GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

TRUST BOARD

CHAIR'S URGENT ACTION MATTER REPORT

DATE OF MEETING	29 January 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**TO RATIFY**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This report details Chair's Urgent Actions taken between the **21/11/2025 – 22/01/2026.** There were two (2) urgent items of business for the Trust Board that was considered via Chairs Urgent Action during this period: 1. Procurement Dashboard – Benchmarking and Analytics Business Justification Case and Commitment of Expenditure 2. GP Locum Hub Wales Contract No objections to approval were received in respect of the item of business considered, although one matter was raised and is detailed in the report.
RECOMMENDATION / ACTIONS	To **RATIFY** the Chairs Urgent Action taken between the **21/11/2025 – 22/01/2026.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**02/12/2025:** Procurement Dashboard – Benchmarking and Analytics Business Justification Case and Commitment of Expenditure
Trust Board Members – Via Email	**11/12/2025:** GP Locum Hub Wales Contract

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Trust Board **APPROVED** the items of business considered via Chair's Urgent Action.

7 LEVELS OF ASSURANCE – N/A
APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chair's Urgent Action between the **21/11/2025 – 22/01/2026.**

2. BACKGROUND

2.1 In accordance with the Trust Standing Orders, 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 Chief Executive, supported by the Interim 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 Interim 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. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

2.2 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.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of the key outcomes from the items of business considered by the Trust Board via Chair's Urgent Action since the last formal meeting of the Trust Board in November 2025:

3.1 Procurement Dashboard – Benchmarking and Analytics Business Justification Case and Commitment of Expenditure

The Trust Board were sent an email and Chair's Urgent Action Report on the **2nd December 2025** in relation to the **Procurement Dashboard – Benchmarking and Analytics Business Justification Case and Commitment of Expenditure** that required urgent approval.

Further to the discussion at Trust Board on 27th November 2025 and the query raised in relation to the Procurement Dashboard – Benchmarking and Analytics Commitment of Expenditure Exceeding Chief Executive's Limit, the following points of clarification regarding the contract have been received and the Quality Impact Assessment, which is enclosed for your review:

The current contract expires on 30 November 2025. It is not a contract extension but is a continuation of system use with the same supplier. This is a new standalone contract to be awarded by GCloud 14 from 1st December 2025.

The Trust Board was requested to:

- **NOTE** the points of clarification regarding the contract renewal.
- **NOTE** the Quality Impact Assessment (QIA).
- **APPROVE** the contract renewal cost value of £450,000 and, in doing so, to also AUTHORISE the Chief Executive to approve the purchase order.

Recommendation Approved by:

- Sara Moseley, Chair
- Carl James, CEO (Interim)
- Lindsay Foyster, Vice Chair
- Andrew Westwell, Independent Member

3.2 GP Locum Hub Wales Contract Business Justification Case and Commitment of Expenditure

The Trust Board were sent an email and Chair's Urgent Action Report on the **11th December 2025** in relation to the **GP Locum Hub Wales Contract Business Justification Case and Commitment of Expenditure** that required urgent approval.

Further to the discussion at Trust Board on 27th November 2025 and the query raised in relation to the GP Locum Hub Wales Contract Extension Commitment of Expenditure Exceeding Chief Executive's Limit (report attached for your information), the points of clarification regarding the contract were received and the Quality Impact Assessment, was enclosed for review.

The Trust Board was requested to:

- **NOTE the points of clarification regarding the contract extension.**
- **NOTE the Quality Impact Assessment (QIA).**
- **APPROVE the additional extension cost value of £271,494.58 as this will take the total contract value over £1m.**

Recommendation Approved by:

- Sara Moseley, Chair
- Carl James, CEO (Interim)
- Lindsay Foyster, Vice Chair
- Vicky Morris, Independent Member
- John Union, Independent Member
- Andrew Westwell, Independent Member

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

<table>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
• A beacon for research, development and innovation in our stated areas of priority ☐
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe ☒</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)</td><td>04 - Organisational Culture</td></tr>
<tr><td rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td>This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.</td></tr>
<tr><td>QUALITY IMPACT ASSESSMENT</td><td>Not required - not a strategic decision</td></tr>
<tr><td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</td><td>Not required</td></tr>
<tr><td>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT</td><td>A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.</td></tr>
<tr><td rowspan="2">FINANCIAL IMPLICATIONS / IMPACT</td><td>Yes - please Include further detail below, including funding stream</td></tr>
<tr><td>Financial impact was captured within the documentation considered by the Board.</td></tr>
<tr><td>EQUALITY IMPACT ASSESSMENT</td><td>Not required</td></tr>
<tr><td></td><td>Yes (Include further detail below)</td></tr>
</table>

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Legal impact was captured within the documentation considered by the Board.

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Trust Board	
Annual Nurse Staffing Levels Report	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rhian Wright, Lead Nurse for Workforce, Education and Standards
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SUMMARY	This paper is to provide an update on compliance with the Nurse Staffing Levels (Wales) Act 2016. This report provides the position from the 1st of October 2024 to the 30th of September 2025. The report highlights that: • There has been no reportable harm as defined by the Nurse Staffing Levels Wales Act Quality Indicators during the review period in respect of nurse staffing levels on the First Floor Ward. • Patient acuity has risen over the last 6 months. Level 3 has increased by 7.53% and Level 4 patients have almost doubled to 23.57% (definitions of levels on page 9). • Average bed occupancy has increased during this period. These factors have contributed to a higher demand for nursing care on the ward. • During October 2025 establishment review it was identified that, given the above factors, and the outcome from a recent ward assurance review, that there needed to be an increase in the number of Health Care Support Workers on a day shift on the Ward which is when patients require the greatest amount of personal care. In addition, some skill mix changes have been agreed to meet changing patient complexity requirements (i.e. additional band 6 establishment opposed to band 5).

	• The revised nursing establishment for the Ward is sufficiently funded to support the planned roster, including the 26.9% headroom and uplift allowance. • It has been identified that all reasonable steps as outlined in the Nurse Staffing Operational Framework are taken to maintain safe and effective nurse staffing levels.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the report in line with the Nurse Staffing Levels (Wales) Act 2016 prior to the report being submitted to the Trust Board and subsequent submission to the Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nurse Forum	05/11/2025
Executive Management Board	25/11/2025
Quality, Safety & Performance Committee	13/01/2026
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Quality, Safety & Performance Committee Endorsed for onward approval at Trust Board	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions ***In respect of 25B area***

1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times
- Improve working conditions for nursing and other staff
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Section 25B of The Nurse Staffing Levels (Wales) Act 2016 requires organisations to have sufficient staff to provide appropriate patient centred care. Section 25A places a duty on Health Boards/Trusts to take due regard to have sufficient nurses to allow nurses time to care sensitively for patients wherever nursing services are provided or commissioned.

Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for

each adult acute medical and surgical ward and paediatric inpatient wards.

There is only one area of the Trust that sits under the requirements of 25B of the Act, First Floor Ward at Velindre Cancer Service. This was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act (2016).

Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out 6-monthly utilising a triangulated approach.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Nurse Staffing Levels Act Reporting

National reporting is annually and 3 yearly, however following suit with the acuity and establishment reviews internally this update will be provided to the Trust Board for noting on progress. The Annual Presentation of Nurse Staffing Levels has been completed and the report (using the national reporting template) is attached. The required establishment figures for the last three establishment reviews are included in ***Appendix 1***. This report is laid out on a national template and will be reported to Welsh Government for onward assurance.

2.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that employs registered nurses. The establishment reviews include all front-line care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (AMaT)
- Acuity that may be formally assessed

- Roster KPI's
- Quality Indicators (25B)
- Service Plans or Clinic Templates as applicable

2.3 Outcome of the establishment review of the First Floor Ward

In line with the regulatory requirements of the Nurse Staffing Levels (Wales) Act 2016, the First-Floor in-patient ward has been assessed against the requirements of section 25B of the Nurse Staffing Levels (Wales) Act 2016. Following the recent review, the number of Health Care Support Workers on day shifts has been increased to four. Additionally, the organisation has plans to expand the number of Health Care Support Workers available through the nurse bank. Assurance is provided that the workforce establishment is fully funded, including the 26.9% headroom and uplift. Skill mix was identified as an ongoing challenge. In response, a plan has been introduced to strengthen the level of experience on the ward, with a particular focus on improving day shift coverage

3. IMPACT ASSESSMENT

<table>
<tr><td colspan="2">TRUST STRATEGIC GOAL(S)</td></tr>
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• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)</td><td>06 - Quality and Safety</td></tr>
<tr><td>QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below
Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
</table>

	The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centred delivery.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for this type of report
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Annual Presentation of Nurse Staffing Levels to the Board						
Health Board	Velindre University NHS Trust					
Date of annual presentation of Nurse Staffing Levels to Board	Xx January 2026					
Period Covered	**01 October 2024 to 30 September 2025**					
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards (inclusive of Oncology & Haematology inpatient wards)**	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
	1					
Required establishment (WTE) calculated (October 2024)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	28.42	14.21				
WTE of required establishment funded (October 2024)	28.42	14.21				
Staffing requirements following Spring Cycle (May 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (June 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	28.42	14.21				
WTE of required establishment funded (June 2025)	28.42	14.21				
Staffing requirements at end of reporting period (September 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (October 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	28.42	17.06				
WTE of required establishment funded (October 2025)	28.42	17.06				
WTE Supernumerary band 7 sister/charge nurse at end of	1 WTE					

reporting period (funded but excluded from planned roster)			
Required establishment (WTE) calculated and WTE of required establishment funded	The required establishment is fully funded. There has been an increase in the number of Health Care Support Workers (HCSWs) required on each day shift which is fully funded; however, the recruitment process is yet to be completed. Rising patient acuity and patient numbers have highlighted the need for additional HCSWs during daytime hours. The ward manager is supernumerary to the planned roster. Additionally, there is a supernumerary Band 6 nurse coordinator who oversees ward activities, manages discharges and admissions, and supports the delivery of Systemic Anti-Cancer Treatment (SACT). The recent split in the roster from the ambulatory unit has highlighted that adequate skill mix is still an ongoing challenge for the ward. There are plans to temporarily redeploy a Band 6 staff member from the 25A area in exchange for a less experienced Band 5 from the ward, in order to optimise the skill mix on the ward.		
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	The triangulated approach, as outlined in the Welsh Levels of Care (WLOC), has been used to inform the calculation of nurse staffing levels on First-Floor. A recent comprehensive ward audit and quality indicators including patient falls, pressure damage, medication errors, and patient complaints have been reviewed to support the decision to increase the number of Health Care Support Workers required to deliver sensitive care to patients. During this period there has been no reportable harm in relation to the quality indicators during the review period in respect of nurse staffing levels on the First Floor Ward. Establishment reviews are conducted bi-annually with the senior nurse management team following the nurse staffing calculations. An additional review is scheduled for January 2026 for First-Floor ward using the tri-angulated approach to assess whether the increased number of Health Care Support Workers (HCSWs) is sufficient to support safe and effective patient care. Patient acuity is measured twice a day using the approved Welsh Levels of Care Tool and recorded in SafeCare.		

Table 1

Acuity Level	Average Acuity Levels April 24 – April 25
Level 5	0.73%
Level 4	12.32%
Level 3	58.77%
Level 2	28.02%
Level 1	0.16%

Table 2

Acuity Levels	Average Acuity Levels Apr 25 - Sept 25 (6 months)
Level 5	0.79%
Level 4	23.57%
Level 3	66.30%
Level 2	9.33%
Level 1	0%

Level	Description
Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable, unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it difficult to predict the outcome of individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

Patient acuity has risen over the last 6 months. Level 3 has increased by 7.53% and Level 4 patients have almost doubled to 23.57%. In addition, average bed occupancy also increased to 25 during the summer period. These factors have contributed to a higher demand for nursing care on the ward, supporting the decision to increase the number of HCSWs on the day shift. All reasonable steps are taken to maintain safe nurse staffing levels. Nurses are encouraged to raise red flags if they have concerns regarding patient care or staffing levels. A recent increase in the raising of red flags has also contributed to the decision to increase the number of HCSW's on a day shift.

When a red flag is raised, it automatically generates an alert to the senior nursing team for prompt review. In addition, a monthly red flag report is produced, shared with the ward manager, and discussed with the senior nursing team to ensure appropriate actions are taken and trends are monitored.

Finance and workforce implications

The nursing establishment for First Floor is sufficiently funded to support the planned roster, including the 26.9% headroom and uplift allowance. There are no financial concerns regarding the staffing of this area.

All reasonable steps outlined in the Nurse Staffing Operational Framework are taken to maintain safe and effective nurse staffing levels. These measures include the redeployment of staff, the utilisation of staff outside the planned roster, and the use of bank or overtime where appropriate. There is a plan to

	expand the nurse bank, with a particular focus on Healthcare Support Workers (HCSWs), to address any staffing shortfalls and support greater flexibility and continuity in shift coverage.
Conclusion & Recommendations	
	• There has been a recent increase in the number of Health Care Support Workers employed on a day shift on First Floor as a result of an increase in patient acuity, patient numbers and feedback from a recent ward assurance review • There are plans to temporarily redeploy a Band 6 staff member from the 25A area in exchange for a less experienced Band 5 from the ward, in order to optimise the skill mix on the ward • The nursing establishment for First Floor is sufficiently funded to support the planned roster, including the 26.9% headroom and uplift allowance • The increase in HCSW's is fully funded including 26.9% headroom and uplift, however the recruitment process is ongoing • All reasonable steps outlined in the Nurse Staffing Operational Framework are taken to maintain safe and effective nurse staffing levels • There has been no reportable harm in relation to the quality indicators during the review period in respect of nurse staffing levels on the First Floor Ward • The ward roster has been separated from the ambulatory ward roster to provide greater clarity and enable more effective scrutiny of roster principles

TRUST BOARD	
TRUST SEAL REPORT: 27 NOVEMBER 2025 – 23 JANUARY 2026	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	FOR NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Non Gwilym, Director of Corporate Governance (interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (interim)
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(27th November 2025 – 23rd January 2026)**.
RECOMMENDATION / ACTIONS	The Trust Board is requested to **NOTE** the contents of the Trust Board Seal Register included below as **Appendix 1.**
GOVERNANCE ROUTE	
N/A	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1 – Seal Register	

1. SITUATION/ BACKGROUND

1.1 The content of the Trust Board Seal Register has been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(27th November 2025 – 23rd January 2026)**.

1.2 Board Members are asked to view the content of the report. Further information or queries should be directed to the Director of Corporate Governance (interim).

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Seal Register

Date	Document Details	Signed
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) B&K Hybrid Solutions Ltd. (Design and Construction of the Timber Frame).	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) Trident Construction Solutions Limited. (Passive Fire Protection Design).	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) Porcelanosa UK Ltd. (Design and Construction of the prefabricated façade).	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) Aerocom (UK) Ltd. (Design and Construction of the Pneumatic Tube System).	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) Car Park Systems Ltd. (Design and Construction of the Car Park Ventilation).	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	Deed of Collateral Warranty between (1) VUNHST and (2) Tyco Fire & Integrated Solutions (UK) Ltd. (Design and	Carl James (Interim CEO) and Sara Moseley (Chair)

Date	Document Details	Signed
	Construction of the automatic sprinklers, dry riser, hydrant and mist systems).	
16/12/2025	Contract for the sale of leasehold land with vacant possession at Unit 25, Samlet Road, Swansea Enterprise Park, Swansea, SA7 9AF, between (1) VUNHST and (2) Welsh Ambulance Services University NHS Trust.	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	(1) VUNHST and (2) JJ Loughran Ltd. Deed of Collateral Warranty of the Design and Construction of the Switchgear, Scada, LV & HV panels system in respect of the new Velindre Cancer Centre in Whitchurch, Cardiff, Wales.	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	(1) VUNHST and (2) Ingenieria y Consultoria Para el Control Automatico, SL. Deed of Collateral Warranty of the Building Management System (BMS), in respect of the new Velindre Cance Centre in Whitchurch, Cardiff, Wales.	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	(1) VUNHST and (2) Pacegrade Limited. Deed of Collateral Warranty of the Design and Construction of the curtain wall in respect of the new Velindre Cancer Centre in Whitchurch, Cardiff, Wales.	Carl James (Interim CEO) and Sara Moseley (Chair)
16/12/2025	(1) VUNHST and (2) Plexus Fire & Security Ltd. Deed of Collateral Warranty of the Fire Detection System in respect of the new Velindre Cancer Centre in Whitchurch, Cardiff, Wales.	Carl James (Interim CEO) and Sara Moseley (Chair)
14/01/2026	Contract for the provision of a Blood Establishment Computer System (BECS) for the Welsh Blood Service, based between (1) Velindre University NHS Trust and (2) GPI SpA.	Carl James (Interim CEO) and Sara Moseley (Chair)
14/01/2026	Data processing agreement between the Controller (Velindre University NHS Trust) and the Processor (GPI Spa).	Carl James (Interim CEO) and Sara Moseley (Chair)

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	29th January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Olayinka Sokoya, Executive Support Assistant
PRESENTED BY	Vicky Morris, Quality, Safety & Performance Committee Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 13th January 2026.

2. BACKGROUND

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

3. HIGHLIGHTS FROM THE MEETING HELD ON 13TH JANUARY 2026

3.1 Triangulated themes

The following triangulated themes were identified:

- The need to better capture and analyse feedback from patients, donors, staff and to improve organisational learning from these insights.
- A renewed emphasis on people and culture, including the value of staff stories, engagement with Trade Unions and social partners, and the influence of organisational culture on finance and change management.
- The importance of prioritising digital, data and insight and the need for a collective approach across committees.

- The challenge of demonstrating positive outcomes and celebrating achievements, rather than focusing solely on areas for improvement.
- The maturity of plans and assurance processes, with a focus on understanding the real impact of actions and assurance activities.
- The value of co-production and enabling patients to share their experiences directly, rather than only through operational channels.
- The sustainability of services and models in light of ongoing and future challenges.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the November 2025 QSP Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-papers/quality-safety-performance-2026/quality-safety-performance-committee-13012025/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	There were no items to alert/escalate to the Trust Board
ADVISE	**Finance Report for the Period Ended 30th September 2025** The Committee discussed the Finance Report in detail, as follows: • The Trust is on track to deliver its financial KPIs for the current year. The financial outlook for 2026/27 is challenging, but recent Welsh Government allocation letters have provided a 1.1% uplift and confirmation of recurrent funding for previously non-recurrent services, equating to approximately £2 million additional funding. • The Trust faces a 3% savings target, as expected by Welsh Government, and will need to focus on productivity and efficiency improvements, including peer benchmarking. • There is a reported £211,000 overspend on enabling works for the new VCC project. Welsh Government holds contingency funds for such risks, and the process for accessing these funds is underway, with the risk considered low. • The revised draft plan now enables the Trust to aim for a balanced financial position from year one, rather than over three years as previously anticipated. • The Committee discussed the introduction of a Financial Reforms Committee to provide dedicated focus and improved governance on financial planning, savings delivery, and productivity. • There is a need for a different relationship with commissioners, particularly regarding service expansion and outreach, to ensure appropriate funding and value for the system.

	• Plans are in place to use the Model Health System in England for benchmarking productivity, efficiency, and quality against specialist cancer centres, as well as ongoing benchmarking for the Welsh Blood Service. • The Committee emphasised the importance of engaging staff in the financial improvement journey, using benchmarking and language that motivates and connects with staff pride in service delivery. • The financial position is high risk, with no additional cash for investment, making productivity and efficiency gains essential to meet demand growth. The Trust must reduce reliance on non-recurrent savings. The Committee **agreed** the applied **assurance level 4**.
ASSURE	**Performance Management Framework (PMF) Report and Supporting Analysis** ***Velindre Cancer Service*** • Progressing towards full national compliance for SACT metrics • Internal improvement plan for booking delays • Focus on SCP compliance with a 75% target for treatment within 24 days by Q2 2026/27 • Data quality issues being addressed. ***Welsh Blood Service*** • Improved turnaround times and donor diversity • Regulatory incidents investigated and closed • Platelet wastage spike addressed with new tools. ***Workforce*** • New heat map identifies workforce hotspots • Sickness absence and turnover remain challenging in specific roles • Robust management processes and plans for holistic staff engagement and digital learning. ***Digital Services*** • Strong progress in Windows 11 migration and business continuity • Digital diagnostics and cyber risk work advancing. ***Estates, Infrastructure, and Sustainability*** • Climate adaptation is now a strategic priority, with a new risk and action plan approved and managed by the Climate Action Board. • Work is ongoing to align with Welsh Government policy on decarbonisation and adaptation. ***Health and Safety*** • Health and safety risks are actively managed, including a recent HSE concern about equipment weight, which was resolved and closed.

