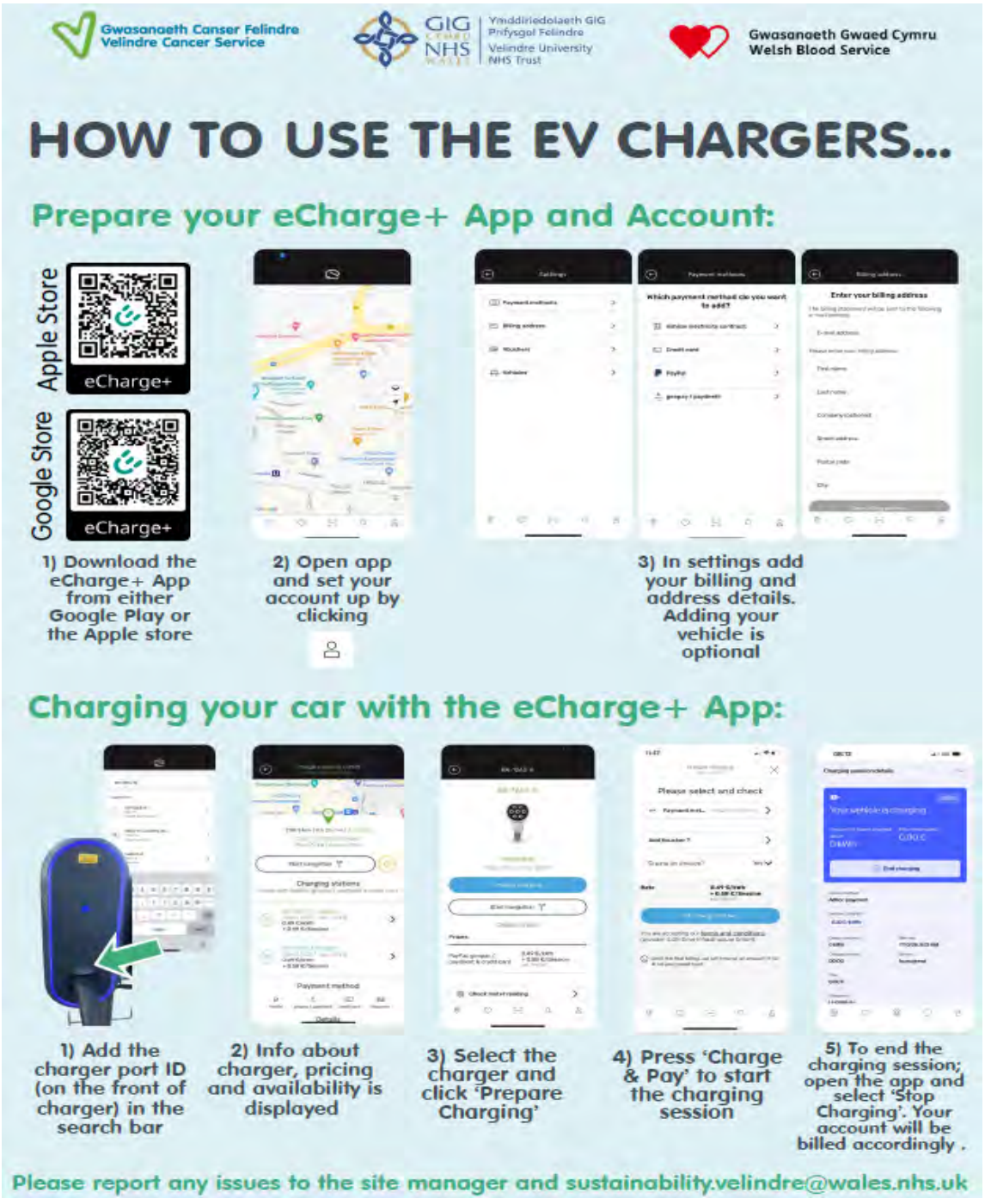
14. MAIN RELEVANT LEGISLATION / STANDARDS

- Well-being of Future Generations (Wales) Act 2015.
- Health and Safety at Work etc. Act 1974.
- Electricity at Work Regulations 1989.
- UK General Data Protection Regulation and Data Protection Act 2018.
- Equality Act 2010.
- Relevant British Standards and manufacturer instructions for electric vehicle charging equipment, where applicable.

15. APPENDICES

Appendix 1: User quick guide

User type	Correct process
Business fleet vehicle	Use the assigned RFID card linked to the vehicle. Do not use the card for personal charging. Return the card with the vehicle/keys as locally agreed.

Staff personal vehicle	Use the eCharge+ App, scan the QR code, add payment details, start and stop the charging session through the app and pay directly. 
Fault or access issue	Report to the Site Manager, log a job on the Estates CAFM system and email sustainability.velindre@wales.nhs.uk.

Appendix 2: Fleet RFID recharge process

1. RFID card is assigned to a specific vehicle registration and department.
2. Charging session data is exported or reviewed by the Sustainability Team.
3. Data is checked for vehicle, department, session count, kWh and cost.
4. Recharge summary is shared with Finance for departmental cross-charge on a quarterly basis, unless otherwise agreed.
5. Any anomalies are reviewed with the relevant Fleet Lead, Site Lead or department before recharge where necessary.

Appendix 3: Local site statement template

Sites may add a local statement confirming charger location, fleet-designated bay, booking arrangements, local escalation route, time limit expectations and any temporary restrictions. Local arrangements must be consistent with this Trust-wide

Appendix 3: Example Local Site EV Charging Arrangements Template

Note: This template is provided as an example to support sites in documenting local EV charging arrangements. Sites are not required to use this template and may develop their own local arrangements where necessary, provided they remain consistent with the Trust-wide Electric Vehicle Charging Policy.