	• Fire safety training and emergency drill alignment (including Terrorism Act requirements) are under review. ***Financial Performance*** • On track to deliver financial KPIs for the year; positive outlook following additional funding and uplift; balanced plan for next year with a 3% savings target; focus on productivity, benchmarking, and value-based healthcare; ongoing need for clear internal communication and alignment with Board priorities. Performance remains strong, with the highest assurance level maintained. **Quarter 2 Integrated Medium-Term Plan Deliverables** The Committee received the quarterly Integrated Medium Term Plan (IMTP) report, outlining performance against planned deliverables. For Q1, there were 17 outstanding deliverables, of which 11 were completed in Q2, leaving six still outstanding. In Q2, there were 25 deliverables, with seven completed to date. The discussion emphasised the need for sharper clarity on commitments, realistic planning, and transparent tracking. There was a focus on aligning IMTP deliverables with the Board Assurance Framework to assess materiality and risk, noting some discrepancies in reporting timelines and status. Suggestions included improving information flow, aligning RAG ratings and assurance levels, and refining the process for next year to address resource, accountability and culture. The Committee **agreed** the assigned **assurance level 3**. **Integrated Medium-Term Plan – Progress against Quarterly (Q3) Actions for 2025 / 2026** The Committee received the Q3 update on the Integrated Medium-Term Plan, noting that nearly all deliverables for the year are on track, with only one outstanding item from Q1 due to a change in approach for the video consultation system. The report provides assurance that IMTP actions are progressing as planned. The **Level of Assurance of 3 is maintained.**
INFORM	**Velindre Cancer Service – Donor Story** The Committee received a donor story from the Welsh Blood Service highlighting a project enabling patients with genetic haemochromatosis to donate blood, at the benefit of both patients and the blood supply chain. The discussion emphasised the project's success in increasing donor numbers, its innovative therapeutic approach, and the importance of continued awareness, funding, and phased rollout, with personal insights from both staff and a live donor reinforcing the positive impact.

	Trust Risk Register The Committee reviewed the Trust Risk Register, noting that most risk target dates have been updated with only two missed and now revised, and four more due for review. The digital leadership risk score was reduced following new controls and recruitment plans, while the SACT administration risk was discussed as a legislative requirement pending funding. Members highlighted the need to review strategic risks, including leadership team changes and procurement delays, for inclusion in the Board Assurance Framework. The register is now more dynamic, though some scoring inconsistencies remain. The Committee **agreed** the applied **assurance level 3**. **Board Assurance Framework** The Committee reviewed the Board Assurance Framework, confirming that all strategic risk scores remained static for the period, with one minor correction noted for a previous reporting period. Plans are in place to review and align strategic risks with the IMTP at a forthcoming Board Development session. The Committee agreed the current **level of assurance remains at 2.** **Culture and Inclusion Report** The Committee received the Culture and Inclusion Report, noting positive staff engagement scores and progress in building a supportive culture, while also identifying key areas for improvement around speaking up safely and managing change. Immediate actions include enhanced reporting, new engagement channels, and targeted support for managers, with a focus on tailored interventions in areas experiencing the most change. The Committee emphasised the importance of ongoing measurement, visible leadership, and learning from past initiatives, and agreed that a clear action plan and regular updates are required to maintain momentum and assurance. **Enhancing the Patient and Donor Voice** The Committee discussed the Enhancing the Patient and Donor Voice paper, supporting the proposed vision and principles for strengthening engagement and experience across the Trust, and emphasising the need for clear direction, resource alignment, and inclusive involvement of staff, patients, donors, and community partners. Regular updates will be provided to track progress, with the next update expected in March. The Committee agreed a **Level of Assurance of 3** is appropriate at this stage. **NHS WALES SHARED SERVICES PARTNERSHIP** **Implementation of Duty of Quality Assurance Update** The Committee received an update on the implementation of the Duty of Quality, noting the integration of divisional quality management systems, accreditation processes, and reporting mechanisms that

	collectively support quality assurance, improvement, planning, and control across services. The Committee noted the structured approach, ongoing alignment with IMTP and national standards. **The Committee ENDORSED:** • WF23 All Wales Flexible Working Policy **The Committee NOTED** the Clinical and Scientific Board Highlight Report **The Committee APPROVED the following Trust policies:** • IPC13 CJD Policy • IG06 Anti-Virus Policy • IG05 Software Policy
APPENDICES	None

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on 13th January 2026.

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Velindre University NHS Trust

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE NEW VELINDRE CANCER CENTRE (nVCC) PROJECT SCRUTINY SUB-COMMITTEE	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Hilary Jones, Independent Member and Interim Chair of the nVCC Project Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Interim Chief Executive
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the nVCC Project Scrutiny Sub-Committee held on 21st October 2025

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation.
ADVISE	**Interdependencies Report** • **Purpose & Structure**: The report aims to ensure service preparedness for the new hospital, integrating change projects and business-as-usual activities, with weekly and monthly coordination between project and commissioning teams.

	• **Key Programmes**: Updates were provided on IRS and RISP programmes, with ongoing discussions and visits planned with external partners. The RISP programme's January go-live date aligns with the overall timeline, though some risks remain regarding delivered functionality. • **Workforce & OD**: Work ongoing to embed workforce and organisational development into change programmes, with emphasis on the need for a cultural baseline and co-created action plan to support staff through the transition. • **Digital and Records**: Positive progress on digitisation, with audits showing fewer pages per record than expected, reducing time and cost. • **Assurance**: More detail and interim milestones to be provided in the reporting, especially for workforce, TrAMS, and Outreach, to provide better assurance. It was agreed to bring more detailed timelines and a cultural baseline to future meetings. • **TrAMS:** Further detail was sought on the restructuring of the TrAMS Programme due to changes in the technical model and its impact on delivery. Recent meetings have taken place with Cardiff and Vale to support their clinical trials requirements, aligning with ongoing discussions about the TrAMS Programme. The team is working to progress from Outline Business Case (OBC) to Full Business Case (FBC) under a tight timeline, aiming for sign-off by December 2025 and agreement on the clinical trials model by November 2025. Further details are being developed for the commissioning plan, as it is likely that a room will need to be fully licensed, with work on these specifics currently underway. • **Outreach**: Further details on the update on progress with the Outreach Programme was requested and the implications of capacity constraints within health boards. Three approaches are being pursued: pharmacy delivery, transition to home delivery, and outreach at various locations. Efforts are focused on enhancing outreach in collaboration with partners. Further meetings scheduled with health boards to explore flexibility for outreach locations. Health boards face significant pressure from Welsh Government regarding planned care, making space limited, but outreach remains on their agenda. Interim plans are in place to maximise use of existing facilities. • **Delivery Confidence**: Clarity was sought on when the delivery confidence rating might move from Amber to Green. Changes to national programme dependencies and evolving plans affect this timeline.

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	The Sub-Committee **NOTED** the VCS Futures Assurance Report, with the understanding that further discussion will be taken offline to clarify expectations for future interdependencies reporting.
ASSURE	**nVCC Project Highlight Report** • **Overall Status and Progress:** The project remains at Amber status, mainly due to delays in finalising elements of the RDD (design documentation). All Trust activities are green, and design elements are complete, but the final coordinated stage 4 design from the contractor is still pending. This delay does not pose a delivery risk, but it is behind the preferred schedule. • **Trust Obligations:** Road construction and high voltage intake room works are on track, with a deferral of completion to February at the contractor's request due to equipment delivery timing. This change is formally documented. • **Health & Safety:** Safety observations remain high, but actual injuries or negative incidents are low. Trust inspections are ongoing and within expected ranges for a complex site. • **Staff Engagement:** The engagement metric will be revised for better representation. Over 200 staff participated in site visits, which were well received. Monthly community events continue, but public attendance is low, reflecting improved community sentiment. • **Community Benefits and Complaints:** Complaints are low (five in the quarter), and the contractor is involved in local initiatives, such as a food bank for affected residents. • **Finance and QRA:** The project is on budget, with minimal drawdown of QRA (contingency funds). Major equipment procurement has been completed within budget and delegated authority. The QRA spend graph was discussed; it accurately reflects low contingency use, and no better presentation method was identified. • **Milestone Tracking:** A new milestone report tracks 250 critical KPIs/deliverables, with clear visibility of baseline and finish dates. Change control is in place for any date changes. Internal audit will review this tracking approach for robustness. • **External Assurance:** Positive feedback received from recent Welsh Government meetings - Health Strategy Board and IQPD meetings, with major risks well understood and significant QRA funds returned. The nVCC Project Scrutiny Sub-Committee **NOTED** the **nVCC Project Highlight Report** and the **Amber** project status for the reporting period.
INFORM	**Communication and Engagement Update Report**

	• **Staff Site Visits**: Successful engagement of over 200 staff in site visits, emphasising the importance of listening to staff feedback during these events to inform future communications and departmental messaging. • **Social Media and Visibility**: Efforts are underway to improve communications via social media and the main VCC channel, aiming to increase project visibility among staff and patients. • **Upcoming Events**: Planning is in progress for a topping out ceremony in November, using key project milestones to communicate progress. • **Staff Feedback Themes**: Staff are increasingly focused on project timelines and departmental impacts, prompting the need for more tailored communications as the project advances. • **Community Drop-In Attendance**: There were concerns about low public attendance at community drop-in sessions. There was a discussion about the potential for low attendance reflects reduced community concerns and effective direct engagement with local residents in partnership with the contractor, although further promotion is being considered. • **Overall Impact**: Communications are having a stronger impact now that staff can see tangible project progress, and engagement is shifting from general updates to more specific, team-focused messaging. The Sub-Committee **NOTED** the Communication and Engagement update report.
APPENDICES	None.

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TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE NEW VELINDRE CANCER CENTRE (nVCC) PROJECT SCRUTINY SUB-COMMITTEE	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Hilary Jones, Independent Member and Interim Chair of the nVCC Project Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Interim Chief Executive
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the nVCC Project Scrutiny Sub-Committee held on 20th November 2025

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation.
ADVISE	**Interdependencies Report** • **Reporting Status** No interdependencies report was presented this month because the VCF Futures Programme reports on a bi-monthly cycle, while this Sub-Committee meets monthly. Previous attempts at

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	monthly reporting resulted in low-value, incremental updates; the bi-monthly rhythm will ensure higher-quality, meaningful reporting that is credible and substantive. • **Assurance Considerations** It was agreed to review whether the current bi-monthly frequency provides the level of assurance required by the Sub-Committee, which will be explored at the upcoming interdependencies meeting between the Independent Members and Chief Operating Officer. The Sub-Committee **NOTED** the verbal update.

ASSURE	**nVCC Project Highlight Report**
	Programme Status
	• Trust-led activities remain on or ahead of plan, demonstrating strong internal delivery.
	• Construction activities by Sacyr are behind plan, with cumulative delays increasing overall programme risk.
	• RAG indicator has moved towards red, reflecting reduced schedule contingency and repeated slippage in construction milestones.
	Key Risks & Slippages
	• Example milestone: Ground floor slab completion delivered 53 days late (planned 8 Aug → actual 30 Sept).
	• Facade installation is 6–7 weeks late and sits on the critical path, significantly heightening timeline risk.
	• Sacyr continues to rely on contingency/float to recover delays, but remaining float is shrinking, limiting future recovery options.
	Contractual & Relationship Challenges
	• Under the MIM contract, the contractor is not required to issue programme revisions at defined intervals, limiting transparency into knock-on impacts.
	• Cultural reluctance within Sacyr to share early warnings has led to communication barriers. Recent senior-level workshops show "green shoots" of improved openness.
	• Trust emphasising that timely completion, not penalties, is the shared goal to support patients and operational planning.
	Quality Assurance
	• Risk of quality deterioration acknowledged as Sacyr attempts to accelerate late activities.
	• Enhanced mitigation in place:
	  ○ Increased on-site witnessing by Trust personnel.
	  ○ Active role of the independent tester.

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Strict validation of milestone completions recorded in the "plan on a page".
Finance Position
Trust and Welsh Government agreed to release ~£6m contingency this period due to risks not materialising, reducing required capital drawdown.
This is a positive indicator of proactive risk management.
Engagement
200+ staff attended site tours across four days; additional dates added to meet demand, reflecting growing organisational confidence and interest.
Topping-out ceremony was successfully delivered, marking a significant project milestone.
The Sub-Committee NOTED the nVCC Project Highlight Report and the Amber project status for the reporting period.
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<tr><td>INFORM</td><td>
Communication and Engagement Update Report
Successful delivery of the Topping-Out Ceremony
Resident Drop-in Sessions
Latest resident drop-in saw no members of the public attending, prompting discussion about engagement effectiveness. Lower attendance may suggest residents feel adequately informed rather than disengaged.

The community is aware of the drop-ins, with previous months showing attendance. Multiple engagement channels (formal and informal) remain active for local residents, including direct contact with Sacyr and the Trust. Engagement approach remains under regular review, especially around major milestones or unusual on-site activity. Following discussion, it was agreed that the sessions should continue, and different approaches are needed to encourage attendance.
Wider Engagement Context
Recent Whitchurch Hospital land disposal engagement events saw high public turnout (circa 60 attendees), reinforcing:
Community channels are functioning.
Interest varies depending on topic and relevance.
The Sub-Committee NOTED the Communication and Engagement update report.
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<tr><td>APPENDICES</td><td>None.</td></tr>
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TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PUBLIC STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Interim Chief Executive
REPORT PURPOSE	FOR NOTING

ACRONYMS	
AMaT	Audit Management and Tracking (System)
CEO	Chief Executive Officer
DHCW	Digital Health and Care Wales
EDI	Equality, Diversity and Inclusion
EMB	Executive Management Board
EPMA	Electronic Prescribing and Medicine Administration
EQIA	Equality Impact Assessment
FBC	Full Business Case
IMTP	Integrated Medium Term Plan
IRS	Integrated Radiotherapy Solution
KPIs	Key Performance Indicators
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, plus other identities
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
QIA	Quality Impact Assessment
QSP	Quality, Safety & Performance Committee
RAG	Red, Amber, Green (risk rating system)
RISP	Radiology Informatics System Procurement
SBAR	Situation, Background, Assessment, Recommendation

SDC	Strategic Development Committee
SRO	Senior Responsible Owner
SRU	Satellite Radiotherapy Unit
TAF	Trust Assurance Framework
TCS	Transforming Cancer Services
TrAMS	Transforming Access to Medicines
VCS	Velindre Cancer Service
VUNHST	Velindre University NHS Trust

1. PURPOSE

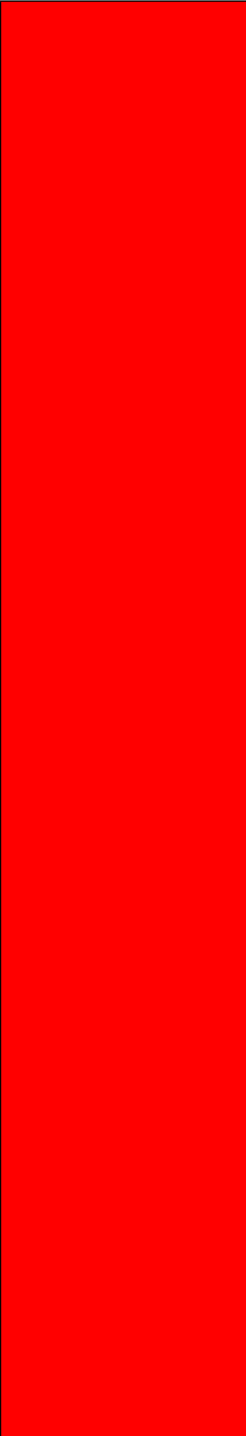
1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Public Strategic Development Committee held on 4th November 2025.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Trust Board is requested to **NOTE** the contents of the report and any actions being taken to address any issues highlighted in the meeting.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**nVCC Digital Assurance and Opportunities Review – Atos** **Board Summary: nVCC Digital Assurance & Opportunities Review (Atos)** The Atos review provides an independent assessment of the digital readiness of the New Velindre Cancer Centre (nVCC). The Committee noted the following key points: • **Strong Digital Foundations** The nVCC programme is expected to deliver a high-quality digital infrastructure, including robust connectivity, data architecture, and building-level systems—providing a solid platform for future digital services. • **Need to Strengthen Delivery Capacity** Atos advised increasing both digital and clinical resource within the programme to reduce delivery risk, reflecting lessons from other smart-hospital developments. • **Targeted Opportunities for Enhancement** Several capability gaps were identified which, with modest additional investment, could elevate nVCC closer to international smart-hospital standards. These include: o Wearable / sensing technologies o Advanced patient-flow and orchestration systems o Enhanced data and automation capabilities • **System-Wide Dependencies** Achieving higher digital maturity is constrained by the absence of a national EPR and cancer information system, limiting

	progression beyond foundational HIMSS levels. • **Operational Integration Required** The Committee emphasised that technology alone will not deliver transformation; behavioural change, workflow redesign, and clinical engagement are essential to realise benefits. The Committee welcomed the review **NOTING**: a) the importance of aligning digital transformation with operational and clinical needs, as well as the need for ongoing engagement and assurance as the project progresses. b) the additional investment recommended in the report will be sought from Welsh Government through the nVCC Project arrangements. **Digital Programme Highlight Report** The Committee received the Digital Programme Highlight Report, noting that most of the substantive points had already been covered in the earlier Digital Deep Dive. • **Service performance:** Digital services were reported to be in a stable and positive position, with core service delivery functioning well. • **National dependency risks:** Members highlighted ongoing challenges with national system Programmes (e.g., RISP, LIMS), which consume disproportionate digital resource and constrain the Trust's ability to progress local transformation. • **Target Architecture and Governance:** Work underway on the national target architecture and the role of the national DDaT Leadership Board, where the Trust is represented. These are essential to aligning national and local digital agendas. • **Key point of assurance:** The report did not introduce new issues beyond those explored earlier in the meeting; however, it reinforced the heavy resource burden created by national Programmes and the need to protect capacity for Trust-critical digital transformation. The Committee **NOTED** the report and accepted the Assurance Level 3 and requested continued visibility of risks and priorities through future reports.
ADVISE	**Digital Diagnostic Update** The Trust has commissioned a three-month Digital Diagnostic with TPX Impact to assess the organisation's capability, capacity, and governance to deliver true digital transformation. The diagnostic will inform how the Trust balances operational digital service delivery with major programme demands (e.g., national systems, nVCC, WBS) and long-term transformation ambitions. **Key Areas of Focus**

- **Digital Transformation Model:**
  The diagnostic will not simply produce technology roadmaps but will define *how the Trust should organise itself* to deliver digital transformation effectively across clinical, operational, and corporate services.
- **Capacity and Capability Assessment:**
  Currently, 60–70% of digital resources are absorbed by core service maintenance, leaving limited capacity for transformation or IMTP-critical work. The diagnostic will explore options to address this imbalance.
- **National Systems Impact:**
  Dependencies on national programmes (RISP, LIMS, EPMA) place pressure on local capacity and constrain digital maturity. The work will examine how these external pressures shape Trust-level prioritisation and resourcing.

Key Issues Identified in Discussion

- Digital maturity is constrained by ageing infrastructure and the absence of a national EPR or cancer information system.
- There is a need to articulate what the Trust cannot deliver due to resource constraints, to support realistic IMTP planning.
- Clinical digital capability is a recognised gap and must feed into workforce and service transformation planning.
- Digital change relies heavily on behavioural and cultural change, not just technology deployment.
- Closer alignment with DHCW is required, given cross-system dependencies and the scale of national programme impacts.

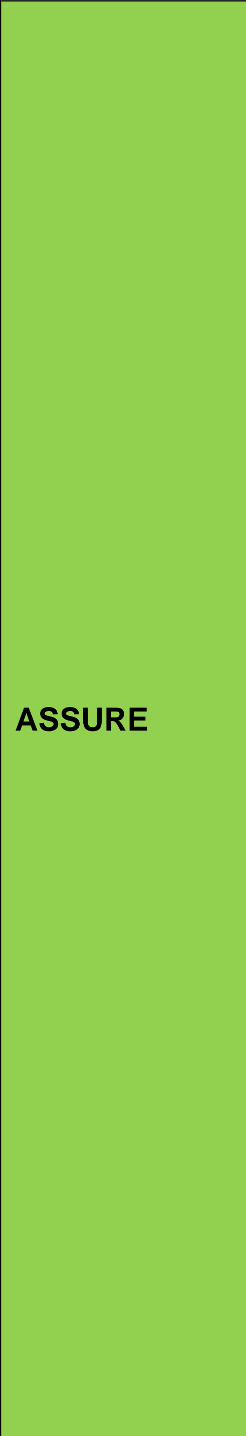
Timeline and Outputs

- Diagnostic launched: 10 November
- Duration: 3 months
- First outputs expected: January, with reporting through EMB, SDC, and to the Trust Board in early 2026.
- Final outputs will include:
  - A Trust-wide digital transformation model
  - Prioritised recommendations
  - Capacity and investment scenarios
  - A clearer understanding of sequencing for digital workstreams

There was strong support for the diagnostic as essential to future IMTP development, NVCC readiness, workforce planning, and overall sustainability.

The Committee emphasised the need for:

- A clear “must-do vs could-do” prioritisation
- A Trust-wide view of digital maturity and capability
- Regular reporting back to SDC and the Board as the diagnostic progresses.

	The Committee **NOTED**: a) the scope for the Digital Diagnostic b) that TPX Impact have been commissioned to undertake the work with the Trust. c) that the report will be completed for presentation in February 2026.
 **ASSURE**	**People Strategy Update** The Committee received an update on progress against the Trust's People Strategy, noting activity across wellbeing, engagement, recruitment, retention, and workforce processes. • **Progress and Achievements** Work continues to build the infrastructure required for effective workforce support, including improvements to wellbeing, engagement, and supply routes for recruitment. Metrics show improvements in several areas compared with the previous year, though further work is needed to understand longer-term trends. • **Key Issues Discussed** o **Trend Data:** The Committee emphasised the need for three-point trend data to properly assess progress and trajectory, rather than relying on year-on-year comparison. The team confirmed this data is available and will be incorporated. o **Workforce Planning:** Members sought clarity on the absence of an overarching workforce plan. It was confirmed that: ▪ Workforce planning is in development but depends on clarity around future service models. ▪ Several areas already have strong plans (e.g., IRS, Red Cell Lab), but a full Trust-wide plan is still being developed. ▪ Workforce planning must align with transformation, not operate in isolation. o **Outcome Measurement:** The Committee noted that reporting remains output-focused rather than outcome-focused. There is a need to demonstrate: ▪ The impact of interventions on staff experience and patient care ▪ How activity supports strategic workforce objectives This aligns with wider conversations on improving assurance and aligning enabling strategies. • **Assurance Level**

Assurance Level 4 was proposed however, the Committee concluded this could not yet be supported due to gaps in outcome evidence and workforce planning clarity.
Assurance was formally agreed at Level 3.

- **Next Steps**
  Trend data to be incorporated into future reporting.
  Development of clearer impact and outcome measures aligned to the People Strategy.
  Continue progressing the Trust-wide workforce plan as service models evolve.
  Strengthening integration of enabling strategies (People, Digital, etc.) within strategic reporting.

The Committee **NOTED** the contents of the People Strategy Update Report.

Board Assurance Framework (BAF)

- The Committee agreed to streamline BAF reporting, removing duplicate "changes" documents and relying instead on a short overview plus the updated BAF, where alterations are already clearly marked.
- Members emphasised the need for stronger alignment between strategic risks, the IMTP, and the Trust's transformation portfolio, noting the current BAF does not yet fully reflect strategic priorities.
- Concerns were raised that some risks appear static or insufficiently reflective of current challenges. The Executive Team will revisit and refine the strategic risk set.
- The Committee highlighted that some entries show gaps in controls/assurance without clear actions and requested clearer articulation of what is being done to close these gaps.
- Going forward greater clarity on the purpose of BAF reporting to SDC was requested, specifically how it should support oversight of strategic delivery risks as distinct from operational assurance considered at QSP. A follow-up discussion will take place with Corporate Governance.

The Committee **NOTED**:

1) the status of the BAF and the Level 2 Assurance.
2) the actions being taken forward to streamline and improve the BAF format and reporting.

Public nVCC Project Scrutiny Sub-Committee Highlight Report.
The Committee **NOTED** the report and focused on whether the assurance levels presented accurately reflected the current position.

- Two items marked "Assure" should instead be "Advise", as further clarification and work were still required, specifically around:
  - Outreach independence assurance

- Day-one readiness for nVCC operations

- The Committee discussed the governance route, noting that reporting will shift toward a streamlined structure: Executive Management Board to nVCC Scrutiny Project Sub-Committee to SDC, ensuring SDC receives strategic-level assurance rather than operational detail.
- Progress overall was described as positive, although ongoing robust discussions with ACORN and several programme interdependencies continue to require attention.
- No new risks were escalated, but the Committee emphasised the importance of continued visibility of key dependencies, including digital readiness and outreach planning, through future reports.

Velindre Cancer Service Futures Assurance Report

The Committee received the VCS Futures update, which focuses on service preparedness across key Programmes leading to the new cancer centre opening.

- **Progress noted:**
  - The **Satellite Radiotherapy Unit** is open and operational.
  - **IRS** (regional/national project) remains **at risk**, requiring continued oversight.
  - **EPMA** are progressing as planned, while **TRAMS** remains dependent on national decision-making, with clarity expected later in the year.
  - Work continues to define milestones for **Outreach** and **Outpatients**, which must be aligned with NVCC timelines.
- **Research Bunker:** Strategic discussions are underway regarding the future research model, with decisions expected following CEO-level engagement.
- **Governance clarity:** The Committee noted that VCS Futures reporting will, in future, feed through the nVCC Scrutiny Project Sub-Committee before coming to SDC for high-level assurance, reducing duplication.
- **Committee emphasis:**
  - Need for clearer articulation of interdependencies, especially around outreach, digital readiness, and national programme timelines.
  - Importance of preparing a consolidated view of what must be in place before nVCC opens.
  - Recommended including updates on research and pathway-wide sustainability in future reports.
- **Assurance:** The Committee accepted the report and agreed that Assurance Level 3 was appropriate.

Welsh Blood Service Futures Assurance Report

	The Committee received the WBS Futures Assurance Report and **NOTED** The overall assurance position was Amber/Green, reflecting good progress alongside a small number of areas requiring close attention.
	• **Key achievements noted:**
	  ○ Successful User Acceptance Testing and validation for the Welsh System Compatibility Waste project — described as a major milestone.
	  ○ Significant progress on the Plasma for Medicines programme, including timely completion of the critical *master file* required for moving into the next production and supply stages, avoiding a potential one-year delay.
	  ○ Steady advancement of the Talbot Green infrastructure business case, on track for expected sign-off in February.
	• **Items requiring monitoring:**
	  ○ A red-rated area associated with the BECS procurement was noted but discussed in private session due to legal considerations.
	  ○ Some national programme dependencies continue to affect timelines, underscoring the need for strong engagement with DHCW (Digital Health & Care Wales).
	• **Committee reflections:**
	  ○ Members formally recognised the substantial progress and the amount of work underpinning the green-rated items.
	  ○ Emphasised the importance of maintaining oversight of national interdependencies, given their material impact on WBS delivery.
	  ○ Assurance Level **3** was accepted as appropriate.

INFORM	**IMTP 2026/27 – 2028/29: Trust Planning Guidance and Approach** The Committee reviewed the planning guidance and proposed approach for developing the 2026–2029 Integrated Medium-Term Plan (IMTP). **Key Points** • **Back Casting Approach:** The Trust will plan backwards from March 2028, aligning to major milestones such as the Welsh Blood Service 5-year plan and transition to the New Velindre Cancer Centre. This provides a clear future end-state and sharper milestone definition. • **Sharper Prioritisation:** The IMTP will focus on a smaller set of core priorities, reflecting organisational capacity and the need for delivery discipline. • **Outcome-Focused Planning:** Members emphasised the need for strengthened strategic narrative and clearer links between actions, outcomes, and benefits for patients, donors, and staff. • **Financial Assumptions:** The plan assumes a flat-cash scenario, driving a need for greater efficiency, productivity, and internal

	resource optimisation before seeking new investment. • **Dependencies:** Workforce, digital capability, service redesign, and national system reliance (e.g., RISP, LIMS) were highlighted as critical enablers and risks that must be fully integrated into IMTP planning. • **Cross-Cutting Themes:** Sustainability, equity, pathway-wide working, and incorporation of emerging innovations (AI, genomics) were identified as essential IMTP components. The Committee: a) **NOTED** the IMTP Planning Guidance 2026 -2029 which will support the development of the IMTP. b) **NOTED** the further opportunity to discuss the approach to the development of the IMTP at the Board Development Session on 16th December 2025.
APPENDICES	**NOT APPLICABLE**

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

TRUST BOARD

PUBLIC CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	29th January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Niké Hooper-Collins, Business Support Officer
PRESENTED BY	Sara Mosely, Chair
EXECUTIVE SPONSOR APPROVED	Anne Carey, Chief Operating Officer
REPORT PURPOSE	FOR NOTING

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its Public meeting held on the 9th December 2025.

Key highlights from the meeting are reported in Section 2.

The committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Board from the meeting of the Charitable Funds Committee (CFC) held on the 9th December 2025:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**Charitable Funds (Trustee) Annual Report & Annual Accounts**

	A draft report was received at the Charitable Funds Committee on 9th December. It celebrates the Charity's work, acknowledges the cost-of-living crisis, and emphasises the importance of sustainable income and supporter relationships. It includes clearer aims and objectives, making it easier to see how funds are used and their impact. It was explained that some financial figures were not yet included, as they depend on the completion of the audit and these will be added once finalised. The final audited version of the report and accounts will be reviewed and endorsed at an extraordinary Charitable Funds Committee meeting on the 27th January 2026, before being submitted to the Trust Board on the 29th January 2026, for approval. The Committee **RECEIVED** and **NOTED** the draft report. **Charitable Funds Terms of Reference** The Committee discussed updating the terms of reference and membership, aiming to circulate revisions before the January 2026 EMB and subsequent Trust Board meeting. This is linked to ongoing governance review work. **Charitable Funds Investment Policy** A revised investment policy was presented to the Committee, noting significant changes based on benchmarking with other charities and input from investment managers. The policy was streamlined to avoid unnecessary restrictions and formalise responsibilities for asset management. It was noted that ethical restrictions (e.g., no investment in tobacco, gambling) remain unchanged, and screening methods were updated to reflect current best practices. It was reported that the investment portfolio has a strong performance on environmental, social, and governance (ESG) metrics, including a portfolio with 18% less carbon intensity than the benchmark and a four-star ESG rating.
ASSURE	**Charitable Funds Audit Plan 2024/25** Three main risks were highlighted: • Management override (a standard risk in all audits). • Related party transactions (due to the lower materiality threshold). • Classification of income, which was flagged because of a high volume of audit adjustments in the previous year. The team has worked proactively to address this risk for the current year.

	The audit is well underway and on track to meet the Charity Commission deadline at the end of January. No significant issues have been identified so far. The estimated audit fee is £25,000, which is higher than last year due to the additional work required previously. The fee is an estimate and may be adjusted depending on the actual work required. Committee members welcomed the proactive engagement between the finance team and Audit Wales, especially regarding income classification. The Committee **RECEIVED** the plan and **NOTED** the fee is in line with benchmarks and appreciated the collaborative approach to resolving previous issues.
INFORM	The were no items to inform.

3. RECOMMENDATION

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

TRUST BOARD	
ASSURANCE REPORT NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	James Quance, Assistant Director of Corporate Services, NWSSP
PRESENTED BY	Alison Ramsey, NWSSP Director of Finance & Corporate Services
APPROVED BY	**Choose an item**
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 14 November 2025.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the contents of the report from the last meeting of the Shared Services Partnership Committee, which took place on 14 November 2025.

<table>
<tr><td colspan="3">GOVERNANCE ROUTE</td></tr>
<tr><td colspan="2">List the Name(s) of Committee / Group who have previously received and considered this report:</td><td>Date</td></tr>
<tr><td colspan="2">Formal Senior Leadership Group (FSLG)</td><td>29/01/2026</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="3">SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
Not applicable</td></tr>
<tr><td colspan="3">7 LEVELS OF ASSURANCE</td></tr>
<tr><td colspan="3">Not applicable</td></tr>
<tr><td>ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR</td><td colspan="2">Select Current Level of Assurance

Not applicable</td></tr>
<tr><td colspan="3">APPENDICES</td></tr>
<tr><td></td><td colspan="2">Not applicable</td></tr>
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SHARED SERVICES COMMITTEE ASSURANCE REPORT – 14 NOVEMBER 2026

1. SITUATION

To provide the Trust Board with details of the key issues considered by the Shared Services Partnership Committee, at its meeting on 14 November 2025 for **NOTING**.

2. BACKGROUND

A summary of the business matters discussed at the Shared Services Partnership meeting held on 14 November 2025, is outlined below.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Reporting Committee	**Shared Services Partnership Committee**
Chaired by	Professor Tracy Myhill OBE, NWSSP Chair
Lead Executive	Neil Frow OBE, Managing Director, NWSSP
Author and Contact Details	Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services
Date of Meeting	14 November 2025
Summary of key matters including achievements and progress considered by the Committee and any related decisions made	
Chair's Report - The Chair updated the Committee on activities since the last meeting, in addition to routine duties, approvals, and providing support to NWSSP, which included: • **Autumn Development Day -** Attended and contributed to the Autmn Committee Development Day and expressed appreciation to those who attended the worthwhile event. • **Chairs' Meeting -** Participated in the October Chairs' meeting, which included an introduction and discussion with the new Director General Health Social Care and Early Years, Jacqueline Totterdale. • **Engagement with NHS Leadership -** Met with the new Chair of Velindre University NHS Trust, Sara Mosley, on multiple occasions for introductory discussions. • **NHS Confederation Event -** Attended the NHS Confederation Dinner, engaging with colleagues and stakeholders. • **NWSSP Audit Committee -** Attended the NWSSP Audit Committee meeting held on 7 November 2025. The Committee **NOTED** the Chair's Report.	
Managing Director Update - The Managing Director presented his report, which included the following updates:	

- **Chair Tenure** - NF was pleased to report that TM has agreed to continue as Chair of the Committee for a further twelve months. The Welsh Government Governance and Accountability Review outcome is still awaited, and current arrangements remain in place under the Director General's direction.
- **Welsh Risk Pool –** Discussions are ongoing with Welsh Government and Chief Executive Officers (CEOs) regarding financial pressures and high-value cases, with a course of action agreed for further engagement. A presentation was delivered to CEOs by AR and Mark Harris (Director of Legal & Risk Services and Welsh Risk Pool). Excluding the Welsh Risk Pool, NWSSP is forecasting a positive financial position and expects to achieve break-even, with potential financial distribution back to organisations.
- **Transforming Access to Medicines Programme (TrAMS) -** The IP5 Radiopharmacy build is nearing completion of construction phase, with production anticipated from April 2026. The South East Hub Full Business Case (FBC) is in development following agreement on scope, with detailed design work underway. Alternative sites are being considered for West Wales, and discussions with Betsi Cadwaladr University Health Board (BCUHB) on the North Wales Hub have been positive, with additional project management support planned. NF also praised the successful Medicines and Healthcare products Regulatory Agency (MHRA) inspection at IP5 for Pharmacy services.
- **Vaccination Programmes -** Vaccination programmes continue successfully, with nearly one million influenza vaccines delivered and 400,000 COVID doses distributed. NF commended the teams for their ongoing efforts.
- **Other Matters** - The overarching report highlighted progress made in Laundry Services, Primary Care and Medical Examiner Services, as well as Personal Protective Equipment, Accommodation and Decarbonisation. Senior Leadership events and Awards and Recognition were summarised, with NF confirming that he attended the More Than Just Words event, promoting Welsh language initiatives. Further, NF congratulated the NWSSP Payroll Services Team on winning the Shared Services Forum UK Future Vision Award for Team of the Year. NF was also pleased to confirm retention of NWSSP's organisational accreditation to the Cabinet Office's Customer Service Excellence standard, for a third consecutive year.

The Committee **NOTED** and **DISCUSSED** the Managing Director's Report.

Presentation

2026-2029 Integrated Medium-Term Plan (IMTP) Progress Update - The Committee received an update on the development of the NWSSP IMTP for 2026–2029.

As a statutory requirement, the IMTP will be produced in line with Welsh Government guidance and financial allocations, which are expected by the end of November 2025. The plan remains iterative and shaped by Cabinet Secretary current priorities, including waiting lists, patient flow, women's health, prevention, community services and digital transformation. NWSSP's role is to support Health Boards in delivering their plans and ensure alignment through divisional objectives.

The planning process builds on previous work and reflects Welsh Government priorities. Divisional plans have been submitted and are undergoing scrutiny for financial viability and resource capacity. The aim is to present a draft IMTP to the Committee in January 2026, with final delivery by March 2026. A refreshed Digital Strategy is also being developed by the new Chief Digital Officer.

A successful Committee Development Day in October 2025 informed the direction of travel, and ongoing quarterly reviews with organisations are reinforcing alignment and identifying local priorities. Staff engagement remains central, with divisional plans developed from the bottom up and input sought from the Local Partnership

Forum, the Equality, Diversity & Inclusion Group and Peer Networks. Five emerging themes have been identified, insofar as digital transformation and innovation, workforce development and culture, operational efficiency, sustainability and decarbonisation, and partnership engagement. The Committee was advised that timelines are on track and that the team is working to deliver a robust plan by March 2026.

The Committee **NOTED** the update and endorsed the approach to IMTP development, recognising the strong engagement process and alignment with National priorities.

Items for Approval

NWSSP Strategy Map Refresh for 2026-2029 - The Committee received the Strategy Map for approval and were informed that it was reviewed following the Committee Development Day to ensure alignment with current and future organisational priorities. Feedback from Committee Members and staff informed refinements to strategic objectives and outcomes. The mission statement, "*Delivering Value, Innovation and Excellence through Partnership*," was confirmed as fit for purpose. Strategic objectives have been updated reflect emerging priorities, including a new objective, Our Partners, focussing on partnership and co-production across NHS Wales. Updated outcome definitions will strengthen performance reporting and provide a clear framework for NWSSP's contribution to NHS Wales priorities, underpinning the next IMTP cycle.

The Committee **APPROVED** the NWSSP Strategy Map Refresh for 2026-2029.

Extension to the Service Level Agreement (SLA) for the Services supporting the National Influenza Immunisation Programme – The Committee received an update that the current flu vaccination programme is 97% complete, equating to 885,000 vaccines delivered to approximately 1,800 sites across Wales. Welsh Government has requested NWSSP to run the same programme for 2026–27. The Committee received a proposal to extend to the existing SLA to enable this, noting that a purchase order would need to be signed by Velindre University NHS Trust within the next few weeks to secure manufacturing slots. The supply contract has already been extended for 12 months within the existing contract terms.

The Committee **APPROVED** the extension to the SLA for the services supporting the National Influenza Immunisation Programme and the procurement of next seasons vaccine. Further, the Committee **NOTED** Velindre's position to note the item.

Revised Stockholding Requirements for Personal Protective Equipment (PPE) and Hygiene Consumable Products – The Committee received the revised stockholding requirements, for approval. The proposed extension formalises Welsh Government's direction, via the Cabinet Secretary, for NWSSP to maintain a national stockpile of PPE and hygiene consumables. NWSSP is sourcing PPE nationally and internationally and has commenced deliveries to achieve the mandated stock levels. These levels are based on demand during the peak of the second COVID wave, with a minimum of 12 weeks' stock in hand for each product. Certain items, such as aprons, gloves, and Type IIR masks, are now considered business as usual and that NWSSP will rotate stock to minimise expiry-related write-offs.

The Committee **APPROVED** the Revised Stockholding Requirements for Personal Protective Equipment (PPE) and Hygiene Consumable Products, as set out in the Change Control Notice.

Fleet Modernisation and Optimisation Programme Business Case (PBC) – The Committee received the PBC for approval, which enables progression to the next stage of governance, which involves noting by the

Velindre Trust Board. The PBC sets out a 10-year fleet replacement strategy split into two five-year programmes. NWSSP currently operates 306 vehicles, of which 198 are owned and 108 leased; 40 vehicles are fully electric, while 266 are diesel or petrol. The fleet covers approximately 4 million miles annually across NHS Wales services. The first five-year phase proposes replacing 124 vehicles, with the strategy considering cost, carbon reduction, air quality improvements, and noise reduction. An optimisation review will run in parallel to assess fleet mix, routing, load capacity, and specialist requirements such as cold-chain capability for vaccination programmes. Annual business justification cases will follow to procure vehicles in line with the approved programme.

The Committee **APPROVED** the Fleet Modernisation and Optimisation Programme Business Case.

Service Level Agreement (SLA) for the Provision of Commercial Medicines Contracting relating to Specialised Medicines – The Committee received the SLA for approval, which was designed to formalise the collaborative arrangements between the Medicines Value Unit (MVU) and the NHS Wales Joint Commissioning Committee (NWJCC) for specialised medicines contracting, for a two-year term. The SLA introduces a structured governance framework to clarify roles, responsibilities, timelines and deliverables.

The Committee **APPROVED** the SLA for the Provision of Commercial Medicines Contracting relating to Specialised Medicines.