Site Name

_____

Charger Locations

_____

Fleet Designated Charging Bays

_____

Access and Booking Arrangements

_____

Charging Time Expectations

_____

Reporting Faults and Issues

_____

Temporary Restrictions

_____

Additional Site Information

_____

Local Approval

Prepared by: _____

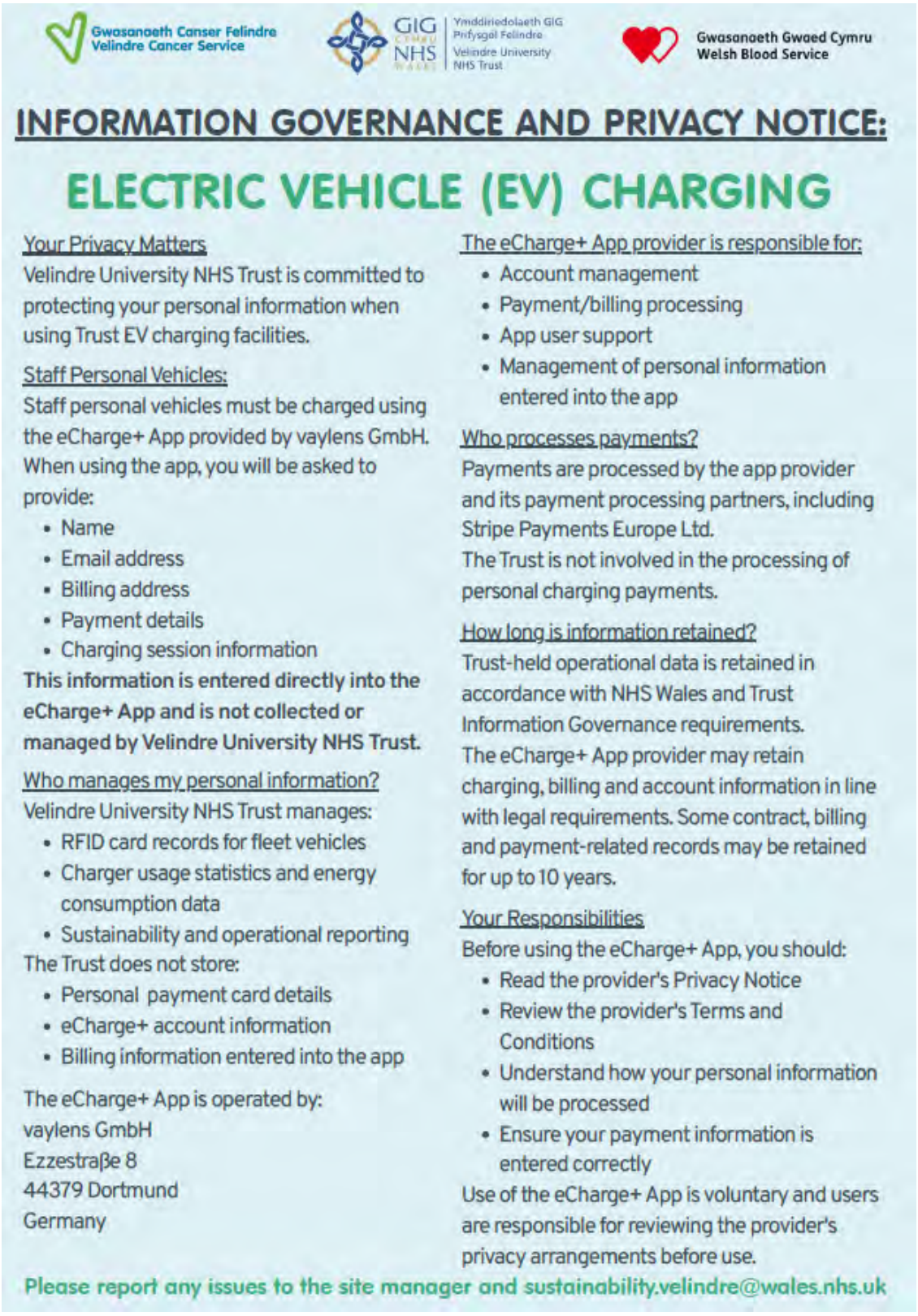
Position: _____

Date: _____

Review Date: _____

Sites may amend, replace or expand this template to meet local operational requirements. Any local arrangements must remain aligned with the Trust-wide Electric Vehicle Charging Policy and associated governance arrangements.

Appendix 4: Information Governance and Privacy Notice



Gwasanaeth Canser Felindre
Velindre Cancer Service

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Gwasanaeth Gwaed Cymru
Welsh Blood Service

INFORMATION GOVERNANCE AND PRIVACY NOTICE:

ELECTRIC VEHICLE (EV) CHARGING

Your Privacy Matters

Velindre University NHS Trust is committed to protecting your personal information when using Trust EV charging facilities.

Staff Personal Vehicles:

Staff personal vehicles must be charged using the eCharge+ App provided by vaylens GmbH. When using the app, you will be asked to provide:

- Name
- Email address
- Billing address
- Payment details
- Charging session information

This information is entered directly into the eCharge+ App and is not collected or managed by Velindre University NHS Trust.

Who manages my personal information?

Velindre University NHS Trust manages:

- RFID card records for fleet vehicles
- Charger usage statistics and energy consumption data
- Sustainability and operational reporting

The Trust does not store:

- Personal payment card details
- eCharge+ account information
- Billing information entered into the app

The eCharge+ App is operated by:
vaylens GmbH
Ezzestraße 8
44379 Dortmund
Germany

The eCharge+ App provider is responsible for:

- Account management
- Payment/billing processing
- App user support
- Management of personal information entered into the app

Who processes payments?

Payments are processed by the app provider and its payment processing partners, including Stripe Payments Europe Ltd.
The Trust is not involved in the processing of personal charging payments.

How long is information retained?

Trust-held operational data is retained in accordance with NHS Wales and Trust Information Governance requirements.
The eCharge+ App provider may retain charging, billing and account information in line with legal requirements. Some contract, billing and payment-related records may be retained for up to 10 years.

Your Responsibilities

Before using the eCharge+ App, you should:

- Read the provider's Privacy Notice
- Review the provider's Terms and Conditions
- Understand how your personal information will be processed
- Ensure your payment information is entered correctly

Use of the eCharge+ App is voluntary and users are responsible for reviewing the provider's privacy arrangements before use.

Please report any issues to the site manager and sustainability.velindre@wales.nhs.uk

Appendix 6: Equality Impact Assessment

(Awaiting approval from People and OD team)

EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	Electric Vehicle Charging Policy		
Manager	Ella Williamson, Energy and Environment Officer		
Date of meeting with OD Manager – ED&I			
Date of submission			
Date of next review			
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	Velindre University NHS Trust Electric Vehicle Charging Policy. The policy sets out how Trust EV charging infrastructure will be accessed, used, paid for, maintained, monitored and managed across applicable Trust sites.
1.2	Who owns it?	FFRESH / Estates and Sustainability, with executive sponsorship from the Director of Place, Portfolio & Partnerships. Operational input will be required from Site Managers, WBS Transport Leads, Finance, Information Governance and relevant service leads.
1.3	What is the aim of the change(s)?	To introduce a clear, fair and consistent Trust-wide policy for EV charging. The policy aims to support safe and appropriate use of chargers, prioritise business fleet requirements where needed, set out staff personal charging arrangements via the eCharge+ App, clarify payment and recharge arrangements, and support the Trust's sustainability and decarbonisation objectives.
1.4	Who is affected most by the change?	Staff using EV charging facilities for personal vehicles, Trust staff using fleet/business EVs, WBS Transport and fleet users, Site Managers managing local car park arrangements, and patients, donors or visitors where they are permitted to use Trust charging infrastructure. People who cannot access digital apps, card payment systems, or standard parking bays may be affected more and should be considered through implementation.
1.5	How does this topic fit into the wider context of the organisation?	The policy supports the Trust's wider decarbonisation, Trust Travel Pln, environmental management and estate management objectives. It also supports Welsh public sector duties around equality, fair access, sustainable development and responsible use of public resources.
1.6	Who is undertaking the EQIA	Ella Williamson, Energy and Environment Officer, with input from FFRESH team.
1.7	When will you start and end the EQIA?	Start: August 2026. End: following consultation and review before final policy approval. The EQIA should be refreshed after the initial implementation period or sooner if significant issues, complaints, provider changes or estate changes arise.