Local Partnership Forum and Sub-Groups Terms of Reference – The Committee received the updated Terms of Reference for the Local Partnership Forum and its sub-groups, for approval. The refresh includes strengthened provisions around speaking up safely and a restructured approach to recruitment and retention, with the former sub-group now renamed as the Attraction and Retention Sub-group. A dedicated sub-group for policy review has also been introduced to ensure systematic oversight of workforce policies. The revisions received positive feedback and endorsement from the Local Partnership Forum.

The Committee **APPROVED** the Local Partnership Forum and Sub-Groups Terms of Reference.

Locum Hub Wales Contract Briefing Report – The Committee received the Locum Hub Wales contract, for approval. The proposal is to extend the contract for two years on a 1+1 basis, allowing time for a full review of the scheme's scope before considering any recommissioning. There is no funding risk, as the programme is fully funded by Welsh Government with direct allocation to NWSSP. Due to the cumulative value of the extension, Velindre Trust Board approval will be required under the Scheme of Delegation.

The Committee **APPROVED** the contract extension for GP Locum Hub Wales, on a 1+1 basis.

Items for Noting and Discussion

Future NHS Workforce Solution - Electronic Staff Record (ESR) Transformation Programme – The Committee received an update on the new NHS Workforce Solution, noting that the programme has moved from planning to mobilisation, at a significant pace.

The award of the £1.2 billion contract to Infosys to deliver the replacement for the ESR system and outlined key activities underway, including identification of early adopters and design workshops. Governance arrangements will involve NWSSP working with NHS Business Services Authority (NHSBSA) and Infosys to ensure a consistent approach, with reporting through this Committee, the NHSBSA Transformation Board, and Welsh Government. A programme management structure and overarching steering group will be established,

supported by task-and-finish groups focused on readiness and business change. Funding discussions with Welsh Government are ongoing to address increased costs under the new contract. ESR audits will commence in January 2026, with formal action plans for organisations to ensure foundational readiness. Additional work includes developing an executive briefing pack for Boards to support local communications. NWSSP will work with Welsh Government to confirm IMTP planning assumptions on costings and fundings arrangements to NHS organisations. Regular updates will be provided to the Committee and through peer-groups.

The Committee **NOTED** the update provided in relation to the Future NHS Workforce Solution – ESR Transformation Programme.

NWSSP Duty of Quality (DoQ) Update – The Committee was informed that NWSSP has successfully achieved re-accreditation for Customer Service Excellence for the third consecutive year across the organisation. The 'always on' reporting mechanism continues and staff engagement remains a key feature, to ensure updates are accessible and meaningful. The Committee receives DoQ updates on a six-monthly basis, with an Annual Report submitted for approval and subsequently published as a separate chapter in the Velindre Trust's Duty of Quality update.

The Committee **NOTED** the NWSSP Duty of Quality Update.

Finance, Performance, People, Programme and Governance Updates

Finance Report – The Committee noted the financial position as at 30 September 2025, confirming a year-to-date surplus of £3.1m, driven by vacancies and underspend in health protection allocation. The forecast remains for a breakeven position by year-end, supported by continued review of expenditure and identification of savings opportunities. Capital expenditure to date stands at £1.9m against an annual limit of £9.4m, with successful funding secured for the next phase of work on the South East Wales TrAMS Full Business Case and further bids submitted for digital and estates schemes. Payment performance and new KPIs remain strong, with improvements noted in invoice processing. The Welsh Risk Pool forecast has risen sharply, creating significant financial pressure across NHS Wales and posing ongoing volatility that will impact next year's planning cycle.

People and Organisational Development Report – The Committee received the latest workforce update to 31 October 2025, which highlighted stable sickness absence trends, turnover has reduced, and compliance for mandatory training and PADRs is among the highest in NHS Wales. Progress continues on recruitment, retention, wellbeing, and diversity initiatives, including the launch of the Equality Diversity and Inclusion dashboard and promotion of the Work in Confidence platform. Preparations are underway for the NHS Wales staff survey and recognition awards. NWSSP also achieved national recognition at the ENEI Awards, receiving Highly Commended for Wellbeing and Belonging at Work.

Performance Information Report – The Committee received the report detailing the Key Performance Indicators (KPIs) from June to September 2025. The report confirmed that the majority of KPIs were met in September, with continued delivery against stretch targets and NWSSP having generated £58 million in professional influence benefits as at 30 September 2025. A review of performance targets is underway as part of IMTP development. There were no areas of concern to be brought to the Committee's attention.

Outcome Measures Report – The Committee received the report focused on outcomes aligned to NWSSP's strategic objectives across services, people and value. NWSSP continues to demonstrate progress in evidencing impact and the overarching report detailed high levels of customer satisfaction, strong employee

engagement, and positive impact across procurement, decarbonisation and foundational economy, with 44% of procurement spend retained within Wales.

Integrated Medium-Term Plan (IMTP) Quarter 2 of 2025-26 Update Report –The Committee received the latest update in respect of progress made against NWSSP's IMTP. The overarching report confirmed that 85% of objectives are on track, with targeted actions in place for off-track items. Performance remains stable, with 104 actions on track and six completed. Areas of challenge are being supported or deferred, where necessary.

Transformation Management Office (TMO) Update Report – The Committee received an update on the work of the TMO. The overarching report summarised the breadth of transformation activity across NWSSP and national programmes, indicating a stable position with 18 projects, 2 programmes and 5 initiatives currently being tracked. Of which, 2 are red, 7 are amber and 16 are green-rated projects. Overall, the portfolio demonstrates consistent delivery momentum across a diverse range of transformation and service improvement programmes, with 92% of projects rated green or amber and several nearing completion.

NWSSP Corporate Risk Register – The Committee received the latest Risk Register update, which was reported as stable and continues to be scrutinised regularly at each Senior Leadership Group meeting. The latest position identifies 17 risks for action, comprising six red, 11 amber and one yellow-rated risk. In addition, four risks are recorded for monitoring, including one amber and three yellow. The overarching report also outlines six emerging risks currently under consideration. Internal Audit has recently provided reasonable assurance on risk management processes.

NWSSP Management Letter 2024-25 – The Committee received the Management Letter for 2024-25, which was prepared by Audit Wales and considered by the NWSSP Audit Committee on 7 November 2025. Positive assurance was provided to NHS external audit teams on the activities of NWSSP for accounts opinion purpose with no recommendations made, for the third consecutive year. Appreciation was expressed to the Finance team and all divisions for their contribution in achieving this outcome. Committee Members acknowledged the significance of this outcome and welcomed the assurance provided.

Nationally Hosted NHS IT Systems Report 2024-25 – The Committee received the report prepared by Audit Wales, which was considered by the NWSSP Audit Committee on 7 November 2025. The report is positive and highlights the complexity of digital systems across NHS Wales and the need for continuous annual improvements. It notes close collaboration with Digital Health and Care Wales (DHCW) and a systems-based approach, emphasising the importance of maintaining robust controls, given ongoing cyber security risks. Audit actions will be addressed and monitored through the NWSSP Audit Committee and NWSSP Senior Leadership Group. Committee Members welcomed the assurance provided, noting it gives confidence to both the Committee and the NWSSP Audit Committee. Progress on IT key controls was commended, particularly given the backdrop of cyber threats.

The Committee **DISCUSSED** and **NOTED** the above Reports.

Part B - Private

The Committee received the NHS Wales Energy Sourcing Decision for 2026/27 and **APPROVED** the Welsh Energy Group's proposal in respect of the All Wales electricity source, to remain with Zero Carbon for Business.

In addition, the Committee received the Draft Welsh Energy Group Minutes of the meeting held on 3 November 2025, for information.

Matters requiring Board/Committee level consideration and/or approval	
The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Date of next meeting	Tuesday 22 January 2026, 10.00am to 12.00pm.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item Not applicable
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required Click or tap here to enter text. **Click or tap here to enter text**
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: **Choose an item**	
If yes select the relevant goals:	

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Assurance / Highlight Report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

No applicable

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Not applicable
WHAT IS THE CURRENT RISK SCORE	Not applicable
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Not applicable
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Not applicable
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	Not applicable
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE VELINDRE NHS TRUST AUDIT COMMITTEE FOR VELINDRE UNIVERSITY NHS TRUST BOARD	
DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Carly Wilce, NWSSP Corporate Services Manager
PRESENTED BY	Gareth Jones, Chair of NWSSP Audit Committee
APPROVED BY	**Choose an item**
EXECUTIVE SUMMARY	This paper has been prepared to provide the Trust Board with details of the key issues considered by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee), at its meeting on 07 November 2025.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the contents of the report from the last meeting of the NWSSP Audit Committee, which took place on 07 November 2025.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Shared Services Partnership Committee (SSPC)	22/01/2026
Formal Senior Leadership Group (FSLG)	29/01/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
Not applicable

7 LEVELS OF ASSURANCE
Not applicable

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** **Not applicable**

APPENDICES	
	Not applicable

NWSSP AUDIT COMMITTEE HIGHLIGHT REPORT – 07 NOVEMBER 2025

1. SITUATION

To provide the Trust Board with details of the key issues considered by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership (NWSSP Audit Committee), at its meeting on 07 November 2025 for **NOTING**.

2. BACKGROUND

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 the issues delegated to them through the Trust and NWSSP Standing Orders. A summary of the business matters discussed at the meeting held on 07 November 2025, is outlined below.

3. SUMMARY OF MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for alert/escalation to the Board.
ADVISE	As part of the Counter Fraud Progress Update, the Committee was advised of a new criminal offence of "Failure to Prevent Fraud" which was introduced by the Economic Crime and Corporate Transparency Act 2023 which came into effect on 1 September 2025. Fraud awareness sessions have been provided to senior leaders around the new offence which covered the commercial and public sectors (including the NHS). It was noted that compliance procedures are already in place.
ASSURE	Update from NWSSP Managing Director The Managing Director provided members with a comprehensive update on significant developments within NWSSP, as outlined below: • Ongoing discussions with organisations across NHS Wales regarding the financial position continue to take place, with some reporting deficits. NWSSP is forecasted to break even for 2025–26, with cash-releasing savings expected to be returned to Welsh Government and NHS Wales, although the final amount was yet to be confirmed. • Organisations face challenges relating to the Welsh Risk Pool (WRP), concerning the significant increase in contributions required under the Risk Share Agreement. Discussions remain ongoing with Welsh Government regarding potential funding solutions. The Director Finance and Corporate Services and Director of Legal and Risk Services provided an update to the Chief Executives Group outlining mitigation options. • Construction of the RadioPharmacy at IP5 was now scheduled for completion in November 2025, with the facility expected to become operational by April 2026. The Outline Business Case (OBC) for the South-East Hub had been approved, and work was progressing on

	the Full Business Case (FBC). Efforts were underway to ensure the FBC is submitted to Welsh Government in line with the agreed timeline to avoid delays. Meanwhile, North Wales was keen to accelerate progress on the North Wales Hub, with a meeting planned to determine the next steps. • The NHS Wales Influenza Vaccination Programme was delivered successfully, with positive feedback from Welsh Government, who have requested NWSSP deliver the programme again in the next financial year. • Significant work has been undertaken with the Medical Examiner Service to support winter planning, incorporating lessons learned from the previous year. • The Welsh Ambulance Services NHS Trust (WAST) would be relocating to one of NWSSP's sites and would take over the lease arrangements. They will also occupy the top floor at Matrix House in Swansea. • Productive discussions have taken place with Welsh Government regarding Personal Protective Equipment (PPE) requirements, and NWSSP was on track to meet the revised agreed targets for PPE stock levels. The Audit Committee NOTED the Managing Director's Update and stressed the importance of adhering to the timeline for the FBC for the South East Hub.
ASSURE	Audit Wales Management Letter 2024-25 Audit Wales presented the Management Letter for NWSSP, confirming that no key findings were identified for the second consecutive year, providing assurance that core financial processes remained materially sound for 2024/25. The Committee NOTED the Audit Wales Management Letter 2024-25.
ASSURE	External Audit Position Statement Audit Wales presented the Position Statement, noting that the 2024/25 audits were in the final stages of completion and preparatory work for the 2025/26 plan would commence shortly. Audit deadlines have been agreed and scheduled and would remain in line with previous years of 30 June 2025. The Committee NOTED the Audit Wales Position Statement 2024-25.
ASSURE	National Fraud Initiative (NFI) Update Audit Wales presented the NFI briefing paper, which was being presented to Audit Committees across Wales to provide an overview of the national position. The paper also outlined the types of local data matches under consideration for investigation. NWSSP is collaborating with NHS

	organisations to address any flagged matches. Governance arrangements for NFI are in place, with designated responsible officers within NWSSP. The Committee NOTED the National Fraud Initiative Update.
ASSURE	Audit Wales Nationally Hosted NHS IT Systems Report The Nationally Hosted NHS IT Systems Report was presented to the Committee, which reviewed the IT systems and infrastructure managed by NWSSP for use by other NHS organisations, providing assurance that robust controls are in place. The report was positive and two recommendations were identified for action. Implementation of these recommendations would be monitored by Corporate Services in line with the Audit Recommendation Tracking process. The Audit Committee NOTED the Audit Wales Nationally Hosted NHS IT Systems Report.
ASSURE	Internal Audit Progress Report The Head of Internal Audit provided an update on progress against the Internal Audit Plan with an overview of other activity since the previous meeting. Key points included: • Four audits have been completed to date, all receiving positive assurance ratings of either Substantial or Reasonable. These were included on the agenda. • Several audits from the Internal Audit Plan were currently in progress, at either draft or testing stages, and remain on track for completion in line with the plan. The Audit Committee NOTED the Internal Audit Position Statement.
ASSURE	Internal Audit Reports The Committee received the Internal Audit reports detailed below, for review and consideration, all of which achieved Substantial or Reasonable assurance. Progress against the resulting actions would be monitored via the Audit Recommendation Tracker, with updates provided at future meetings. • Primary Care Services General Ophthalmic Services (GOS): Substantial assurance awarded; controls for administering payments were found to be robust, with one minor improvement identified for action and it had already been implemented. • Accounts Payable: Reasonable assurance awarded; accuracy of invoice processing and controls confirmed, with some duplicate payments identified and addressed, with three key findings for action identified. • Risk Management: Reasonable assurance awarded; risk management frameworks were well established, with regular oversight and escalation of significant risks. Two key actions were

	identified, including the need for improvements within the Laundry Services risk registers. • Radiopharmacy Capital: Reasonable assurance awarded; project controls for the South-East Wales unit were in place, with key actions on guarantees and budget monitoring completed. There were 10 key matters arising identified for action. The Audit Committee NOTED the Internal Audit Reports outlined above.
ASSURE	Counter Fraud Progress Report The Committee received the Q2 Counter Fraud Position Statement from NWSSP's Local Counter Fraud Manager (LCFM), providing an overview of activity to date. The Counter Fraud Progress Report for Q2 was presented. Fraud awareness training uptake continues to improve, with the Senior Leadership Group monitoring completion rates. Six new case referrals were received in the last quarter, with one active case related to the NFI data matching exercise. The Audit Committee NOTED the Counter Fraud Q2 Progress Update.
ASSURE	2026-29 Integrated Medium-Term Plan (IMTP) The Director of Planning, Performance and Informatics provided an update on the development of the 2026–29 IMTP. Early internal planning was underway to ensure readiness and alignment with evolving priorities and the challenging financial position across NHS Wales, which would require NWSSP to deliver additional savings for its partners. The 2025–29 NHS Planning Framework has not yet been published but was scheduled for launch on 30 November 2025, alongside a financial allocation letter from Welsh Government expected in December 2025. A letter from the Cabinet Secretary in July outlined key priorities, including delivering Welsh Government objectives. NWSSP would align its plans to support Health Boards in achieving these priorities. A balanced financial plan for 2025–26 is anticipated, though significant risks remain. The 2025–28 plan was approved by the Shared Services Partnership Committee in February 2025, with formal confirmation from Welsh Government in July 2025. While the plan supports NWSSP's role in enabling the wider NHS Wales system, particularly in areas under operational or financial pressure, it acknowledges ongoing risks that require close management. Progress is monitored through quarterly review meetings, which are reported to the Shared Services Partnership Committee.

	The 2026–29 draft three-year IMTP will be reviewed by the Formal Senior Leadership Group on 18 December 2025, before submission to the Shared Services Partnership Committee for approval in January 2026. The Committee NOTED the update.
ASSURE	2025-26 Losses and Special Payments Report for Quarters 1 and 2 The Deputy Director of Finance presented the Audit Committee with the losses written off and special payments made, from 1 April 2025 to 30 September 2025, excluding bad debt, in accordance with the Standing Financial Instructions and Welsh Governments Manual for Accounts Chapter 6. • Total losses for the six-month period: £631,000 of this, £146,000 related to stores, primarily due to slow-moving or obsolete stock. The figure was consistent with the previous year's report for 2024/25. • £483,254 of these costs related to COT3 settlement agreements. • No individual items exceeded £50,000 (the threshold requiring Welsh Government approval). The Committee NOTED the Losses and Special Payments Report.
ASSURE	Governance Matters The Governance Matters report detailed the contracting activity for the last quarter. 42 contracts had been let for NWSSP and 22 further contracts for NHS Wales. 5 declarations had been made as to gifts, hospitality or sponsorship since the last meeting and there were no internal audit reports concluded with limited or no assurance. Of 117 audit recommendations, 113 had been implemented, 4 were not yet due and there were none to report as overdue. The NWSSP Corporate Risk Register contains 6 red risks, 11 amber and 1 yellow, for action. The Audit Committee NOTED the Governance Matters Report for the period.
INFORM	The following items were received for information • NWSSP Annual Review 2025-26; and • NWSSP Audit Committee Forward Plan 2025-26.
APPENDICES	Not applicable

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: [STRATEGIC RISK DESCRIPTIONS]*	Choose an item Not applicable
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* Click or tap here to enter text
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision

The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required Click or tap here to enter text. **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: **Choose an item**	
If yes select the relevant goals:	
• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities.	☐
• A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.	☐
• A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health	☐
• A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances	☐
• A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities.	☐
• A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language,	☐

encouraging people to participate in the arts, and sports and recreation. • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Assurance / Highlight Report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	New offence of Failure to Prevent Fraud introduced by the Economic Crime and Corporate Transparency Act 2023.

5. RISKS

Not applicable

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Not applicable
WHAT IS THE CURRENT RISK SCORE	Not applicable
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Not applicable
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Not applicable
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	Not applicable
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

TRUST WIDE POLICIES APPROVED UPDATE

DATE OF MEETING	29 January 2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **November 2025 to January 2026.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **November 2025 to January 2026.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Executive Management Board	22/12/2025
• Quality, Safety and Performance Committee	13/01/2026

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The following policies were **ENDORSED** by the Executive Management Board and **APPROVED** by the Quality, Safety and Performance Committee:

- IPC13 - Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldz-Jakob Disease) Minimising the Risk of Transmission
- IG06 - Anti-Virus Policy
- IG05 - Software Policy

7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1	IPC13 – Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldz-Jakob Disease) Minimising the Risk of Transmission
Appendix 2	IG05 – Software Policy
Appendix 3	IG06 – Anti-Virus Policy

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been through the Trust governance process and approved during the period **November 2025 to January 2026.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last report, the Quality, Safety and Performance Committee **APPROVED** the policy below, which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	IPC13 – Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldz-Jakob Disease) Minimising the Risk of Transmission	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/01/2026
2	IG05 – Software Policy	Executive Director of Strategic Transformation, Planning & Digital / Deputy CEO	Quality, Safety & Performance Committee	13/01/2026
3	IG06 – Anti-Virus Policy	Executive Director of Strategic Transformation, Planning & Digital / Deputy CEO	Quality, Safety & Performance Committee	13/01/2026

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 – Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒ A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result
	Each policy will be individually assessed to ensure compliance with EIA requirements.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC13

POLICY FOR THE PREVENTION AND CONTROL OF TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (CREUTZFELDT-JAKOB DISEASE) MINIMISING THE RISK OF TRANSMISSION

Executive Sponsor & Function	Executive Director of Nursing, AHPs & Medical Science
Document Author:	Infection Prevention and Control
Approved by:	Quality, Safety and Performance Committee
Approval Date:	13 January 2026
Date of Equality Impact Assessment:	29 January 2019
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	January 2029
Version:	9

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ABBREVATIONS

ACDP	Advisory Committee on Dangerous Pathogens
BSE	Bovine Spongiform Encephalopathy
CFS	Cerebral spinal fluid
CNS	Central nervous system
CJD	Creutzfeldt-Jacob Disease
COSHH	Control of substance hazardous to health
CSSU	Central Sterile Services Unit
DOH	Department of Health
FRSM	Fluid Resistant Surgical Mask
HCW	Health Care Worker
JPAC	Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee
IPCT	Infection Prevention & Control Team
LP	Lumbar Puncture
NPC	National Prion Clinic
OCCH	Occupational Health
PPE	Personal Protection Equipment
SCIPS	Standard Infection Control Precautions
TSE	Transmissible Spongiform Encephalopathies
vCJD	Variant CJD

1. POLICY STATEMENT

This policy aims to prevent the transmission of prion diseases, including Creutzfeldt-Jakob Disease (CJD) and variant CJD (vCJD), within Velindre University NHS Trust through the implementation of proportionate, risk-based controls in accordance with national guidance.

While the Trust does not currently undertake surgical or endoscopic procedures involving medium or high-risk tissues, should such services be introduced, appropriate decontamination protocols, instrument tracking, and traceability systems must be established prior to commencement.

2. SCOPE OF POLICY

This policy applies to all healthcare workers (HCWs) and contractors within Velindre University NHS Trust who may provide care to, or handle specimens from, individuals with suspected or confirmed CJD/vCJD, or those identified as being at increased risk.

Welsh Blood Service colleagues should refer to the latest guidance from the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) and the Department of Health and Social Care (DHSC), including the September 2024. JPAC Position Statement and updated laboratory containment measures (Nov 2021).

3. AIMS AND OBJECTIVES

To ensure all staff are informed of the risks associated with transmissible spongiform encephalopathies (TSEs) and are equipped to prevent iatrogenic transmission, particularly during invasive procedures and the handling of instruments, tissues, and clinical waste..

4. RESPONSIBILITIES

4.1 **The Chief Executive**: Holds overarching accountability for Infection Prevention and Control (IPC), including ensuring adequate resources and organisational compliance.

4.2 **Executive Director of Nursing, Allied Health Professionals & Health Science**: Acts as the executive lead for IPC, responsible for providing expert advice, overseeing training and monitoring compliance.

4.3 **Departmental Managers/ Clinical Directors**: Ensure staff access and adhere to the policy; notify IPCT of relevant cases; maintain traceability; provide PPE and training; support incident management.

4.4 **Clinical staff**: Apply SICPs, assess patient risk, notify IPCT of suspected or confirmed cases, use single-use devices where appropriate, report exposures, and liaise with Occupational Health.

4.5 **Theatre Staff**: Review infection alerts, verify instrument integrity and tracking, use single-use instruments for medium/high-risk tissues, and ensure documentation systems are in place.

4.6 **Infection Prevention and Control (IPCT)**: Provide expert guidance, conduct surveillance, review policy, and coordinate incident responses with senior leadership and external agencies.

5. KEY DEFINITIONS

Prion diseases, or transmissible spongiform encephalopathies (TSEs), are fatal neurodegenerative disorders caused by the accumulation of misfolded prion proteins. These may be sporadic, familial, or acquired (including iatrogenic and variant forms). They have prolonged incubation periods and no known effective treatment.

High-risk tissues include the brain, spinal cord, cranial nerves, cranial ganglia, and posterior eye structures. In cases of vCJD, additional tissues such as tonsils, appendix, spleen, thymus, adrenal glands, lymph nodes, and gut-associated lymphoid tissue are also considered high-risk. Other tissues and fluids are generally low risk.

Classification of TSEs:

- ***Idiopathic***: Sporadic CJD, Sporadic Fatal Insomnia, VPSPr
- ***Familial*: ** Familial CJD, GSS, Fatal Familial Insomnia
- ***Acquired*: ** Iatrogenic CJD, Kuru, Variant CJD

5.1 Transmission

CJD is not transmitted through casual contact. Standard Infection Control Precautions (SICPs) are sufficient for routine care. Additional precautions are required for procedures involving high/medium-risk tissues or potential contamination with CSF, neural, or lymphoid tissue.

Patient Groups:

- *Symptomatic*: Definite, probable, or possible CJD/vCJD – refer to neurology.
- *Asymptomatic but at increased risk*: Includes familial mutations, historical iatrogenic exposures, and notified blood component recipients – notify IPCT.

Decontamination and Waste Management

- Spills must be promptly contained and disinfected using 10,000 ppm chlorine.
- Skin/mucosal exposure requires immediate washing and reporting to OCCH.
- Waste from high/medium-risk tissues must be incinerated; low-risk waste is managed as standard clinical waste.

Diagnosis	High/Medium-Risk Tissues	Low-Risk Tissues/Fluids
Definite CJD/vCJD	Incinerate	Standard clinical waste
Probable CJD/vCJD	Incinerate	Standard clinical waste
At increased risk	Incinerate	Standard clinical waste

5.2 Inoculation/Exposure Incidents

Provide first aid, report the incident, complete documentation, and contact OCCH. Manage in line with the Trust's sharps policy. No occupational transmission has been confirmed to date.

5.3 Incident Management (retrospective exposure)

If a patient with suspected/confirmed CJD/vCJD has previously undergone surgery or endoscopy, notify IPCT immediately. An incident review must be convened and relevant external agencies informed.

5.4 Care of the Deceased

Standard precautions apply. Use body bags as appropriate and complete the Infection Hazard Notification Sheet. Post-mortems require consultation with a Consultant Histopathologist and can be conducted in any suitably equipped mortuary.

5.5 Diagnosis of Definite, Probable and Possible CJD

Refer to ACDP guidance for internationally accepted criteria for definite, probable, and possible CJD/vCJD. Suspected cases must be referred to a neurologist or appropriate specialist.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209761/Annex_B_-_Diagnostic_criteria.pdf.

5.6 Asymptomatic Patients at familial risk

Includes individuals with two or more affected blood relatives or those with confirmed genetic mutations linked to familial CJD.

5.7 Asymptomatic Patients at Iactogenic Risk

Includes recipients of human-derived pituitary hormones, dura mater grafts, and those exposed to instruments or biological materials from individuals who later developed CJD/vCJD.

Some recipients of UK-sourced blood products (1980–2001) may fall into the 'at risk' category for vCJD.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 General Hospital Care

Patients with CJD do not require isolation and may be cared for in open wards using Standard Infection Control Precautions (SICPs). Routine contact poses no known risk; however, procedures involving cerebrospinal fluid (CSF), biopsies, or blood samples require enhanced PPE, including gloves, apron, fluid-resistant surgical mask (FRSM), and eye protection.
Although CJD/vCJD cases have been reported in healthcare workers, no occupational transmission has been confirmed. The greatest risk arises from exposure to high-infectivity tissues via sharps injuries or mucosal contact. Staff must be informed of relevant risks and appropriate safety measures.
Most body fluids and secretions are considered low risk. Small-volume blood exposures are also low risk, though transmission via large-volume transfusion has been documented.

6.1.1 Used or Foul Linen

- Contaminated linen should be placed in a red water-soluble alginate bag within a white linen bag and processed according to IPC 05 guidelines. No additional treatment is required.

6.1.2 Ward-Based Invasive Procedures

- Such procedures must be performed only by trained personnel. Single-use items must be used and disposed of via high-temperature incineration.

6.1.3 Laboratory Specimens

- Routine specimens may be processed normally. High-risk samples (e.g. brain, spinal cord, eye, lymphoid tissue) require prior consultation with the receiving laboratory and must be clearly labelled as biohazard. CJD is classified as a Hazard Group 3 agent under COSHH.

Hazard Group Definitions:

- Group 1: Unlikely to cause human disease
- Group 2: May cause disease; low community risk; treatment available
- Group 3: Severe disease; serious occupational hazard; may spread; treatment available
- Group 4: Severe disease; high community risk; no effective treatment

6.1.4 Drug Administration

Only staff aware of the associated risks should administer injections or collect samples. Procedures must follow SICPs, using appropriate PPE, avoiding sharps injuries, and ensuring safe disposal of waste and equipment.

6.2 CARE OF PATIENTS KNOWN, SUSPECTED OR ‘AT RISK’ FOR TSE/CJD

6.2.1 Patient Groups Requiring Specific Precautions

Precautions apply to the following groups:

- Symptomatic patients (definite/probable/possible CJD/vCJD)
- Asymptomatic patients identified as ‘at risk’
- Patients with familial or iatrogenic risk factors

The Infection Prevention and Control Team (IPCT) must be notified of all such cases. Fouled linen requires no additional precautions. Waste must be treated as clinical waste and incinerated.

6.2.2 Invasive Medical Procedures

Procedures such as lumbar puncture must follow strict guidelines due to prion resistance to standard decontamination methods.

6.2.3 Precautions to be taken

- Invasive procedures must be performed with care to avoid inoculation injuries.
- PPE must include gloves, apron, gown, FRSM, and eye protection.
- Use impervious bedding protection during procedures.
- Single-use instruments must be used and incinerated if contaminated.
- Blood collection must follow standard precautions to prevent parenteral exposure.

6.3 PROCEDURES FOR DISINFECTION OF SURFACES, SPILLAGES, SKIN

6.3.1 Surfaces and Spillages

- Prompt removal and cleaning of spills is essential.
- Use 10,000 ppm chlorine disinfectant after cleaning.
- Dispose of contaminated materials, including cleaning tools, as clinical waste.
- Ensure adequate ventilation during disinfection.

6.3.2 Skin and mucous membranes

- Wash contaminated skin with soap and water.
- Irrigate exposed mucous membranes with clean water.
- Report all exposures immediately and follow sharps policy guidance.

6.3.3 CSF and Non-Neural Biopsy Tissue

Only trained staff should collect CSF or biopsy specimens. PPE must be worn. All contaminated equipment, including non-disposable items, must be incinerated.

6.4 CLINICAL WASTE

Clinical waste from patients with definite, probable, or increased risk of CJD/vCJD must be managed according to the level of tissue infectivity. High or medium-risk tissues require disposal via high-temperature incineration in authorised facilities, as outlined in Welsh Health Technical Memorandum 07-01.

Diagnosis	High/Medium risk tissue	Low risk tissue/fluids
Definite CJD/vCJD	Incinerate	Standard clinical waste disposal
Probable CJD/vCJD	Incinerate	Standard clinical waste disposal
At increased risk	Incinerate	Standard clinical waste disposal

Low-risk materials include urine, saliva, sputum, blood, and faeces. Blood from vCJD patients is considered low risk unless transfused in large volumes.

6.5 INNOCULATION INJURIES

In the event of sharps injuries or contamination:

- Encourage bleeding, wash with warm soapy water, and apply a waterproof dressing.
- Irrigate eyes or mouth thoroughly if exposed.
- Report incidents to the Ward Manager and submit an adverse event report.
- Notify Occupational Health (OCCH), which will maintain records of all exposures.
- No occupational transmission has been confirmed to date.

6.6 ACTIONS FOLLOWING NOTIFICATION OF SUSPECTED CJD OR vCJD IN A PATIENT WITH PRIOR SURGERY OR ENDOSCOPY

Any suspected case of CJD/vCJD must be reported to the IPCT, regardless of inpatient status. An incident review committee will be convened, comprising:

- Executive Director of Nursing, AHPs & Health Sciences
- Head of Infection Prevention & Control (or deputy)
- IPC Doctor/Microbiologist
- Health and Safety Manager (or deputy)
- Head of Nursing VCC (or deputy)
- Decontamination Lead
- Medical Director (or deputy)

Public Health Wales and the National CJD Research and Surveillance Unit (NCJDRSU) must be informed as appropriate.

7. RELEVANT NATIONAL REQUIREMENTS

The policy aligns with the Health and Social Care Act 2008 and its associated Code of Practice on infection prevention and control (updated 2015).

Comprehensive guidance on the prevention and management of CJD and vCJD is available via the Department of Health and Social Care and the Advisory Committee on Dangerous Pathogens (ACDP) TSE Subgroup:

https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

Key documents include:

- Health and Safety Management of Transmissible Spongiform Encephalopathy (TSE).
- Laboratory containment and control measures (updated November 2021)
- Infection Control in healthcare and community settings
- Annexes covering tissue infectivity, diagnostic criteria, decontamination, transport, endoscopy, post-mortem care, surgical instrument management, and risk assessments across specialities (e.g. ophthalmology, urology, liver transplantation).

Additional resources:

- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Donor Selection Guidelines. https://www.transfusionguidelines.org/dsg
- Welsh Health Technical Memorandum 01-01: Decontamination of surgical instruments (medical devices) used in acute care. Part A: Management and Provision. https://nwssp.nhs.wales/ourservices/specialist-estates-services/specialist-estates-services-documents/whtms-library/whtm-01-01-decontamination-of-surgical-instruments-medical-devices-used-in-acute-care-part-a-management-and-provision-pdf/

8. REFERENCES, BIBLIOGRAPHY, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

Advisory Committee on Dangerous Pathogens (ACDP) https://www.gov.uk/government/groups/advisory-committee-on-dangerous-pathogens

Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) https://www.gov.uk/government/groups/advisory-committee-on-the-safety-of-blood-tissues-and-organs

Association of British Neurologists
http://www.theabn.org/

CJD International Surveillance Network
http://www.eurocjd.ed.ac.uk/

CJD Letter to Neurologists from UK CMOs 2025
https://bso.hscni.net/wp-content/uploads/2025/09/25-08-29-CJD-letter-to-neurologists-from-UK-CMOs_final.pdf

CJD Support Network
http://www.cjdsupport.net/

Department of Health and Social Care (2021). Minimise transmission risk of CJD and vCJD in healthcare settings. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) subgroup. https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

DA (81)22 Report of the Advisory Group on the Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob Disease) (CJD).

DA (84)16 Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob disease) (CJD).

Health and Care Quality Standards 2023. https://www.gov.wales/sites/default/files/publications/2023-05/health-and-care-quality-standards-2023.pdf

HSE (2023). The Approved List of biological agents. Advisory Committee on Dangerous Pathogens. Health and Safety Executive. http://www.hse.gov.uk/pubns/misc208.pdf

HSE (2019). Managing infection risks when handling the deceased. Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation.HSG283. http://www.hse.gov.uk/pUbns/priced/hsg283.pdf

Infection prevention and control of CJD and variant CJD in healthcare and community settings Department of health (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427854/Infection_controlv3.0.pdf

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (2024). Position Statement. Variant Creutzfeldt-Jakob disease. https://www.transfusionguidelines.org/document-library/position-statements

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC). https://www.transfusionguidelines.org/red-book

National CJD Research Surveillance Unit (NCJDRSU) http://www.cjd.ed.ac.uk/

National Prion Clinic (London) http://www.prion.ucl.ac.uk/clinic-services/

NEUROPRION Network of Excellence https://www.neuroprion.org/

NHS Blood and Transplant http://www.nhsbt.nhs.uk/

NICE interventional procedures guidance https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-interventional-procedures-guidance

NICE (2020): Reducing the risk of transmission of Creutzfeldt-Jakob disease from surgical instruments used for interventional procedures on high-risk tissues https://www.nice.org.uk/guidance/ipg666/resources/reducing-the-risk-of-transmission-of-

creutzfeldtjakob-disease-cjd-from-surgical-instruments-usedfor-interventional-procedures-on-highrisk-tissues-pdf-1899874227866821

Public Health England
https://www.gov.uk/government/collections/creutzfeldt-jakob-disease-cjd-guidance-data-and-analysis

Public Health Wales
http://www.wales.nhs.uk/sitesplus/888/page/43948

University of Edinburgh's Centre for Clinical Brain Sciences
http://www.ed.ac.uk/clinical-brain-sciences
Welsh Blood Service
https://www.welsh-blood.org.uk/

Welsh Health Technical Memorandum 07-01: Safe Management of Healthcare Waste'. https://nwssp.nhs.wales/ourservices/specialist-estates-services/specialist-estates-services-documents/whtms-library/whtm-07-01-safe-management-of-healthcare-waste-pdf/

9. GETTING HELP

9.1 Internal Support

For advice and support regarding CJD-related infection prevention and control, contact the Velindre Infection Prevention and Control Team (IPCT):
📞 02920 196129

9.2 National Organisations

Healthcare professionals can seek expert guidance from the following:

- **National CJD Surveillance Unit (NCJDRSU)** – Clinical and neuropathological advice: https://cjd.ed.ac.uk/
- **National Prion Clinic (UCLH)** – Specialist services and consultation: https://www.uclh.nhs.uk/our-services/find-service/neurology-and-neurosurgery/national-prion-clinic
- **CJD Support Network** – Support for patients and families, coordination of care: http://www.cjdsupport.net/

10. RELATED POLICIES

This policy should be read in conjunction with the following Trust document:-

- IPC 04 - Decontamination of Equipment Policy
- IPC 05 - National Infection Prevention and Control Manual (NIPCM)
- IPC 11 - Transport of Specimens
- Verification of Expected/ Anticipated Death by a Registered Nurse Policy (Nursing Policy)
- QS 24 - Medical Devices and Equipment Management Policy
- QS 35 - Safe Use of Sharps Policy
- PP 08 - Trust Waste Management Policy
- SOP 22 - Clinical Trial Human Biological Sample Spillage/Breakage

Commented [HJ1]: Need to check this

11. INFORMATION, INSTRUCTION AND TRAINING

11.1 Training Requirements

All relevant staff must complete mandatory annual IPC training, with role-specific updates identified through training needs analysis.

12. MAIN RELEVANT LEGISLATION

Compliance with the following legislation is essential to ensure the safe handling of devices and substances, and to prevent cross-contamination affecting patients and healthcare workers:

Health and Safety at Work etc. Act 1974
www.legislation.gov.uk/ukpga/1974/37

Management of Health and Safety at Work Regulations 1999
The Stationery Office www.legislation.gov.uk/uksi/1999/3242/contents/made

Control of Substances Hazardous to Health Regulations 2002 (revised 2020)
The Stationery Office www.legislation.gov.uk/uksi/2002/2677/contents/made

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
www.legislation.gov.uk/uksi/2013/645/pdfs/uksi_20130645_en.pdf
www.hse.gov.uk/pubns/hsis7.pdf

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
www.legislation.gov.uk/uksi/2013/1471/made

Appendix1: Infection Hazard notification sheet (HSE Document)

1	Name of deceased		
2	Date and time of death		
3	Source (hospital, ward or other)		
4	Infection risk from the deceased [1]		
4a	Does the deceased present an infection risk? (ring as appropriate)		
	Yes	Suspected	None suspected
4b	If yes, what are the likely routes of transmission? (ring all that apply) [2]		
	Airborne	Droplet	Contact
4c	Infection (if permitted to disclose) [3]		
4d	Provide any relevant information to enable the deceased to be handled safely [4]		
5	Condition of the deceased [5]		
5a	Is the deceased leaking body fluids? Please provide details		
5b	Have accessories that present a risk of sharps injury been removed?		
5c	If yes, have the puncture points been covered or sealed?		
5d	If no, please provide details and location		
5e	Does the deceased have an implantable device? (ring as appropriate)		
	No	Yes and switched off	Yes but not switched off
5f	If yes please provide details and location		
5g	Was the deceased receiving radiotherapy? (If yes, please provide details)		
6	Signed [6]		

	Print name	
	Hospital	

Infection Hazard Notification Sheet v1 June 2019

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc. Act 1974). This form provides one means of sharing the pertinent information.

Notes

1. Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

2. When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3. If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4. In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (e.g. embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

5. In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, e.g. sharp medical devices or implantable devices (e.g. pacemakers), their location and whether they need to be removed.

6. In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (e.g. community setting), the doctor with knowledge of the deceased's condition is asked to sign.

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

Ref: IG 05

SOFTWARE POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital / Deputy CEO
Document Author:	Assistant Director of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	13 January 2026
Date of Equality Impact Assessment:	November 2025
Equality Impact Assessment Outcome:	No impact
Review Date:	January 2029
Version:	5

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1. INTRODUCTION

1.1 Software refers to the collection of programs, applications, and digital services that enable computing devices, including desktops, laptops, servers, tablets, and mobile phones to perform specific tasks. It encompasses both traditional system software and modern mobile applications, distinguishing itself from hardware, which comprises the physical components of a device.

1.2 It is illegal to make or use unauthorised copies of software. As a result, legal action may be taken against both the organization and Trust employee (penalties for so doing include imprisonment and/or fines). It is the responsibility of staff not to make illegal copies and the responsibility of managers to ensure that this is practice does not occur.

1.3 The installation of unauthorised software poses a significant risk to the integrity and performance of Trust IT systems and increases the likelihood of information security breaches. This risk applies to software from all sources, including public domain applications, internet downloads, and content bundled with magazines or other media.

To mitigate this risk, only software explicitly authorised by the local Digital Services team may be installed on Trust-managed devices, including desktop PCs, laptops, servers, tablets, and mobile phones.