2.1	What data is available to help inform the EQIA?	Available information includes the draft EV Charging Policy, previous EV Charging Protocol and Guidance, charger location and access arrangements, planned use of RFID cards for fleet vehicles, eCharge+ App process for staff personal charging, feedback and enquiries from staff, local site knowledge, tariff and recharge proposals, Information Governance/DPIA discussions, and Trust sustainability/decarbonisation objectives.
2.2	What information is still needed?	Further information is needed on confirmed charger locations and bay layouts, whether any chargers will be made available to patients/donors/visitors, accessibility of charging bays, bilingual signage requirements, staff feedback following consultation, provider accessibility information for the eCharge+ App, and final Finance/IG approval of payment and data arrangements.
2.3	How will missing data be collected?	Missing data will be collected through policy consultation
2.4	What is considered relevant information and data?	Relevant information includes who can use chargers, how access is managed, whether payment and app-based access creates barriers, availability and location of charging bays, fleet priority requirements, bilingual and accessible communications, fault reporting arrangements, and any evidence of disproportionate impact on staff, patients, donors or visitors with protected characteristics or socio-economic disadvantage.

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

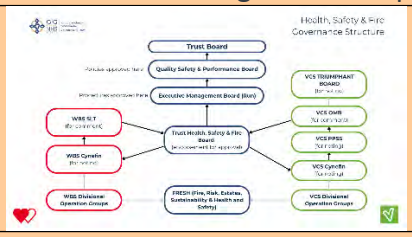
Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle-aged people* *Older people* *Other…*	☒	☒		Potential positive impact for staff, patients, donors and visitors who use electric vehicles, including older people who may benefit from convenient charging when visiting or working on site. Potential negative impact if app/payment processes are difficult for some users.	Ensure local parking arrangements are clear, charging bays are not used in a way that creates unfair access issues, and alternative parking remains available. Monitor complaints and feedback by site.
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*	☒	☒		Potential positive impact where charging bays support access for disabled EV users. Potential negative impact if bays are not physically accessible, are poorly located, require trailing cables, or if the app/payment process is not accessible to people with sensory loss, neurodiversity, learning needs or digital access barriers.	Review bay layouts, signage, lighting, cable management and app accessibility information. Provide clear alternative support routes for faults or access issues. Consider reasonable adjustments where issues are identified.
Gender re-assignment *Would this affect those in/post-transition differently?*			☒	No specific differential impact identified. The policy applies equally to all authorised users regardless of gender reassignment.	Use inclusive language in communications and ensure any consultation route is open to all staff and users.
Marriage or civil partnership			☒	No specific differential impact identified. The policy applies equally to all authorised users regardless of gender reassignment.	No additional action identified beyond monitoring feedback.

Are single people affected differently? *Are married people or civil partners treated differently?*					
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			☒		
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			☒		
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			☒		
Sex/Gender *Does it only apply to men / women?* *Could this affect one*			☒		

group more than the other?					
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			☒		
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*	☒	☒		Potential negative impact because EV ownership and app/card payment requirements may be less accessible to lower income groups, people without smartphones or people without payment cards. The policy could be perceived as a benefit for a limited group if access is not explained clearly.	Be clear that personal charging is paid by the user and not free. Review tariffs to recover costs while avoiding unnecessary barriers. Monitor use, feedback and complaints. Signpost that the policy supports fleet/business use and decarbonisation objectives, not preferential parking.
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?* *1. Does the subject treat the Welsh language less favourably than the English language?*	☒			Positive impact where key information, signage and staff communications are available bilingually. The policy should not treat Welsh less favourably than English.	Ensure final communications, signage and key user guidance are available bilingually where required, and that Welsh language requirements are considered before launch and during future changes.

2. Have you considered the Cultural opportunities / Promotion of the project? E.g. literature / Visual art representing Welsh artists *3. Are you assured that all aspects of this project / policy etc has considered the needs of Welsh speakers?* *If yes, identify the specifics If no, state what should be included.*					

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	
4.3	Could be policy be implemented in a different way to avoid negative impact?	
4.4	How will this change promote equality of access and equality of opportunity?	
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	
5.1	What do you have so far?	The draft policy is available and has identified key areas for consideration: staff personal charging via eCharge+ App, fleet RFID charging, departmental recharges, local site management, fault reporting, maintenance

		responsibilities, IG/DPIA considerations and Finance arrangements.
5.2	Have any themes emerged?	Emerging themes include the need for fair access, clear payment arrangements, fleet prioritisation, accessibility of bays and app-based access, bilingual signage and guidance, clear fault reporting, and a need to monitor whether charger access creates unintended parking or socio-economic impacts.
5.3	What do people have to say about our work?	Initial feedback has included staff interest in using EV chargers and the need to resolve governance, payment and DPIA/provider issues before wider use. Further comments will be gathered through consultation before final approval.
5.4	How will you consult widely on your topic?	Consultation will be carried out through circulation of the draft policy to relevant stakeholders and governance process.
5.5	Who will you consult with?	
5.6	How long will the consultation stage last?	1 week from the date of each meeting stated above
6.1	The action plan must appropriately evidence the decision for one of the following policy options:1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	
6.2	What will you do with the comments or information you have gathered from your consultations?	Comments and information gathered will be reviewed by the policy lead. Relevant amendments will be incorporated into the policy, supporting guidance, signage, communications, local arrangements and implementation plan. Any unresolved issues will be escalated through the relevant governance route.

6.3	How did the consultation help guide new policy?	Consultation will help confirm whether the policy is clear, whether access arrangements are fair and workable, whether there are barriers for disabled users or digitally excluded users, and whether local site arrangements require amendment before launch.
6.4	Will you make any changes to the draft report you produced?	Yes. The draft policy may be amended to strengthen scope, responsibilities, staff personal charging and third-party app wording, Finance/recharge arrangements, accessibility considerations, Welsh language requirements and monitoring arrangements.
7.1	Confirm actions	
8.1	Establish timetable for reviewing actions and refreshing the assessment	

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
2				
3				

Strategic Alignment

	Future Generations Act Wellbeing Objectives	Links to Objective
1	A prosperous Wales	☒
2	A resilient Wales	☒
3	A healthier Wales	☒
4	A more equal Wales	☒
5	A Wales of more cohesive communities	☒
6	A Wales of vibrant culture and thriving Welsh language	☒
7	A globally responsible Wales	☒

Double-click to add your signature below:	Double-click to add signature below:
X Lead Officer	X Equality & Diversity Manager

Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

TRUST BOARD		
ASSURANCE REPORT FROM THE SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC) MEETING HELD ON 15 SEPTEMBER 2026		
DATE OF MEETING	26 November 2026	
STATUS	Public	
REPORT AUTHOR	Roxann Davies, NWSSP Corporate Services Manager	
PRESENTED BY	Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services	
REPORT SPONSOR	I, Alison Ramsey, confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	09/11/2026	Shared Services Partnership Committee (SSPC) Committee Members (by email)
ONWARD SCRUTINY ROUTE	This Assurance Report has been sent to all SSPC Members for cascading to their respective organisations' Board, for noting and assurance purposes.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	To provide the Trust Board with assurance that key controls are in place.	
EXECUTIVE SUMMARY	This paper has been prepared to provide the Trust Board with details of the key issues considered by the Shared Services Partnership Committee, at its meeting on 15 September 2026.	
ACTION / DECISION	The Trust Board is asked to **NOTE** the contents of the Assurance Report.	
ADDITIONAL RESOURCES	Not Applicable.	
RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):		
This section is not applicable, as NHS Wales Shared Services Partnership (NWSSP) is a hosted organisation.		

QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:		
There are no quality and safety implications identified from the activities outlined in this highlight report.		
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.		
Status: QIA not required - not a strategic decision		
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)		
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report		
APPENDICES	**Appendix no.**	**Appendix title**
	Appendix 1	Shared Services Partnership Committee (SSPC) Assurance Report 15 September 2026

1. SITUATION

1.1 To provide the Trust Board with details of the key issues considered by the Shared Services Partnership Committee, at its meeting on 15 September 2026, for **NOTING**.

2. BACKGROUND

2.1 A summary of the business matters discussed at the last Shared Services Partnership Committee meeting, is outlined in Appendix 1.

3. MATTERS FOR CONSIDERATION

3.1 FINANCIAL IMPLICATIONS

3.1.1 Not applicable.

3.2 LEGAL IMPLICATIONS

3.2.1 Not applicable

3.3 PEOPLE IMPLICATIONS

3.3.1 Not applicable

3.4 WELSH LANGUAGE IMPLICATIONS

3.4.1 Not applicable

3.5 RISKS / REPUTATIONAL IMPLICATIONS

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

Not Applicable

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to **NOTE** contents of the Shared Services Partnership Committee Assurance Report for 15 September 2026.

ASSURANCE REPORT
NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Services Partnership Committee (SSPC)**
Chaired by	Dr Susan Barnes, Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager
Date of Meeting	15 September 2026

Summary of key matters including achievements and progress considered by the Committee and any related decisions made

Managing Director's Update Report – The Managing Director presented an update on key NWSSP developments since the previous meeting, with particular focus on two strategic programmes: Transforming Access to Medicines Service (TrAMS) and the Future Workforce Solution (FWS). The report highlighted continued focus on major programmes, operational resilience and partnership delivery, with the Committee receiving assurance on progress and key dependencies. The Committee emphasised the need for continued Senior Leadership Group oversight of programme delivery, workforce capacity, funding and system resilience through established governance arrangements.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Update Report.

Items for Approval

NWSSP Fleet Modernisation Programme Annual Business Justification Case 2026-27 – The Committee considered the Year 2 Business Justification Case and an associated capital funding request of £1.290m, excluding VAT, to replace 22 fleet vehicles during the next financial year. The proposal forms part of the wider 10-year Fleet Modernisation Programme and comprises five Battery Electric Vehicles and 17 Plug-in Hybrid Electric Vehicles. Members noted that this mix reflects route requirements, vehicle range, charging infrastructure and service-continuity considerations, particularly for rural routes and the transportation of high-value and temperature-sensitive products. The fleet optimisation review will also consider the future ownership and managed-service model, opportunities for greater national collaboration and liaison with Welsh Ambulance Services University NHS Trust.

The Committee **APPROVED** the Year 2 Business Justification Case and associated request for capital funding of £1.290m, excluding VAT, prior to submission to Velindre Trust Board and Welsh Government.

Items for Noting

All Wales Finance and Procurement System Replacement - The Committee received an update on the procurement of a new Oracle Financial Managed Service (FMS) contract, which underpins finance, procurement and warehouse management services across NHS

Wales and is managed by NWSSP on behalf of Health Boards, Trusts and Special Health Authorities. Members noted that the current managed service contract expires on 31 March 2028, with no further extension options available, and that the approved procurement roadmap is being progressed to maintain continuity of a compliant national finance and procurement system. Assurance was provided that the Oracle upgrade to version 12.2.15 was successfully completed in July 2026 and that market engagement will now be undertaken to test supplier interest, specification deliverability and commercial models ahead of the formal procurement process.

The Committee **NOTED** the Briefing Paper and that the contract award will be presented for consideration once the procurement process has concluded.

Future Workforce Solution (People Portal Update) – The Committee received an update on the Future Workforce Solution, now branded as Porth Pobl GIG Cymru / NHS Wales People Portal, which will replace the current Electronic Staff Record system with a modern cloud-based workforce platform supporting the full employee lifecycle. The Electronic Staff Record service transferred successfully from IBM to Infosys on 1 September 2026, and the overall programme remains scheduled for completion by December 2030. However, the Early Adopter phase has been re-planned to February 2028, compressing the later delivery timetable, and future funding arrangements will be a matter for the Welsh Government to consider. A formal request has also been submitted to move the proposed NHS Wales go-live from February to the end of March 2028, avoiding financial year-end crossover and the parallel operation of two systems; a response remains outstanding. Although the NHS Business Services Authority continues to classify the programme as green, the Committee concluded that unresolved funding, resource requirements, organisational capacity and compressed timescales warranted a more cautious assurance position and continued oversight.

The Committee **NOTED** the Future Workforce Solution (People Portal) update.

Strategic Equality Plan Biannual Update - The Committee received the biannual update on NWSSP's Strategic Equality Plan development, following Welsh Government feedback on the May 2026 self-assessment, which was deferred from the July meeting. Members noted that Welsh Government agreed NWSSP's overall and workforce self-assessment scores at level 3, recognising strong governance, engagement, partnership arrangements and early progress on equality data, while assessing access and experience at level 2 due to the need for stronger evidence of how stakeholder feedback informs strategic decision-making. Assurance was provided on the actions being taken to address the feedback.

The Committee **NOTED** the current status of NWSSP's progress in developing its Strategic Equality Plan and the actions being taken to address Welsh Government feedback.

Workforce Equality Standard Update - The Committee received an update on NWSSP's Workforce Equality Standard (WES) report, which has replaced the Workforce Race Equality Standard from 2026 and is intended to support more targeted workforce equality improvement. Members noted that the initial Welsh Government report received in July

2026 did not accurately reflect NWSSP's position because of limitations relating to Single Lead Employer (SLE) staff survey participation and appraisal data. Assurance was provided that the agreed approach with Welsh Government and Health Education and Improvement Wales will provide an interim 2026 report for non-SLE colleagues and, from 2027, separate reporting for SLE and non-SLE staff using more appropriate data sources, including General Medical Council (GMC) National Training Survey data and appraisal information held by Health Education and Improvement Wales.

The Committee **NOTED** the current status of NWSSP's WES report and the agreed actions to address the identified data limitations.

Decarbonisation and Adaptation Update - The Committee received the biannual update on NWSSP's Adaptation and Decarbonisation progress to July 2026. Members noted that the overall programme was rated green, with 23 of 25 initiatives either delivered or progressing to plan. The Programme Board had challenged the underlying risk assessments to ensure that reporting was not overly optimistic, resulting in further review and strengthening assurance over the reported position. Progress highlighted included sustainable transport plans for the IP5 and Matrix House sites, increased procurement spend covered by carbon reduction plans, 16 additional electric vehicle charging points at Matrix House and the low-vision equipment initiative developed through the Cooler Climate Challenge. The Committee also noted that the Climate Response Plan would be presented at its next meeting for approval.

The Committee **NOTED** the biannual update on NWSSP's Adaptation and Decarbonisation progress.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee received the Finance Report as at 31 July 2026, noting a year-to-date surplus of £1.275m, primarily driven by pay underspends linked to vacancies being held, recruitment challenges and delays in backfilling posts. Members noted that, while the position remains positive at this stage, material risks remain within the financial plan, including unconfirmed funding for Electronic Prescribing, Future Workforce Solution implementation support, Radiopharmacy transitional costs and energy and fuel price pressures. Assurance was provided on the capital position, Welsh Risk Pool expenditure and key financial performance indicators, alongside continued grip and control actions, zero agency usage and work with Service Directors to identify recurrent and non-recurrent savings opportunities for NHS Wales.