1.4 The Trust must ensure that all staff are aware of the policy and comply with it. Therefore, the scope is:

- All Trust use of Software
- All Trust staff (outside personnel under Trust staff guidance are the responsibility of that staff member e.g., students, volunteers & visiting colleagues)
- All staff of Velindre hosted organisations
- All Trust Honorary Contract holders
- Third party contractors i.e. medical device manufacturers / support – Note: need to identify how this will be communicated out of the policy i.e. contract terms & conditions

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

2.1 Velindre University NHS Trust licenses the use of computer software from a variety of external companies and other non-commercial sources. The Trust does not have the right to alter, copy or distribute software unless authorised by the software developer or vendor under the license agreement. Software licensed by the Trust must not exceed license allocation; therefore, software cannot be installed onto additional corporate or home computers without the consent / involvement from the local Digital Services department.

2.2 Software license agreements may apply to single machine use, multiple machines, single or multiple users, or use on Local Areas Networks (LANs). In all

circumstances, Trust employees are required to comply with license agreements. Advice on appropriate licensing arrangements for software should be sought from the Digital Services department.

2.3 Trust employees learning of any misuse of software or related documentation within the Trust must notify the department manager or the local Digital Service Desk.

2.4 According to UK Copyright Law, illegal reproduction of software can be subject to civil damages with no financial limit, and criminal penalties, including fines and imprisonment.

2.5 Installation of unauthorised software and / or personal content (including, but not limited to documents, pictures, audio & video files etc.) on any Trust computers can affect the proper operation of those computers and increase the risk of information security breaches or introduce clinical risk and is therefore not permitted.

2.6 Trust employees who make, acquire or use unauthorised copies of computer software or install personal content will be subject to the formal disciplinary process. This may include termination of employment. The Trust does not condone the illegal duplication or use of software.

3. OBJECTIVES

- To ensure that Velindre University NHS Trust complies with the law
- To protect our corporate reputation
- To comply with the information security policy
- To protect our investment in IT
- To increase control of software resources
- To increase discipline among staff who under-estimate the value of software
- To ensure corporate machines operate effectively
- To reduce the financial risk through potential litigation
- To ensure the use of software within Velindre University NHS Trust aligns with national (NHS Wales / Welsh Government) policies and standards, such as the requirement to deliver digital services ‘cloud first’.

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

- To provide appropriate solution/resources to fully implement this policy
- To fully endorse, support and implement the controls outlined in this policy

4.2 Trust executive

The executive lead for digital is the Executive Director of Strategy & Planning / Deputy CEO. The executive lead for information governance is the executive director of finance. They have responsibility to:

- Ensure ALL staff are aware of and adhere to this policy
- Ensure this policy is part of the induction and ongoing awareness process
- Make decisions on disciplinary action required in cases of non-compliance and to empower local IT departments to place immediate orders to legalise software use

4.3 **Digital Services Department**

- Ensure that auditing / monitoring software is used on an ongoing basis to monitor software licensing compliance and relicense where / when necessary
- Carry out regular audits of software against the list of authorised software within the Divisions of the Trust
- Any non-compliance must be notified to the departmental manager and to the Division Management for immediate action
- Ensure Trust staff are trained in the legal use of software as part of the induction / ongoing training programme
- Ensure appropriate software asset management, to ensure prudent use of Trust funds – for example, ensuring the Trust no longer pays for unused software applications

4.4 **Managers**

All Managers are directly responsible, ensuring that:

- Users are aware of this policy
- Users are made aware of changes to this policy
- Users are trained appropriately
- Suspected incidents are reported and investigated
- Work in collaboration with the Digital Services department to ensure appropriate plans, business cases etc. are in place to support the procurement, maintenance/support and renewal of critical operational and clinical IT systems

4.5 **Users**

Users are responsible for their own actions and must:

- Adhere to this policy and associated policies and procedures
- Report incidents to appropriate managers as quickly as possible
- Discuss any identified risks and security issues with the service to the appropriate mangers
- Ensure ongoing awareness of policy
- Advise of any requirements for non-standard software
- Report the use of unauthorised software.

5. IMPLEMENTATION

- Disseminate Trust policy on copyright compliance so that employees are made aware of the implications of installing unauthorised software
- Ensure this policy is communicated to all staff via appropriate Trust / Divisions' means, to include via appropriate training programmes, so that employees and contracted third parties can be given information related to their obligations under copyright law.
- Ensure all software deployments have the required information security and information governance oversight – specifically, the completion of a Data Privacy Impact Assessment (DPIA), Cloud Risk Assessment (CRA) and/or Cyber Security Impact Assessment (CSIA)
- Implement approval process
- Implement a Software Asset Register in which all authorised software in use within each Division is recorded
- Software in use within the Trust is audited at regular intervals to ensure each piece of software is correctly licensed.

6. FURTHER INFORMATION

Further information can be obtained from the local Digital Service Desk.

7. REFERENCES

This policy should be read in conjunction with the following documents:

- Information Security Policy
- Anti-Virus Policy
- Internet Use Policy
- Information Governance Policy
- Welsh Health Circular (2017) 025 – Guidance on Cyber Security and Information Governance requirements relating to suppliers and the supply chain

WHC (2017) 025:

WHC 3rd parties holding NHS Wales D

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IG 06

ANTI VIRUS POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital / Deputy CEO
Document Author:	Assistant Director of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	13 January 2026
Date of Equality Impact Assessment:	November 2025
Equality Impact Assessment Outcome:	No impact
Review Date:	January 2029
Version:	5

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1. INTRODUCTION

1.1 For the purpose of this Policy, all forms of malicious code—created with the intent to disrupt, damage, or compromise the operation of networks, computer systems, mobile devices, or computer-controlled equipment will be referred to collectively as **viruses.**

1.2 Software viruses are like human viruses in that they can spread from one computer to others, and in the worst case all computers on a network can be affected within a very short period of time. The effects differ significantly depending on the intention of the creator of the virus i.e., in some cases the symptoms can be obvious in that the affected computer begins to malfunction, but in others the actions of the virus can be partially or completely hidden to enable the affected computer to send sensitive information out of the Trust or to disrupt other computers throughout the network, resulting in what's known as a "Denial of Services" attack. Other types of malicious code include Spyware, Malware, Worms & Trojans etc.

1.3 As a result of becoming infected by a virus, the Trust's capability of day-to-day operation may be compromised, or depending upon the virus's capability to traverse interconnecting networks NHS Wales may be negatively impacted as a whole.

1.4 This policy is aimed at raising awareness amongst Trust employees; and by complying with the policy and associated anti-virus procedures, we can minimise the risks to the Trust and other NHS Wales organisations.

The scope of this policy includes (but is not restricted to):

- All digital devices managed by the Trust , including desktop computers, laptops, servers, tablets and mobile phones
- All Trust staff regardless of role or location
- Personnel under guidance / direction of Trust employees (e.g., students, visiting colleagues, engineers etc.)
- Staff working within organisations hosted by Velindre
- Individuals holding Honorary Contracts with the Trust

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

2.1 The risk of infection from malicious software such as viruses, ransomware, and other forms of malware is a serious concern for the Trust's digital infrastructure. To protect against these threats, local Digital Services teams will implement technical safeguards, including the deployment of approved anti-virus solutions and the regular updating of virus definition files. These measures are designed to detect, prevent, and contain infections across Trust managed devices.

The main routes of infection are listed below:

- Downloading unauthorised software from the Internet
- Virus's hidden in e-mail attachments

- Using non-NHS internet-based e-mail systems without approval of your local IT Department / Service Desk (as their use is normally prohibited in Email Policy)
- Insertion of removable media, that may have been used outside the Trust, into a Trust computer without checking for viruses (e.g., CDs, DVDs, memory sticks / USB memory devices and any other removable media capable of carrying data or programs)
- Connecting a non-NHS Trust laptop or PC to the trust's network
- The Software, E-mail and Internet Policies provide further detail on the risks and guidance on risk mitigation

2.2 The effects of viruses can vary from the infection of just one computer to many machines or potentially a whole network resulting in a major information security breach.

2.3 Please Note: Any unusual behaviour of the computer may be due to a virus and should be reported to the local IT Department / Service Desk as soon as possible.

2.4 Installation of unauthorised software and / or personal content (including, but not limited to documents, pictures, audio & video files etc.) on any Trust computers can affect the proper operation of those computers and increase the risk of information security breaches or introduce clinical risk and is therefore not permitted.

2.5 Failure to comply with this policy and associated local Digital anti-virus procedures may result in disciplinary action being initiated against the employee.

3. OBJECTIVES

- To ensure all Trust employees are aware of the dangers of malicious code (Spyware, Malware, Worms & Trojans etc.) and their responsibilities to minimise the likelihood and impact of viruses to the trust and NHS Wales
- To protect the Trusts reputation
- To comply with the Information Security policy
- To effectively manage software resources

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

- To provide appropriate solution/resources to fully implement this policy.
- To fully endorse, support and implement the controls outlined in this policy.

4.2 Trust Executive

- Ensure ALL staff are aware of and adhere to this policy
- Ensure this policy is communicated to all staff via appropriate Trust / Divisions' means, to include via appropriate training programmes

- Ensure the Cyber Security Manager (and those staff with IT responsibilities) in the Trust have the resources to purchase, deploy and maintain anti-virus software and to train staff to use the software.

4.3 Cyber Security Team

- Ensure appropriate local Trust Division anti-virus procedures are in place and updated in accordance with new threats and vulnerabilities.
- Ensure that anti-virus software is reviewed for efficiency and re-licensed on an ongoing basis.

4.3 Local Digital Services Department

Comply with local anti-virus procedures and in particular:

- Deployment of the anti-virus solution appropriately including each new release of the software from the software supplier
- Set-up facilities to automatically update virus definition files for all computers on the network
- Ensure users awareness is maintained in regard to the recognition and danger of viruses and anti-virus procedures by regular briefings, publicity and training
- Record occurrences of virus infection according to local Cyber security incident procedures. (Note: in the event that a potentially significant infection is identified, management must be made aware that critical services may be affected or systems / services shutdown to avoid further spread of the infection)
- Check Third Party machines for appropriate anti-virus software and virus definition files before allowing connectivity to segregated areas of the trust network
- Any exceptions to this policy e.g., using medical devices without anti-virus installed or maintained must be discussed with the local Digital department, in order to identify and agree alternative / compensating controls to reduce the likelihood and impact from infection and cross infection to other devices

4.4 Managers

All Managers are directly responsible, ensuring that:

- Users are aware of this policy
- Users are made aware of any changes to the policy
- Users are trained appropriately
- Suspected incidents are reported and investigated

4.5 **Users**

Users are responsible for their own actions and must:

- Adhere to this policy and associated policies and procedures
- Report incidents to appropriate managers and digital support as quickly as possible

- Discuss any identified risks and security issues with the service to the appropriate managers
- Comply with local anti-virus procedures and in particular:

  - All suspected occurrences of a virus detected by any means MUST be reported to your local Digital Department / Service Desk, and the computer switched off until a technical representative has carried out action according to the local anti-virus procedure and confirmed that the computer is free from infection

  - Unauthorised software from whatever source (e.g., screen savers; internet; memory sticks CD-ROMs, or web sites, etc.) must not be used on Trust computers without approval of your local Digital Department / Service Desk and Cyber Security team (refer to Trust Software Policy for further details

  - All removable media or downloaded files from outside the Trust must be processed in accordance with local anti-virus procedures before being accessed

  - Comply with the Trust E-mail and Internet policies to minimise risk of infection

  - Users must follow local Digital Department / Service Desk procedures to ensure PCs and laptops and other portable computing devices receive regular virus definition updates (e.g., PCs left powered on (but logged off) overnight and portables returned to base at least every 2 weeks)

  - Users must not allow Third party IT hardware to be connected to the network without approval from their local Digital Department / Service Desk, who will ensure appropriate anti-virus software is installed with the latest virus definitions

5. FURTHER INFORMATION

Further information can be obtained from the local Digital Service Desk.

6. REFERENCES

This policy should be read in conjunction with the following documents:

- Information Security Policy
- IT Software Policy
- Internet Policy
- Information Governance Policy

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

VELINDRE UNHST CHARITABLE FUNDS ANNUAL REPORT 2024-25

DATE OF MEETING	29/01/2025

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Claire Bowden, Head of Financial Planning and Reporting Paul Wilkins, Charity Director
PRESENTED BY	Anne Carey, Chief Operating Officer
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The Charitable funds (Trustee) Annual report and accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice.

RECOMMENDATION / ACTIONS	• The Trust Board is asked to **NOTE** the Annual Report for 2024-25 and

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
APPROVED at Charitable Funds Committee	**27.01.26**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Velindre UNHST Charitable Funds Annual Report 2024-25

1. SITUATION / BACKGROUND

1.1 The Charitable funds (Trustee) Annual report and accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it is effective and applies from 1 January 2015.

1.2 As with previous years, the aim of the annual report is to demonstrate how the money raised through Charitable Funds allows the Charity to make a difference and enhance the services provided.

2. ASSESSMENT

2.1 Refer to the Annual report attached as Appendix 1.

3. SUMMARY MATTERS FOR CONSIDERATION

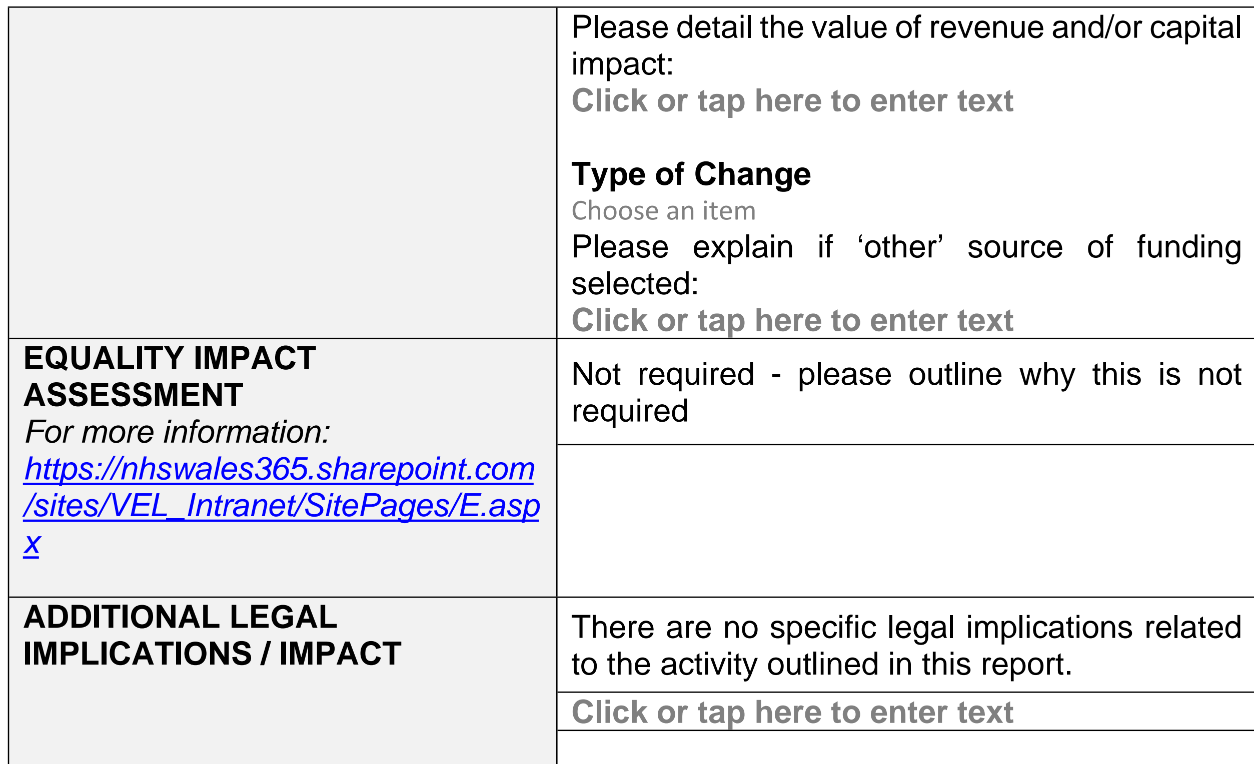
3.1 The Trust Board is asked to **NOTE** the Annual Report for 2024/25.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	10 - Governance

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed, and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text**
QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: https://www.gov.wales/socio-economic-duty-overview	Click or tap here to enter text
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change**



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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
All risks must be evidenced and consistent with those recorded in Datix	

Annual Report and Accounts
Velindre University NHS Trust Charity
April 2024 - March 2025

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Codi Arian
CANOLFAN GANSER VELINDRE CANCER CENTRE
Fundraising

FR REGULATOR
Reg Charity No 1052501

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Glossary of Abbreviations

AHPs
Allied Health Professionals

AHSC
Academic Health Science Centre

CFC
Charitable Funds Committee

CNS
Clinical Nurse Specialist

COVID 19
Coronavirus2019

CTU
Clinical Trial Unit

ESOL
English for Speakers of Other Languages

FR
Fundraising Regulator

FRS
Financial Reporting Standard

ISAs
International Standards on Auditing

NPHS
National Public Health Service

PARS
Physical Activity Rehabilitation Programme

PCH
Prince Charles Hospital

POC
Point of Care

R&D
Research & Development

RD&I
Research, Development & Innovation

ROM
Range of Motion

RT
Radiotherapy

SABT
Stereotactic Ablative Body Radiotherapy

SACT
Systemic Anti-Cancer Therapy

SC
Supportive Care

SOFA
Statement of Financial Activities

SORP
Statement of Recommended Practice

UGI CNS
Upper Gastrointestinal Clinical Nurse Specialist

UK
United Kingdom

VAT
Value Added Tax

VCS
Velindre Cancer Service

WBS
Welsh Blood Service

Interim Chief Executive's Introduction

As Interim Chief Executive of Velindre University NHS Trust, I am honoured to present our Annual Report and Accounts for 2024–2025.

I am continuously struck by the strength of our community: a network of passionate professionals, volunteers, donors, and supporters, all united by a shared mission to deliver hope and healing across Wales. That sense of purpose has only deepened over the past twelve months, as I've witnessed the extraordinary work that takes place every day across Velindre Cancer Service and the Welsh Blood Service.

This year, we have continued to deliver world-class cancer care and life-saving blood and transplant services, while also expanding our reach and impact. We've faced challenges, economic pressures, rising demand, and the ongoing ripple effects of the pandemic, but our teams have responded with resilience, compassion, and innovation. Their commitment to excellence has ensured that patients and donors remain at the heart of everything we do.

In the year ahead, the charity is committed to developing a fully integrated strategy that prioritises sustainable income streams. This approach will reduce reliance on short-term fundraising and create a stronger foundation for long-term impact, ensuring we can continue to support patients, staff, and research effectively. We recognise the critical need to provide ongoing support for cancer and blood services, while also acknowledging the significant challenges currently facing the charity sector.

Our strategy will be shaped to address these realities and maintain the highest level of care and innovation for those who depend on us. In doing so, we are committed to fully embracing the diversity and inclusiveness of the organisations and communities we serve, ensuring that our work reflects and respects all voices and perspectives.

To our staff, thank you for your tireless dedication. To our leadership team, Chair, and Board, thank you for your guidance and trust. And to everyone who contributes to the Velindre story; thank you for helping us write a new chapter, one defined by courage, compassion, and collective impact.

As we look ahead, I do so with confidence and optimism. Together, we will continue to deliver care that transforms lives and build a future where no one faces illness alone.

Thank you.

Carl James
Interim Chief Executive Officer
Velindre University NHS Trust

Foreword from the Chair

It is with heartfelt pride and a deep sense of purpose that I introduce our Annual Report and Accounts for 2024–2025. As the newly appointed Chair of Velindre University NHS Trust, joining in September 2025, I feel privileged to be part of an organisation that holds such a vital place in the lives of people across Wales.

My professional journey has taken me through communications, policy, leadership, and charity work. I've seen first-hand the power of compassionate care and the difference it makes when services are not only excellent but accessible, fair, and human. That is what Velindre delivers every day.

This past year has been one of extraordinary progress. Our teams have continued to innovate, collaborate, and care with unwavering commitment. Whether through the expert cancer care delivered by Velindre Cancer Service or the life-saving work of the Welsh Blood Service, we are united by a shared goal: to offer hope, dignity, and support to every person who walks through our doors.

We've also seen the transformative impact of our Charity, whose support has enabled us to expand services, invest in pioneering research, and enhance wellbeing for both patients and staff. The generosity of our donors, volunteers, and fundraisers is woven into every story of progress you'll find in this report and we are deeply grateful.

We know the challenges facing our communities are complex and evolving. The cost-of-living crisis, the lingering effects of the pandemic, and the emotional toll of illness all demand a response that is both practical and compassionate. Velindre continues to meet that challenge head-on, offering not just clinical excellence but wraparound support that makes a real difference in people's lives.