People and Organisational Development Report – The Committee received the People and Organisational Development Report as at 31 July 2026, noting areas requiring continued Executive and divisional focus, including sickness absence above target in several divisions, mandatory and non-mandatory learning compliance, Professional Appraisal and Development Review (PADR) compliance, resourcing control and corporate induction compliance, which stood at 56.90%. Members welcomed the separate presentation of Single Lead Employer (SLE) data, which provided clearer visibility of issues affecting the resident doctor population, including training and sickness-management

compliance. It was noted that work would be progressed during the autumn with health boards to refresh Employment Management Agreements (EMAs) and examine the SLE data in greater detail. Members also noted activity to strengthen employee experience including preparations for the NHS Wales Staff Survey, Employee Recognition Award nominations, the Supporting You roadshow, increased engagement with Work in Confidence and wider diversity, inclusion and wellbeing activity. The assurance focus remains on sustained Senior Leadership Group and divisional action to address underperformance while maintaining focus on the moments that matter for staff.

Performance Information Report – The Committee received the Performance Information Report for April to July 2026. One key performance indicator did not meet target: in-year procurement savings excluding pharmacy were £6.3m against the July year-to-date target of £8m, owing to delays in planned contracts. Assurance was provided on mitigating actions to address this variance. Overall performance remained positive, with most reported indicators achieving target in July, the All-Wales Time to Hire target continuing to be met for more than 12 months, and professional influence benefits reaching £115m at the end of July, demonstrating the continued value delivered by NWSSP across NHS Wales.

Outcome Measures Report – The Committee received the Outcome Measures Report for July 2026, noting that the report has been refreshed to align with the four strategic objectives set out in the 2026-29 Integrated Medium-Term Plan (IMTP). Members noted strong performance across key service areas, positive trajectories in employee satisfaction and professional influence benefits, and continued contribution to decarbonisation and the foundational economy. Assurance was provided that Voice of the Customer feedback is now incorporated more directly within the Our Partners section, with organisational-level data being developed where possible to improve transparency and relevance, and that the format will continue to evolve with further measures and trend analysis during the year.

Transformation Management Office (TMO) Update Report – The Committee received an update on the current transformation and service improvement portfolio supported by the Transformation Management Office (TMO), comprising 30 active schemes and a further 10 schemes now closed. Members noted that 37% of the current portfolio is All-Wales in scope and 63% is NWSSP-focused, reflecting both partnership-wide delivery and internal service modernisation priorities. Key areas requiring continued oversight include Transforming Access to Medicines (TrAMS), which remains red overall due to delivery and timing risks; Welsh Risk Pool Assurance, which has moved to amber; and a number of amber-rated schemes including IP5 Power Resilience, Low Vision Equipment Feasibility, Primary Care Workforce Intelligence System (PCWIS) Professional Registration and Surgical Materials Testing Laboratory (SMTL) IT Modernisation. The assurance focus remains on continued delivery discipline, active risk management, benefits realisation and appropriate escalation where dependencies sit outside NWSSP's direct control.

Integrated Medium-Term Plan (IMTP) Quarter 1 2026-27 Update – The Committee received the Quarter 1 position against the 2026-27 Integrated Medium-Term Plan (IMTP) objectives, noting strong overall delivery with 91% of objectives completed or on track. Members noted that 13 objectives required escalation or mitigation, comprising two off

track, five at risk of becoming off track and six off track due to external factors. The report highlighted progress across the 140 objectives within the plan, including digital transformation, workforce, operational efficiency, strategic partnerships, sustainability and resilience. Assurance was provided that additional scrutiny has been applied through the quarterly review process to objectives off track or at risk, with targeted actions identified for Quarter 2.

NWSSP Corporate Risk Register – The Committee received the NWSSP Corporate Risk Register. The current profile comprises 16 Risks for Action: eight red-rated, seven amber-rated and one yellow-rated. The principal red-rated risks relate to cyber security; pharmaceutical supply resilience; Transforming Access to Medicines (TrAMS) and Radiopharmacy delivery; pharmacy workforce capacity; the Future Workforce Solution; and Welsh Risk Pool forecast accuracy. No new risks had been escalated since the previous meeting. The Student Streamlining Programme risk had reduced and moved to monitoring, while the COVID-19 Inquiry risk had closed following publication of the Module 5 report. The Senior Leadership Group continues to review the overall risk profile, focusing particularly on material risks affected by external dependencies, workforce capacity, programme funding or system resilience. Members were reminded that risk appetite was scheduled to be discussed as part of the SSPC Development Session on 9 October.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Items for Information

The Committee received the following items for information: Finance Monitoring Returns for Months 3 and 4 of 2026-27; Personal Protective Equipment (PPE) Dashboard; NWSSP Audit Committee Assurance Reports from 15 June 2026 and 7 July 2026; Shared Services Partnership Committee (SSPC) Forward Plan 2026-27; and Annual Reports 2025-26 for NWSSP Information Governance and the Welsh Infected Blood Support Scheme.

Part B – Private

Deep Dive Presentation - The Committee received and **NOTED** a detailed presentation on Cyber Resilience within NWSSP. Members were briefed on the current cyber resilience position, areas of ongoing risk and the controls in place to support service continuity, operational resilience and protection of critical systems. The discussion reinforced the importance of continued Senior Leadership Group oversight, active risk management and sustained investment in cyber resilience as a key organisational and partnership-wide assurance priority.

The Committee discussed and **AGREED** proposals relating to:

1) Motor Fleet Insurance – Year 4 NWSSP Health Courier Services
2) Dispatch and Logistics Software for Health Courier Services
3) Provision of Cleaning and Security Services
4) All Wales Supply of Energy (Gas and Electricity)

Matters requiring Board/Committee level consideration and/or approval	
The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Date of Next Meeting	Thursday 19 November 2026, 10.00am to 12.00pm

TRUST BOARD		
HIGHLIGHT REPORT FROM THE VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP AUDIT COMMITTEE) MEETING HELD ON 13 OCTOBER 2026		
DATE OF MEETING	26 November 2026	
STATUS	Public	
REPORT AUTHOR	Carly Wilce, NWSSP Corporate Services Manager	
PRESENTED BY	Gareth Jones, Chair of NWSSP Audit Committee	
REPORT SPONSOR	I, Gareth Jones confirm that – as the report sponsor – I have reviewed this report and approve it for publication.	
SCRUTINY ROUTE TO DATE	**Date**	**Report considered by committee/group**
	26/11/2026	Formal Senior Leadership Group
	19/11/2026	Shared Services Partnership Committee
ONWARD SCRUTINY ROUTE	Submitted to the Trust Board for noting.	
PURPOSE OF THE REPORT	FOR ASSURANCE - Level 7 - BLUE (Evidence of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months)	
	To provide the Trust Board with assurance that key controls are in place.	
EXECUTIVE SUMMARY	This paper provides the Trust Board with a summary of the key issues considered by the NWSSP Audit Committee at its meeting held on 13 October 2026.	
ACTION / DECISION	The Trust Board is asked to: • **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 13 October 2026.	
ADDITIONAL RESOURCES	Not Applicable	

RELEVANT TRUST STRATEGIC GOALS This report addresses the following goal(s) within the Trust's strategic plan:
• Outstanding for quality, safety, and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development, and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all • A sustainable organisation that plays its part in creating a better future for people across the globe
RELEVANT TRUST WELLBEING GOALS This report addresses the following wellbeing goal(s):
• A Prosperous Wales • A Resilient Wales • A Healthier Wales • A More Equal Wales • A Wales of more Cohesive Communities • A Wales of Vibrant Culture and Thriving Welsh Language • A Globally Responsible Wales
QUALITY AND SAFETY IMPLICATIONS This report impacts one or more of the following Six Domains of Quality:
• Safe • Timely • Equitable • Efficient • Effective • Patient Centred
QUALITY IMPACT ASSESSMENT (QIA) A completed and signed QIA must be attached for all reports requiring a strategic decision.
Status: QIA not required - not a strategic decision
EQUALITY, DIVERSITY, AND INCLUSION IMPLICATIONS - Equality Impact Assessment (EQIA)
Status: Not required - There are no specific equality, diversity or inclusion impacts related to the activity in this report

APPENDICES	Appendix no.	Appendix title
	Appendix 1	Key Considerations

APPENDIX 1 – KEY CONSIDERATIONS

1. SITUATION

1.1 To provide the Trust Board with details of the key issues considered in Part A by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) at its meeting held on 13 October 2026, for noting.

2. BACKGROUND

2.1 The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee) provides assurance to the Shared Services Partnership Committee (SSPC) on matters delegated to it through the Trust's and NWSSP's Standing Orders. A summary of the business considered at the meeting held on 13 October 2026 is set out below.

3. MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for **alert/escalation** to the Board.
ADVISE	There were no matters for **advice/escalation** to the Board.
ASSURE	**Managing Director's Update** The Managing Director provided a comprehensive update on developments across NWSSP. Key updates include: • Governance and accountability arrangements: the review found arrangements to be fundamentally sound, with minor clarification required in some areas and most recommendations implemented. The Welsh Government (WG) Working Group was expected to conclude in November 2026, followed by a closure report to the Shared Services Partnership Committee and NWSSP Audit Committee. • Finance: Month 5 position showed a £1.6m year-to-date surplus. Welsh Risk Pool pressures remained, although the 2026/27 requirement had reduced by £40m and would be reflected at Month 6. Capital expenditure remained on plan. • TrAMs/Radiopharmacy: the South-East Radiopharmacy project had been completed. Its proposed January 2027 launch remained subject to validation inspections and licensing. Separately, the approved South-East Hub Final Business Case had been submitted to WG. • Future Workforce Solution: rebranded as NHS Wales PeoplePortal, with launch expected in February 2028. Clarification of the funding model remained outstanding, with WG having confirmed the first two years of funding requirements.

	• Covid Inquiry Module 5: NWSSP was working with WG to implement learning from the UK-wide recommendations on PPE procurement and strengthen readiness for a future pandemic. • Shared Services Partnership Committee Development Day: the event generated positive discussion on NWSSP's role in supporting NHS Wales, with outcomes informing the 2027/28 IMTP and future years.
ASSURE	**Audit Wales Update** Audit Wales reported that the NWSSP assurance work for 2025/26, undertaken to support NHS external audits, was complete and had provided positive assurance to auditors across other NHS organisations. No issues were identified, and Audit Wales thanked NWSSP colleagues for their co-operation during the audit.
ASSURE	**Audit Wales Management Letter** Audit Wales presented the Management Letter, which confirmed that NWSSP financial processes were materially sound for 2025/26. No issues or recommendations were identified for the third consecutive year. Audit Wales also outlined planned work on the overall assurance arrangements for clinical negligence and Welsh Risk Pool reporting during 2026/27, with fieldwork scheduled for January 2027. An update on this work would be presented at the next meeting scheduled on 9 February 2027.
ASSURE	**Nationally Hosted NHS IT Systems Report** The report confirmed that financial values produced by NWSSP-hosted systems for 2025/26 were free from material misstatement. Eight recommendations were made to strengthen controls, with good progress reported against prior-year recommendations. Management confirmed that actions due by 31 October 2026 remained on track.
ASSURE	**Internal Audit Progress Update** The Head of Internal Audit reported that two reviews had been finalised since the previous meeting and were presented on the agenda. A draft Accounts Payable Services report had been issued, while Payroll Services and other audits remained in progress. An audit of Speaking Up Safely had been agreed as the replacement for the deferred ESR replacement audit.
ASSURE	**Internal Audit Reports** The NWSSP Audit Committee received two Internal Audit reports: • Primary Care Services Electronic Prescribing Smartcard Access: an advisory review identified three observations to support development of the assurance framework. A working group had been established to address the associated

	actions by 31 December 2026, with work underway with DHCW to document end-to-end access arrangements. • NWSSP Grip and Control Arrangements: the review provided Substantial Assurance that the self-assessment was comprehensive, accurate, evidence-based and reflective of practice. No management actions were agreed.
ASSURE	**Counter Fraud Progress Update Q2** The NWSSP Counter Fraud Manager presented the Counter Fraud Update for Q2. Key points to highlight include: • 95 days delivered against the annual plan of 212 days as at 30 September 2026; • four new investigations received during the quarter, two cases closed and six investigations ongoing at quarter-end; • fraud awareness sessions delivered to 138 staff, with e-learning completion increasing from 52.05% to 59.61%; and • Procurement training completed by 428 of 850 staff, with alternative and bespoke face-to-face provision being progressed for colleagues with limited computer access.
ASSURE	**Financial Control Procedures 3 and 4** The NWSSP Audit Committee considered refreshed procedures relating to capital investment and the monitoring of capital expenditure. The updates incorporated learning from the Internal Audit review of Radiopharmacy and reflected revised job titles, roles and internal decision-making groups. The procedures aligned with Velindre University NHS Trust financial policies and had been shared with the Velindre Finance team for comment. The NWSSP Audit Committee **APPROVED** Financial Control Procedures 3 and 4.
ASSURE	**Losses and Special Payments 2026-27 Q1** The NWSSP Audit Committee considered the losses and special payments report and the associated Annex 3 checklists before submission to WG for formal approval. The report included the prior-year comparison previously requested by the Committee. The Committee discussed anticipated PPE write-offs arising from the requirement to retain FFP3 and facial visor stock equivalent to 12–16 weeks of exceptional COVID-19 demand. Management confirmed that alternatives to disposal would continue to be explored, including earlier sale while stock retained usable shelf life. All disposals were discussed with WG in advance, with regular monitoring and reporting of remaining shelf life. Write-offs were expected to peak in 2026/27 as FFP3 stock purchased in 2021 reached the end of its five-year shelf life. The NWSSP Audit Committee **NOTED** the report and supported submission of the associated checklists to Welsh Government for approval.