I am proud to serve a Trust that reflects the values of our nation: kindness, resilience, and community. I want to thank every person who contributes to our work: our staff, supporters, partners, and patients. Your dedication inspires us to keep improving, keep listening, and keep striving for better.

Together, we will continue to build a future where care is not only world-class but deeply personal.

Diolch o galon, thank you sincerely, for being part of this journey.

Sara Moseley
Chair
Velindre University NHS Trust

Welcome from our Corporate Trustee Board

On behalf of the Corporate Trustee of Velindre University NHS Trust Charity, we present the Charitable Funds (Trustee) Annual Report together with the Audited Financial Statements for the year ended 31 March 2025. On behalf of the Trustees of Velindre University NHS Trust Charity, it is our privilege to welcome you to this year's report.

The past year has been one of resilience, hope, and compassion. Against the backdrop of rising living costs and economic pressures, our community has continued to stand with us. We have witnessed remarkable generosity, generating £4.374 million. Our donors and fundraisers are, and continue to be, at the very heart of everything we do, serving as the driving force behind the lasting impact our Charity can achieve.

This support is more than financial; it is a lifeline of comfort, strength and hope for those who need it most. The impact of this kindness is felt each day throughout the Velindre Cancer Service and Welsh Blood Service by patients, donors, carers and their families.

We extend our deepest gratitude to our dedicated staff who work tirelessly each day to deliver exceptional care and support to those who need it most.

From caring for patients at the bedside, to collecting vital blood and bone marrow donations, to supporting fundraising efforts behind the scenes, your unwavering commitment shines through and we are profoundly grateful to you.

This period has also been one of change and growth. As our Charity team expands and our community of supporters grows stronger, we are evolving to meet new challenges and opportunities. We thank our passionate Charity team for their commitment and dedication in taking each new opportunity and for everything they do to inspire hope.

As we look ahead, we do so with determination and optimism. With your continued support, we will keep building on this resilience and making a lasting difference in 2025-26 and beyond. With the new Velindre Cancer Centre on the horizon, the future brings positive change and exciting opportunities. We will continue to work in partnership with our donors, fundraisers, staff and trustees to create a future that is both meaningful and impactful.

What our annual report will tell you?

The Velindre University NHS Trust Charity Annual Report showcases how the funds raised through Charitable activities in 2024-25 have made a difference and enhanced the services provided by the Trust. The report provides information about the Charity's performance this year, key activities and developments, and plans for 2025-26 and beyond.

The Charity's priorities are shaped by its Vision, Mission, Objectives, and Aims, which are set out on pages 7 and 8 of the report.

The report outlines the achievements, financial expenditure, and plans of the Velindre University NHS Trust. The Trust is committed to ensuring the delivery of safe, high quality, and effective care to its patients and donors, and to continuous quality improvement to achieve this.

In accordance with our commitment to the Well-being of Future Generations (Wales) Act 2015, hard copies will be available on request, in addition to the digital copy of our Annual report available on our Trust website. As such, if you would like copies of our Annual Report in print form and/or alternative formats or languages, please contact us using the details below:

Telephone: 029 2019 6161
Email: Corporate.Services2@wales.nhs.uk
Website: www.velindre-tr.wales.nhs.uk
Address: Velindre University NHS Trust, Corporate Headquarters
Unit 2, Charnwood Court, Parc Nantgarw, Cardiff, CF15 7QZ.

Our Purpose

Vision

Invest in promoting Quality, Care and Excellence in the services provided by Velindre University NHS Trust.

Mission

To support the Trust's provision of world class research-led treatment, care and support for patients and families affected by cancer as well as other patients supported by the Trust and those who are involved in the donation of blood or stem cells.

Aim

To improve the quality and quantity of research undertaken by the Trust.

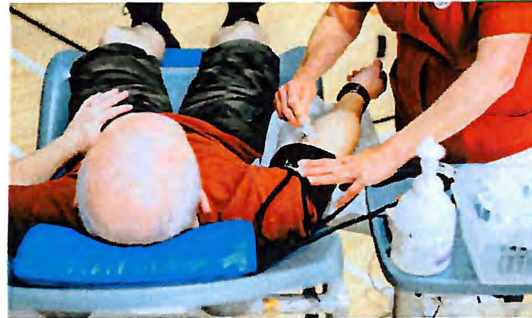
Aims specific to Velindre Cancer Service:

1. Improve outcome for cancer patients.
2. Improve conditions and support for cancer patients and their families that are treated by Velindre Cancer Service.
3. Ensure that cancer patients treated by Velindre Cancer Service have access to the best possible treatment, care and support by helping with the development of its facilities, services and training its staff.
4. Improve the scope of successful treatment by assisting with the development of Velindre Cancer Service research activities and medical education.
5. Ensure the people affected by cancer will have their information, needs, and support addressed effectively.
6. Raise awareness about the prevention and early diagnosis of cancer within our community.

Aims specific to Welsh Blood Service:

1. Provide donors with the best care and experience possible and ensure donors feel fully valued.
2. Promote blood donation to grow the donor pool.
3. Improve donor care through the development of research activity at the Welsh Blood Service and utilise research and development activity to support the delivery of evidence-based care.

Our Objectives



General:

For Charitable purposes relating to the general or specific purposes of Velindre University NHS Trust or to purposes relating to the Health Service and for any other Health Services for which specific monies have been donated for use within the UK or overseas.

Donors:

For the promotion of blood and stem cell donation to grow the donor pool and to improve donor care and experience.

Staff:

For the relief of sickness by promoting the efficient and effective performance and duties of Velindre University NHS Trust staff.

Patients:

For the relief of illness of patients suffering from cancer or its effects as well as other patients that are/or have been treated by Velindre University NHS Trust.

Research:

For any charitable purpose or purposes principally (but not exclusively) at or in connection with Velindre University NHS Trust which will further our research goals overleaf.

Research Goals

- The investigation of the causes of cancer and the prevention, cure, treatment and defeat of cancer in all its forms.
- The advancement of scientific and medical education and research in topics related to cancer.
- The furtherance of any other charitable purpose for the relief of persons diagnosed with cancer.
- To support research and development into new and novel uses of blood, blood components and cellular technology for the benefits of patients.
- Improve donor care through the development of research activity.
- Improve quality and safety of blood components and products; and support research to approve outcomes in transplantation.

Overview of Charity Activity

Wales United Against Cancer Lunch

May 2024

A celebratory lunch was held at the Principality Stadium to honour the remarkable achievements of Velindre patient and supporter Craig Maxwell OBE, who raised an astounding fundraising total for Velindre Cancer Service and the QuicDNA study.

This incredible fundraising effort was the result of several challenges, most notably the Wales Coastal Path Walk Challenge, during which Craig walked 780 miles in just 26 days around the Wales Coastal Path carrying the match ball for the Wales vs France Six Nations fixture. Among the guests were Jonathan Davies, Rupert Moon and Tom Shanklin, all of whom had joined Craig during his coastal challenge and came together once again to celebrate his extraordinary contribution. The event was proudly sponsored by Seat Unique and the Moondance Foundation.

Jiffy's Cancer 50 Challenge

August 2024

339 cyclists joined Velindre President Jonathan 'Jiffy' Davies on his fourth annual Jiffy Cancer 50 Challenge, which raises funds for Velindre and Swansea Bay Health Charity. This 50-mile ride, which starts in Cardiff City Stadium and finishes at the Lighthouse Restaurant in Swansea, was sponsored by Andrew Scott Ltd and Philtronics.

Castle 2 Castle (10th Anniversary Special Event)

September 2024

This year marked the 10th anniversary of the annual Castle to Castle run and, as well as celebrating a milestone, the event attracted a record number of runners and a record amount raised. 1281 runners ran the 11-mile run from Caerphilly to Cardiff Castle largely along the Taff Trail, including former Wales rugby star Shane Williams and social media influencer Liam Reardon.

The popular fun run, sponsored by Peter's and Castle Dairies, was established in 2014 by Charity Ambassador Steve Sullivan who continues to play an active role in its success. Along with the event sponsors, the event is also supported by Caerphilly Runners, Brecon Carreg, The London Mint, SiteServ Recycling, Event Clean and many more.

Castle 2 Castle continues to attract a diverse audience of supporters ranging from competitive running clubs, first time runners and a number of Velindre patients who take on the event as their personal goal post-treatment. Together, these participants create an inspiring atmosphere for all.

Key West Bike Ride
November 2024

74 dedicated cyclists took on Velindre Cancer Charity's 10th overseas cycling challenge – cycling a gruelling 625km in just 4 days from Cocoa Beach to Key West, the southernmost point in the United States. The group, including Velindre Patrons Shane Williams and Sean Holley, battled scorching heat, torrential rain, strong winds, and even flooded roads to reach the finish line. The event was generously sponsored by Hugh James, MMS Group, Andrew Scott Ltd and Philtronics.

Celebration Lunch
November 2024

A special celebration lunch was held in Cardiff to recognise the extraordinary efforts of donors, fundraisers and corporate partners since 2007, the year Jonathan "Jiffy" Davies joined the charity as a Patron before becoming President soon after. Jonathan was joined by close friend and rugby legend Nigel Owens, alongside Charity Patron Sean Holley, who hosted the event. The event, sponsored by Andrew Scott Ltd, brought together Charity Ambassadors, supporters, patients, relatives and staff to reflect on memorable moments, share stories of impact, and express heartfelt thanks to everyone who has contributed to Velindre's success over the years.

Wear Red for Wales and Velindre

February 2025

Once again, schools, businesses and individuals donned red clothing, held red themed fundraising events and took part in red themed activities to raise funds for Velindre. This year, support spanned from Pencoed in South Wales to Perth in Australia. Some highlights from the day included our young Ambassadors, Riley and Macey, walking 16 miles from Pencoed to Velindre in memory of their grandad, and Charity President Jonathan Davies surprising staff and patients with a visit to the cancer centre.

20th Anniversary Grand Slam Lunch

March 2025

On Friday 21st March 2025, a special commemorative lunch was held at the Principality Stadium in Cardiff to mark the 20th anniversary of Wales' iconic 2005 Grand Slam victory - their first since 1978. The event brought together some key players from that unforgettable campaign, including Charity Patrons Shane Williams and Martyn Williams, Adam Jones, Rhys Williams, Tom Shanklin and Dwayne Peel. They were joined by Charity President Jonathan "Jiffy" Davies, who commentated during the series, to reflect on the triumph and share some personal stories and memories from one of Welsh rugby's most celebrated eras. The lunch was proudly sponsored by Pitch International and raised funds for the Maxwell Family Geonomics Fund at Velindre.

Supporter Activity

Volunteering

During 2024/2025, volunteering activity across our organisation reached new levels of engagement and impact. We were proud to see increased participation in event support, bucket collections, and contributions from our charity of the year partners. Corporate teams from Active Quote, Lloyds, Cat Sci, Apple, and Motonovo Finance delivered dedicated volunteering days, undertaking projects such as maintaining our patient gardens and distributing Easter eggs and advent calendars to patients, bringing joy and comfort throughout the year.

Our volunteers also played a vital role in the success of our events, providing essential support by handing out water and medals, joining cheer squads to motivate participants, and assisting with set-up and pack-down to ensure smooth delivery. These collective efforts demonstrate the strength of our community partnerships and highlight the generosity of individuals and organisations who continue to make a tangible difference to patient wellbeing and the success of our fundraising activities. Volunteers play such an integral role in the delivery of inspiring, engaging and meaningful events and activities at the charity and we are grateful to all who have donated their time to Velindre.

Looking ahead, we are committed to broadening the range of opportunities available so that everyone can get involved in a way that suits them. By offering greater choice and access, we aim to ensure that volunteering is inclusive, welcoming, and accessible to people from all backgrounds, empowering each individual to contribute in the way that best reflects their skills, interests, and availability.

Supporter Activity

This year has been marked by an outstanding range of supporter-led activities, reflecting the creativity, commitment, and generosity of our community. From bake sales to running challenges, bucket collections to band nights, supporters have found diverse and meaningful ways to show their support for Velindre.

Our supporters are motivated by many different reasons: some stand alongside loved ones currently undergoing treatment, others honour the memory of those they have lost, and many draw on their own personal experiences with cancer. While these motivations are deeply individual, they converge in a shared determination to make a lasting difference. It is this unity of purpose, expressed through countless acts of kindness, energy, and dedication, that defines the strength of our supporter network.

Together, these efforts have created a powerful impact, ensuring that our services can continue to reach those who need them most. The breadth of activities and the passion behind them demonstrate that, regardless of the starting point, our community of supporters is united by a common goal: to bring hope, comfort, and tangible support to cancer patients and families in Wales.

Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising
TRECHU CANSER
VICTORY OVER CANCER
www.velindrefundraising.com
HUUB
Performance Review

Income Highlights

Events, Fundraising, Grants and Donations: £ 3.182m

During 2024 to 2025, the total amount raised from general donations, grants, events and fundraising was over £ 3.1m, which is a testament to the immense generosity, passion, commitment and dedication of our staff and loyal supporters. We are grateful for their continued support, recognising that our future plans would not be possible without the support of our dedicated fundraisers. We remain extremely grateful for their efforts.

Legacies: £ 0.633m

In the period of 2024 to 2025, the total amount of legacies received was in excess of £ 0.6m. The Charity continues to receive legacies, which are a crucial source of income, and we express our gratitude to those who have the generosity and foresight to remember Velindre by leaving a gift in their will.

Total Expenditure

Research: £ 1.560m

Every year, the funds raised by the charity are utilised to support innovative research and clinical trials. These trials can aid in the development of advanced treatments that enhance patient and donor care, and improve the quality and safety of blood components and products.

Patients, Staff Wellbeing and Amenities: £ 0.845m

The funds raised through the charity has a significant impact on patients and staff welfare by funding support services, therapies, equipment, and more. These resources help improve the quality of patient care and contribute to employee well-being.

Fundraising: £ 0.884m

Our charity relies heavily on fundraising, which is not only a crucial source of income but also plays a vital role in raising awareness and gaining continued support from the public. The cost of raising funds is in line with other charities of similar size and nature.

Support Costs: £ 0.246m (including £0.097m supporting research and £0.107m supporting patients, wellbeing &amenities)

Support costs and fees are kept to a minimum, however, to ensure that the charity can be run effectively it is essential that a clear management and governance structure is in place. Support costs are in line with other Charities of similar size and nature.

Investment Management Fees: £ 0.044m

The investment fees paid to the Charity's Investment Management Advisors account for a small proportion of expenditure. However, this expert advice is crucial in ensuring that the Charity's Investment Portfolio is managed effectively in line with agreed guidelines and policies.

Examples of activity that the monies raised supported during 2024-2025

Arts Coordinator

This role offers creative activities that help our patients, families and staff meet others in similar situations whilst improving their mental and physical health and wellbeing. Through activities like creative writing and art workshops, musical activities and art exhibitions at the centre, participants can find moments of connection, comfort and joy during some of the most challenging times.

First Cancer Academy in Wales

Velindre Oncology Academy

We're proud to fund the establishment of the Velindre Oncology Academy. The academy aims to put patients at the heart of its mission by developing a knowledgeable, talented and skilled workforce that improves patient outcomes, experiences and ultimately survivorship. It also aims to enhance staff wellbeing by offering transformative opportunities for career development.

Clinical Psychology, Counselling and Complementary Therapy Services

To support our patients, families and staff with their mental health and wellbeing, we fund an entire team of clinical psychologists and counsellors, who provide one-to-one support for up to 400 patients a year. Mental health therapies can help patients to process complex emotions, come to terms with their diagnosis, voice their concerns about the future and feel empowered as they navigate their cancer pathway.

We also fund three complementary therapists and an on-site therapy room here at Velindre. Complementary therapies are an essential part of the integrative supportive care services available for patients at Velindre. Together with clinical treatments, they can help alleviate cancer symptoms and treatment side effects, while empowering patients and enhancing their quality of life.

Patient Engagement Hub

Our investment in Patient Engagement led to the relaunch of the Patient and Carer Partnership Board made up of current and former patients and carers of our service. The board champions the patient voice always and works closely with our clinical teams to help develop and shape services, resources and support that meets the needs of our patients, carers and their families. Charitable funds also enabled the re-launch of the Velindre Volunteer programme.

Clinical Nurse Specialists

Alongside their in-depth clinical knowledge, CNS's look holistically at the bigger picture of patient care, identifying issues that patients may be having beyond their treatment and ensuring they get the in-depth support they need, whether that's counselling, complementary therapies or welfare rights advice. This holistic approach is essential for patients experiencing the emotional and physical challenges caused by cancer.

Early Phase Trials and Implementing the Velindre Cancer R&D Ambitions

Here at Velindre, we know that the quality of cancer care is better when delivered in a research-rich environment. Every year, we invest into pioneering research and clinical trials to expand our collective understanding of cancer, drive advances in treatment and provide all-important hope to patients and their families. By supporting Velindre to collaborate with research centres, universities and other specialist hospitals, we ensure that patients directly benefit from the latest advancements in cancer research, whether that's by extending their time with loved ones, reducing their side effects or transforming their treatment outcomes.

Thanks to new research and clinical trials like PEARL, QuicDNA and FAKTION, we are supporting earlier detection, providing longer, higher-quality lives for those affected by cancer and improving patient outcomes on a national and international scale.

Supportive Care Services for Patients and Families.

With your help, we fund essential supportive care and wellbeing services that provide a lifeline to patients and families facing the wide-reaching impacts of a cancer diagnosis.

Children's Resources

Often, a patient's biggest concern is how a cancer diagnosis will impact their children. We help families to navigate this journey together by funding 100% of the children and family resources at Velindre Cancer Service. We provide children with items like specialist storybooks, loveable lion teddies, worry monsters and memory boxes. The 'Caring for My Family with Cancer' book series can be used to explain cancer and its treatment to children..

Hair Loss Services

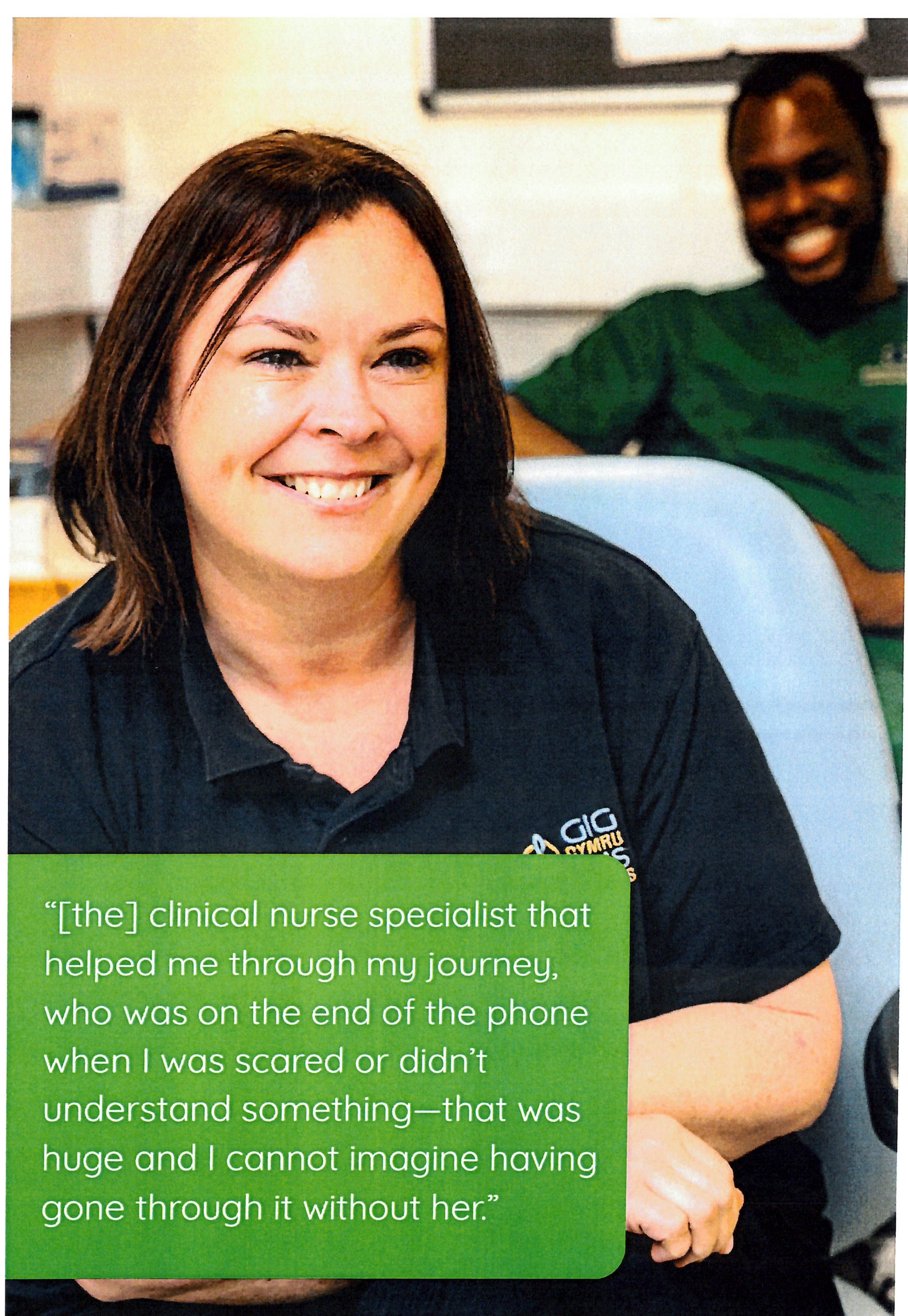
We support patients and ease their worries by funding free head scarves, wig vouchers and 100% of Velindre's cold caps, which are worn during treatment to help minimise hair loss. Our wig vouchers help to alleviate financial pressures on patients by supporting them to purchase a wig, so they can focus on feeling more like themselves..