ASSURE	**Governance Matters** The NWSSP Audit Committee received an update on contracting and governance activity since the previous meeting. Key points included: • 36 contracts were let by NWSSP during the reporting period, three of which were not progressed in accordance with Standing Orders and Standing Financial Instructions; • 14 All-Wales contracts were at briefing stage and eight at procurement outcome stage; 11 contract extensions had been utilised; • one declaration relating to gifts, hospitality and sponsorship was reported; and • a nil return had been submitted to WG for Q2 in relation to audit reports receiving Limited or No Assurance; • 122 of the 129 audit recommendations had been implemented, with the remaining seven not yet due; • the NWSSP Corporate Risk Register recorded eight red, seven amber and one yellow risk requiring action. A deep dive discussion on the PeoplePortal will take place at the next meeting in February. The NWSSP Audit Committee received assurance that robust governance, control and risk management arrangements are operating effectively across NWSSP.
ASSURE	**Fighting Fraud Strategy for NHS Wales** The NWSSP Audit Committee received the refreshed Fighting Fraud Strategy for NHS Wales. The update included collaborative work to deliver the strategy objectives, sharing good practice across Local Counter Fraud Services, progression of a data analytics service-level agreement with the NHS Counter Fraud Authority and an Audit Wales pilot using National Fraud Initiative data and ophthalmic claims through App Check.
ASSURE	**Audit Committee Effectiveness Survey Results 2026** The Assistant Director of Corporate Services presented the survey results confirming that ten of the 19 eligible respondents completed the anonymous survey, giving a response rate of 52.6%, compared with 60% in the previous year. The responses demonstrated a high level of confidence in the Committee's effectiveness, with most ratings recorded as agree or strongly agree. An improvement plan covering approximately three or four areas would be brought back to the Committee. The Committee's Terms of Reference would also be reviewed through the wider Governance and Accountability Review assurance work, with proposed changes clearly identified.
INFORM	**The following item was received for information:** Information Governance Annual Report 2025-26.

Part B – Private	
ASSURE	**2026/27 Losses and Special Payments 2026-27 Q1** The NWSSP Audit Committee noted the proposed write-off of a doubtful debt associated with Personal Protective Equipment (PPE), prior to its submission to WG for formal approval. The Director of Finance and Corporate Services presented the supporting paper and checklist. The item was considered in private session due to the confidential information and legal advice contained within the supporting documentation.
APPENDICES	Not applicable

3.1 FINANCIAL IMPLICATIONS

3.1.1 Not applicable

3.2 LEGAL IMPLICATIONS

3.2.1 Not applicable

3.3 PEOPLE IMPLICATIONS

3.3.1 Not applicable

3.4 WELSH LANGUAGE IMPLICATIONS

3.4.1 Not applicable

3.5 RISKS / REPUTATIONAL IMPLICATIONS

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

Not Applicable

Operational Risks

3.5.1 Not applicable

Risk Number	Risk title	Risk lead	Current score

4. RECOMMENDATIONS FOR ACTION / DECISION

4.1 The Trust Board is asked to:

- **NOTE** the contents of the report from the NWSSP Audit Committee meeting held on 13 October 2026.

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	21/07/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Juliet Brown, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Juliet Brown, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered at its public meeting on 21 July 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted July 2026 - NHS Wales Joint Commissioning Committee).

Status	Update
Alert / Escalate	The Committee Secretary highlighted the need for adequate executive attendance at Sub-Committee meetings, this was noted as a particular issue for the Quality, Safety and Outcomes (QSO) Sub-Committee, it was agreed that the use of deputies would be further discussed.
Advise	The Chief Commissioner's Report incorporated Director of Commissioning Reports to highlight performance and quality issues that had arisen since updates shared at Sub-Committee meetings in June 2026. These updates included: • JACIE Certification A response is expected imminently in relation to the certification. The Chief Commissioner has received a request to support the required capital investment. • Rural Response Options Members noted that a formal update on rural response options would be received at November's JC Meeting. In the meantime, it was agreed that there is a need to develop an information pack and an engagement plan for external stakeholders and the public. This would be a collaborative effort between the HBs, the Welsh Ambulance Services University NHS Trust and the NWJCC with consideration given by Llais. • St Andrew's Healthcare There are currently 5 remaining patients remaining within St Andrew's Healthcare. Plans have been put in place for admissions to alternative providers for 2 patients with arrangements continuing for the remaining 3. • Gender Service Review Confirmation of the initiation of an independent gender service review to be conducted by the end of December 2026 and recommendations to be produced by March 2027, with providers fully engaged in the process. A Manchester Arena Inquiry Update Report was received. Members noted the ongoing risks in relation to some recommendations due to funding constraints, the need for continued monitoring and for communication with Welsh Government. Members approved the following recommendations: • Correspondence to WG outlining the due diligence that has been undertaken in response to the WAST report, and recommendations on appropriate roles and responsibilities to respond to this, including the role of WG. • Correspondence to WAST on formal response to reports received, along with actions that will be required from the organisation following commissioner consideration, specifically including details of mutual aid explored and contributed to across the UK. A new Risk Management and Assurance Framework including a Risk Management Procedure, Joint Committee Assurance Framework (JAF), Template Report and Proposed Strategic Risks, Risk Appetite

Status	Update
	Statement and Matrix, were presented and approved by the JC. The documentation aims to support the management and review of the NWJCC's risks. All supporting appendices (documents 4.3.2.1-4.3.2.6) can be accessed here.
Assure	The Committee received the following Sub-Committee assurance reports: - Quality, Safety and Outcomes Sub-Committee - Planning, Performance and Finance Sub-Committee The NWJCC Organisational Risk Register as of 31 May 2026 was received and approved. There were 13 risks with a score of 15 or above as of 31st May 2026. The NWJCC Annual Plan 2026-27 – Progress Against Delivery at Quarter 1 Report was received. All strategic priority areas had made progress in Quarter 1 with the core foundations for delivery now in place and all Quarter 1 deliverables either on track or completed. The main risk for delivery pertains to the access to data/data analysis and the capability within the NWJCC to deliver the data analytics required for larger projects, emphasising the need to consider additional resources or expert support.
Inform	The Chair's Report summarised the cancellation of the JC Strategy Session scheduled on 16 June 2026, and the subsequent Risk Management Workshop that took place in its stead between Lay Members and the Corporate Governance Team; Lay Member Appraisals having taken place; and the scheduling of NWJCC Updates at HB Development Sessions. The Committee received the Month 03 Finance Report 26/27 and the Operational Performance Report including: • Conversation around the need for a review of the escalation process and clarification of pathways out of escalation. • Detailed conversation around modernisation and transformation with further conversation to take place at the next Collaborative Commissioning Leadership Group (CCLG) meeting. The Corporate Governance Report included updates on Welsh Health Circulars, the NWJCC Internal Audit Programme and the ongoing review of hosting arrangements between the NWJCC and CTMUHB. Further updates were provided on the sign off of the NWJCC Accountability Report, Annual NWJCC Update to HBs and the NWJCC Governance Framework. The Annual Committee Effectiveness Self-Assessment Results Report 25/26 update was received which detailed key themes across the JC and Sub-Committee meetings. Concurrent themes include, but are not limited to:

Status	Update
	• Reporting improvements (focussed on size, relevancy of content and strategic focus). • Lack of HB participation in relation to QSOC. • Focus from a commissioning perspective.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken a Quality Impact Assessment Screening?		This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* Equality *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- Note the highlights outlined in Section 2 of this report.

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	22/09/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Assurance & Risk Officer, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Juliet Brown, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Juliet Brown, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered at its public meeting on 22 September 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted September 2026 - NHS Wales Joint Commissioning Committee).

Status	Update
Alert / Escalate	Welsh Gender Service The service was placed in Level 3 escalation following clinical safety and quality concerns relating to the higher surgical referral rate compared to England alongside concerns raised by clinicians working within the pathway. Gender-affirming surgery, referrals for surgery and new surgical assessments were paused while an urgent independent clinical review is undertaken. Other elements of the service, including psychological support, hormone therapy, speech and language therapy and new referrals, continue. Priority for the clinical review is being given to people whose booked surgery was paused between August and September 2026, with approximately 60 people expected to be reviewed by the end of 2026. Affected individuals had been written to and are able to access psychological support through the service if needed. Staff wellbeing is also being supported. In addition, a wider whole-service review of Gender Services is being undertaken in parallel which forms part of the routine programme of service reviews undertaken across all commissioned services. An initial report of the broader review will be provided by December 2026 with a final report to the JC by March 2027.
Advise	Chief Commissioners Report In addition to the Welsh Gender Service, the report incorporated Directors of Commissioning reports to highlight performance and quality issues that had arisen since updates shared at the Sub-Committee meetings in August 2026. These included: • Welsh Fertility Services (WFI) - Members noted that referrals to the WFI had been temporarily paused due to the absence of the designated responsible person but had since resumed on a phased basis. The incident highlighted the fragility of the current service model, with longer-term solutions being explored with Swansea Bay University Health Board. • Neonatal Services - Members noted the Thirlwall Report and its relevance to the NWJCC's ongoing scrutiny of quality and safety across commissioned services. It was confirmed that the report's recommendations would inform the commissioning of neonatal services from the Countess of Chester Hospital and the ongoing neonatal strategic review, ensuring that learning is embedded within future commissioning arrangements. • Plastic Surgery Services - Members sought assurance regarding communication with patients awaiting plastic surgery and requested clarification of contingency arrangements should additional funding not be secured. It was noted that a funding application had been submitted to Welsh Government to support the all-Wales plastics pathway and that alternative commissioning arrangements may need to be considered if unsuccessful. Patient communication arrangements with Swansea Bay University Health Board would be confirmed.

Status	Update
	• Rural Response Model - an update on public engagement plans for the Rural Response Model and wider ambulance and patient transport services was received. Members noted that engagement was expected to commence in October 2026 and that stakeholder discussions were helping to inform the development of a rural transport commissioning strategy for Wales. Further updates would be provided as the work progressed. • Clinical Assessment Model - Members received an update on the future development of the Remote Clinical Assessment model. Engagement to date had highlighted support for a more locally owned service aligned to health board Single Points of Access. Work was underway with health board partners to explore and test potential delivery models. • Caswell Clinic - progress was noted following implementation of the majority of required actions which had enabled the service to be de-escalated to Level 2, with routine monitoring arrangements now in place. • Children and Young People's Gender Service - Members noted ongoing service developments following the Cass Review, including the introduction of twice-weekly clinics in Cardiff by the Bristol service, improving access for Welsh residents. • Traumatic Stress Wales – It was noted that the TUPE process was underway, and the service remained on track to transfer to Public Health Wales in November 2026. Renal Network Review An update on the Renal Strategic Review was received and noted enhancements to the evidence base, including further analysis of health inequalities and access to home therapies. Members recognised the growing challenge of kidney disease in Wales and supported the proposed strategic priorities and work programme, noting the opportunity to improve outcomes, strengthen commissioning arrangements and support the long-term sustainability of renal services. Individual Patient Funding Request (IPFR) Deep Dive The deep dive is intended to improve transparency on expenditure, activity and patient outcomes. Emerging recommendations include redesign of prior approval, improved outcomes monitoring through patient-reported measures, support for repatriation, clearer commissioning responsibilities between the NWJCC and Health Boards, and simplification of the current process to reduce complexity and inequity. Final recommendations will be presented in November 2026 following engagement with Health Board IPFR teams.
Assure	The Committee received the following Sub-Committee assurance reports: - Quality, Safety and Outcomes Sub-Committee - Planning, Performance and Finance Sub-Committee

Status	Update
	- CTM Audit, Risk and Assurance Committee Financial Performance Report Month 5 2026/27 The Month 5 position reported a £2.0m underspend to date and a forecast year-end underspend of £2.2m. Members noted that delivery of the £16.2m funding uplift remains challenging. A detailed review is assessing progress, slippage in planned developments, options for the remainder of the year and the likely year-end position. The outcome will be reported at Month 6 and considered at the October JC development session. Ambulance Services Winter Dashboard Update The enhanced Winter 2026-27 assurance arrangements and scorecard measures for emergency medical services, NHS 111 Wales and discharge and transfer services were endorsed. Members requested that median performance be considered alongside the 90th percentile and wider outcome measures so that long waits and rural variation are visible, with clearer correlation between hospital handover performance, ambulance response and patient outcomes. Annual Plan 2026-27 Update The Committee received an update on delivery of the 2026-27 Annual Plan and noted a broadly stable position across the nine strategic priorities, with improvement reported in the IPFR programme. Members discussed the low delivery confidence rating for the Referral Management workstream, seeking greater assurance on the anticipated benefits, delivery approach and resource requirements. It was agreed that further clarity would be required to support future decisions on investment and programme delivery. Joint Assurance Framework The first Joint Committee Assurance Framework was received, identifying six strategic risks and the associated controls, assurances and gaps. The framework will continue to develop to strengthen risk management and assurance arrangements for the NWJCC. Discussion focused on the financial sustainability risk, with agreement that it will be revisited to reflect the wider potential consequences for Health Boards if the £16.2m financial requirement is not achieved, with strengthened mitigation and assurance measures to be considered.
Inform	Chair's Report The extension of the Independent Patient Funding Request Panel Chair's term of office for up to 12 months was approved while a full recruitment process is undertaken. Meetings with Welsh Government and Ministers concerning the Welsh Gender Service were noted, together with the offer of technical briefings to political groups represented in the Senedd.

Status	Update
	Performance Report Month 4 2026/27 The Committee noted the Month 4 Performance Report, including ongoing escalation in the Welsh Gender Service and Electronic Assistive Technology Service. Continued concerns regarding long waits for some specialised services. An update was received on the accreditation risk affecting Blood and Marrow Transplantation and Advanced Therapies, noting that Cardiff & Vale University Health Board had submitted its response, including capital plans. The outcome of the accreditation review is awaited. Members also discussed ambulance performance, seeking further assurance on outcomes and rural variation, and noted that more detailed analysis would be presented to a future QSOC meeting. Immunoglobulin Update The proposed all-Wales commissioning approach was supported in principle, acknowledging that it would introduce consistent clinical commissioning policies, patient registration, follow-up and audit arrangements and an all-Wales Immunoglobulin Advisory Panel. Members emphasised the need to fully understand the financial implications of transferring commissioning responsibility and agreed that further financial assessment should be undertaken before the proposals return to the JC in November 2026.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd	Effective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* Equality *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
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Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- Note the highlights outlined in Section 2 of this report.