Spiritual and Pastoral Care Services

Available 24/7, the chaplaincy offers our patients, families and staff, the opportunity to have those big and sometimes difficult conversations in a safe and supportive space. In addition, we fund a multi-faith room that offers a place for reflection and dignity during some of the most challenging times.

Welfare Rights Advisor

Welfare Rights Advisors play a vital role in supporting cancer patients by helping them navigate the often complex world of benefits, entitlements, and financial support. Their expertise ensures that patients and families can access the assistance they are entitled to, easing the burden of financial worries at a time when health and wellbeing must take priority.



"[the] clinical nurse specialist that helped me through my journey, who was on the end of the phone when I was scared or didn't understand something—that was huge and I cannot imagine having gone through it without her."

Charity Governance, Audit, and Finance

Structure, Governance and Management of Charitable Funds

The Velindre University NHS Trust Board as a Corporate Trustee is ultimately accountable for charitable funds donated to Velindre University NHS Trust Charity. Details of our Trustees are on pages 48 to 49 of this report.

The Chair and Independent Members of the Trust Board are appointed through a public appointments process overseen by the Welsh Government while the Chief Executive and Executive Directors are appointed by the Trust Board. Collectively, these individuals form the Corporate Trustee, and have a collective responsibility for controlling the management and administration of the Charity.

The duties of members of the Corporate Trustee are to:

- Ensure the Charity is carrying out its purposes for the public benefit
- Comply with the Charity's Governing Document and the law
- Act in the Charity's best interests
- Manage the Charity's resources responsibly
- Act with reasonable care and skill
- Ensure the Charity is accountable

The Charity Commission has written guidance which sets out what is required of a Charity Corporate Trustee, including their responsibilities to the Charity. This guidance is available here.

In order to facilitate the administration and management of the charitable funds the Trust Board has established a Charitable Funds Committee to provide advice and recommendations to the Board. The Charitable Funds Committee manages, on behalf of the Trust Board, all aspects of control, investment and expenditure of the Trust's charitable funds. The members of the Corporate Trustee have been appointed under section 11 of the NHS and Community Care Act 1990.

The Charitable Funds Committee may delegate authority to commit expenditure but cannot delegate accountability.

The Chief Operating Officer is responsible for board level managerial oversight of the charity, supported by the Charity Director who has responsibility for its day to day running. The Executive Director of Finance is responsible for control of the administration of the charitable funds and reports to the Charitable Funds Committee. The Executive Director of Finance has particular responsibility to ensure that the spending is in accordance with the objectives and priorities agreed by the Charitable Funds Committee and the Board; that the criteria for spending charitable monies are fully met; that full accounting records are maintained and that devolved decision making or delegated arrangements are in accordance within the policies and procedures set out by the Board as the Corporate Trustee.

The Charitable Funds Committee is supported by a Sub-Committee, the Investment Performance Review Sub-Committee which has particular responsibility for managing the Charity's Investment Portfolio together with the Charity's Investment Management Organisation (LGT Wealth Management).

The main objectives of the Investment Performance Review Sub-Committee are to

- Ensure that when investing charitable funds Trustees achieve an appropriate balance for the Charity between the three objectives of:
- Providing an income to help the Charity carry out its purposes effectively in the short term; and;
- Maintaining and, if possible, enhancing the value of the invested funds, to enable the Charity to carry out its purpose in the longer term.
- Ensure that the standards as defined in the Trustee Act are followed, whether they are using the investment powers in that Act or not.

This is to ensure that the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and to the discharge of the specific duties which the Act attaches to the use of investment powers.

Secondly, that the Charity is complying with the following specific duties:

- Trustees must consider the suitability for the Charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for the Charity.
- They also have a duty to consider whether a particular investment of that type is a suitable one for the Charity to make, based on the overall investment policy set by the Charitable Funds Committee.
- Trustees should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.
- Trustees must periodically review the investments of the Charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the Charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. A review of the investment should be carried out at least once a year.
- Trustees must monitor the overall performance of the portfolio and, in so far as it is possible, compare the rate of return with returns achieved by other similar organisations. The rate of return will need to be reported annually to the Charitable Funds Committee as part of its annual report.
- Before exercising any power of investment, and when reviewing the Charity's investments, Trustees must obtain and consider proper advice from a suitably qualified adviser.

The Charitable Funds Committee is also supported by the Charity's Senior Leadership Group, to monitor the strategic delivery and operational application of all Charitable Funds held within the Velindre University NHS Trust Charity.

Within the charity there are a number of designated funds relating to particular areas. The charity manages spending through the Individual Fund Holders who are allocated part of the total budget to spend in accordance with agreed authorisation limits.

Fund Holders for each of the designated funds manage these funds on a day-to-day basis within the Trust's Standing Orders and Standing Financial Instructions and powers of delegated authority set by the Corporate Trustee (The Velindre University NHS Trust Board).

The Corporate Trustee oversees the work of the Fund Holders and has the power to revoke a Fund Holders remit or, subject to any specific donor restriction, direct the use to which funds are put.

Charity Related Policies

The Charitable Funds Policies and Procedures are managed in accordance with the Velindre University NHS Trust Policy for the Management of Policies, Procedures and Written Control Documents; this provides the Trust Board with robust assurance that the charitable funds are handled with efficiency and effectiveness. The Charitable Funds policies are available here.

Management of Concerns

Concerns received in relation to the Charity are managed in accordance with the Velindre University NHS Trust Handling Concerns Policy. Any concerns received against the Charity would be captured and reported as required to the Charitable Funds Committee. In response to findings identified from any concerns raised against the Charity the Charitable Funds Committee would consider any lessons learned and identify areas where improvements could be made. There were no concerns received against the Charity in 2024-25.

The Trust Board as Corporate Trustee is responsible for the Charity's risk management and the effectiveness of internal control systems. The Trust Board and Charitable Fund Committee reviews major risks in accordance with the Trust Board appetite and the Audit Committee works to ensure that reasonable measures are taken to manage these risks.

The impact of the continuing economic uncertainty remains a major risk to the Charity. Therefore, plans, reserves and investment policies are frequently reviewed. The members of the Corporate Trustee have considered the risks that the Charity faces and confirm that systems, procedures, and policies are in place to ensure that any risks are minimised.

The risk register is updated by the Charity's Senior Leadership Group as required and is subsequently reported to the Charitable Funds Committee via any escalated risks in line with the Trust's overarching Risk Management and Assurance Framework, to ensure actions are taken in the areas that have been identified as appropriate. This approach will continue to strengthen the position of the Charity and ensure the Trustees are indemnified in accordance with the Welsh Risk Pool (NHS Insurers) expectations.

The Charity's investment policy focuses on minimising the Charity's exposure to losses and this is explained in the Investment policy.

As the present economic situation continues, the Charity needs to ensure that it is able to meet its liabilities as and when they fall due. The Charity has procedures in place to control its cash flow and commitment forecasts additionally, its reserves policy is continuously reviewed.

Relationships with Related Parties/External Bodies

During the year, none of the Trustees or members of the key management staff or parties related to them have undertaken any material transactions with the Velindre University NHS Trust Charity. Board Members (and other senior staff) take decisions both on Charity matters and endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions.

Most grants made are to Velindre University NHS Trust Charity to support the activities relating to the objectives of the charity. For example, The Charitable Funds do not directly employ the staff, working on different activities, grants are made to Velindre University NHS Trust to employ those staff.

Audit Requirements

The Velindre University NHS Trust Audit Committee reviews any Internal Audit and External Audit reports from audits undertaken across key operations of the Charity and its risks.
The Audit Committee meets with the external auditor on a regular basis to discuss findings and risks that the Charity could face.

Financial Risk Management

The Charity's activities expose the Charity to credit risk, market risk and liquidity risk. The Charity's financial activities are governed by policies approved by the Charitable Funds Committee and the Trust Board, and these activities are directly supported by the Charity's Senior Leadership Group, Executive Director of Finance and the Senior Finance and Procurement team.

The principal financial assets are bank balances, investments, and receivables. Credit risk is mainly attributable to bank balances, and these are well controlled. A number of the Charity's investments are subject to market activities and have recorded some limited realised and unrealised gains in the year.

Governance Activity

The key priorities for the Trust's Charitable Funds governance in 2024-25 have been successfully addressed. We aligned the Charity's aims and objectives with its strategic vision, consistent with the Trust's Integrated Medium Term Plan. The Business Case Expenditure and Evaluation Process was reviewed to enhance the quality of submissions to the Charitable Funds Committee. We also revised the patron and ambassador model to ensure greater inclusivity and completed a thorough review of the induction programme for new Executive Directors and Independent Members regarding their roles as Corporate Trustees. Additionally, the effectiveness of the Charitable Funds Committee continues to be regularly assessed and refined.

Social Investment Activity

The Charities (Protection and Social Investment) Act 2016 ('the 2016 Act') provides a statutory power for charities to make social investments. This came into force on 31 July 2016. The Charity commission guidance states the following:

In the legislation, a 'social investment' means a 'relevant act' of a charity which is carried out 'with a view to both directly furthering the charity's purposes and achieving a financial return for the charity'. In this interim guidance, the term 'social investment' has the same meaning as it has in the 2016 Act.

A 'relevant act' means one of two things:
- An application or use of funds or other property by the charity; or
- Taking on a commitment in relation to a liability of another person which puts the charity's funds or other property at risk of being applied or used, such as a guarantee.

In this context, an application or use of funds or other property achieves a 'financial return' if its outcome is better for the charity in financial terms than expending the whole of the funds or other property in question and this interim guidance generally uses the term in this way.

It is important to remember that whether a social investment is being made is determined by the motivation of the charity – if the reasons for applying funds in a particular way include both directly furthering the charity's purposes and making a financial return then the proposed action will be a social investment. In view of this, the Charity will continue to actively consider which (if any) activities of the charity fall within the definition of 'social investment'. This is because the members of the Corporate Trustee have specific legal duties which apply when making social investment decisions and they should be able to show that they have made these decisions in good faith.

Financial Summary for the Year ended 31st March 2025

Thanks to the donations, grants and legacies received and income generated we have achieved a total income of £4.374m (2024: £14.467m). Expenditure on charitable activities for the year was £2.609m (2024: £2.497m) which we used for patient and staff welfare, improvement of facilities and research.

Investment Policy and Performance

At the 31 March 2025, the market value of the investment portfolio is £9.172m (2024: 6.169m). The portfolio is managed by the Charity's investment brokers LGT Wealth Management. They work within the limits of the investment policy to achieve the charities financial objectives: generating growth, maximising returns, supporting the reserves policy and ensuring risks and liquidity are managed. The investment policy ensures that funds are not invested in tobacco, alcohol, gambling and armament related entities.

The value of the investments increased by £ 3.003m over the financial year. The Charity has a long-term time horizon for its investments and is able to weather short-term volatility in order to meet its long-term objectives. The Trustees of Velindre University NHS Trust Charitable Funds, have agreed to operate within a Medium risk investment strategy. The level of investment risk taken is reviewed regularly and has been appropriately mitigated by apportioning the funds into a well-diversified risk portfolio.

Investment decisions are supported by the advice of the investment advisors.

The performance of LGT Wealth Management in their role as investment managers and advisors is monitored and regularly reviewed by the Trustees.

Unrestricted Funds Reserves Policy

Reserves are part of the charity's unrestricted funds that are available to spend on any of the Charity's purposes. Reserves are maintained at a level, which enables the charity to ensure financial commitments are met as they fall due, and to manage any short-term volatility. This assessment of the required level of reserves excludes those funds that are designated or restricted as they are only available for a specified purpose.

The Trustees consider that reserves should be set at a level which is equivalent to estimated planned commitments for the following four months at any given point. At this level, in the event of a significant reduction in charitable funding, it is anticipated that the Charity would be able to continue with the current programme of activity for such time as is necessary to allow for a properly planned and managed change in the activity programme and/or the generation of additional income streams.

In accordance with the above, the unrestricted reserve target for the general-purpose fund was set at £1,944,768 as at 31st March 2025 (2024: 1,421,834).

The balance £9,751,696 (2024: £8,815,596) exceeds the target by £7,806,928 (2024: £7,393,762) and excludes an apportionment of dividends, management fees, realised and unrealised losses and transfers to/from unrestricted/designated Funds. Trustees will continue to monitor the Charity's future funding strategies and detailed budget plans to ensure these are of the highest standard and the unrestricted funds reserve policy is met.

Grant Making Policy

Grants are awarded for funding requests which meet the objectives of the Charity in support of its mission to support the Trust's provision of world class research-led treatment, care and support for patients and families affected by cancer and those who are involved in the donation of blood products and stem cells. Grants are predominantly awarded to Velindre University NHS Trust; however, grants are also awarded to other institutions to support the overall objectives of the charity. A rigorous process of review and evaluation is carried out on all funding requests to ensure they are of the highest standard.

Funds held as Custodian Trustee on behalf of others

On 1st October 2009, Public Health Wales NHS Trust was established which incorporated the former Screening and National Public Health Service (NPHS) divisions of Velindre University NHS Trust. The Charitable Funds relating to the Screening and NPHS divisions have remained in Velindre University NHS Trust Charitable Funds. The total amount of these funds held is £51,859 (2024: £61,000).

Board Members of the CorporateTrustees

The Board Members of the Corporate Trustee are responsible for preparing the Annual Report and Accounts in accordance with applicable law and United Kingdom Accounting Standards.

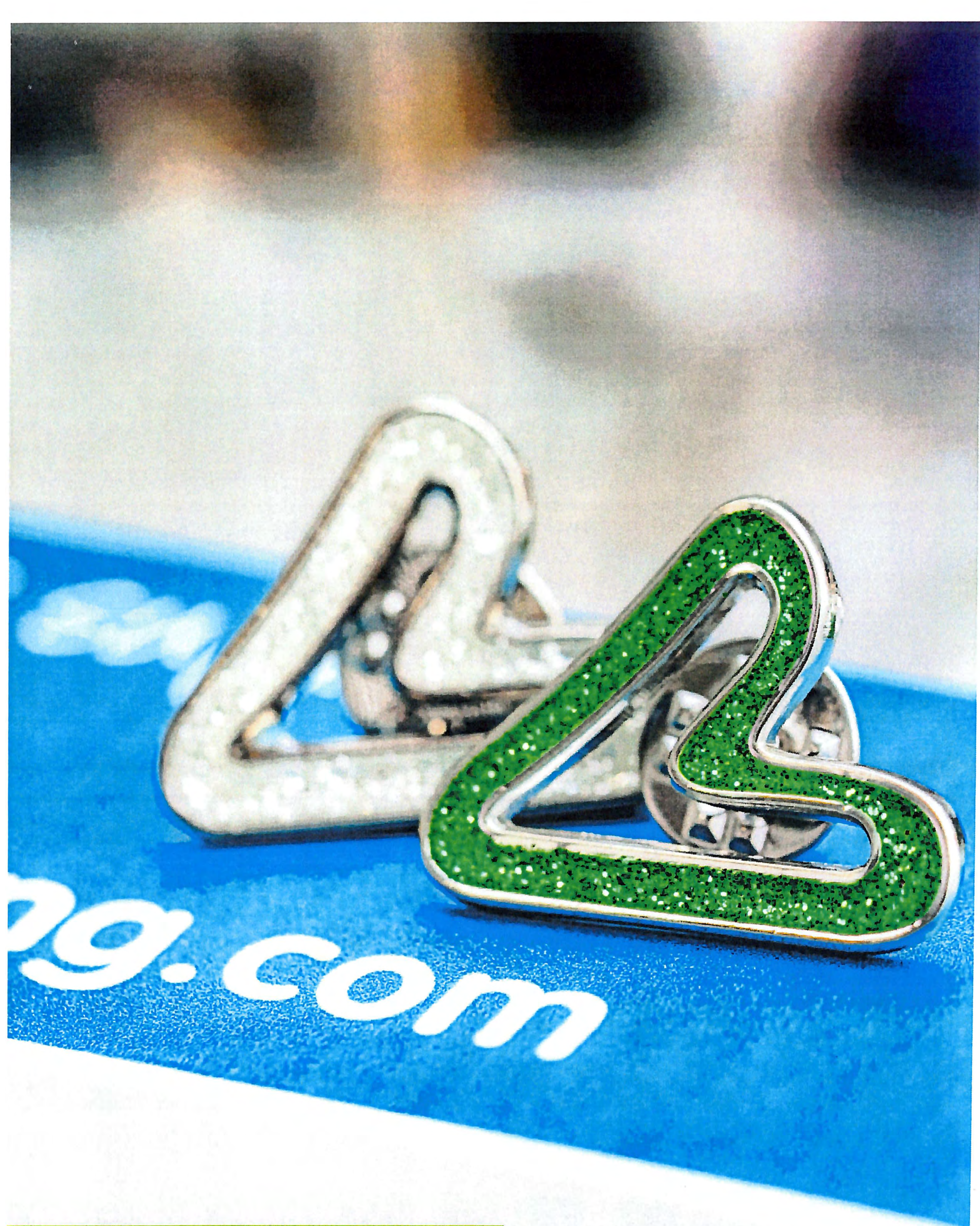
The law applicable to Charities in England and Wales requires the Board Members of the Corporate Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- To establish and monitor a system of internal control;
- Observe the methods and principles of the Charities SORP FRS 102 and Charities Act 2011;
- Make judgments and estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any departures disclosed and explained in the financial statements.

Sara Moseley
Trust Chair

Matthew Bunce
Executive Director of Finance

Approved by the Members of the Board of the Corporate Trustee and authorised for issue on: 27th January 2026



Finance Reports

The independent auditor's report of the Auditor General for Wales to the trustees of the Velindre University NHS Trust Charity

Opinion on financial statements

I have audited the financial statements of the Velindre University NHS Trust Charity for the year ended 31 March 2025 under the Charities Act 2011.

The financial statements comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cashflows and related notes, including the significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice). In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2025 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report.

My staff and I are independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue. My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- the information given in the financial statements is inconsistent in any material respect with the trustee report.

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee's responsibilities, the trustee is responsible for:

- maintaining sufficient accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the trustee determine is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustee anticipates that the services provided by the charity will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.
My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the charity's policies and procedures concerned with:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and the posting of unusual journals;
- Obtaining an understanding of the charity's framework of authority as well as other legal and regulatory frameworks that the charity operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the charity; and
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the charity's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Adrian Crompton
Auditor General for Wales
30 January 2026

1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

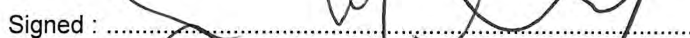
Velindre University NHS Charitable Funds
Statement of Financial Activities for the Year ended 31 March 2025

	Note	Unrestricted funds £000	Restricted funds £000	Total Funds 2024-25 £000	Total Funds 2023-24 £000
Incoming resources from generated funds:					
Donations and legacies	3	2,238	166	**2,404**	**12,300**
Charitable activities		0	0	**0**	**0**
Other trading activities	3	1,052	0	**1,052**	**1,595**
Grants	3	0	359	**359**	**323**
Investments	5	559	0	**559**	**249**
Other		0	0	**0**	**0**
Total incoming resources		**3,849**	**525**	**4,374**	**14,467**
Expenditure on:					
Raising Funds	6	965	4	**969**	**816**
Charitable activities	7	2,375	234	**2,609**	**2,497**
Other		0	0	**0**	**0**
Total expenditure		**3,340**	**238**	**3,578**	**3,313**
Net gains / (losses) on investment	12	(175)	0	**(175)**	**226**
Net income / (expenditure)		**334**	**287**	**621**	**11,380**
Transfer between funds	17	0	0	**0**	**0**
Net movement in funds		**334**	**287**	**621**	**11,380**
Reconciliation of Funds					
Fund balance brought forward	18	19,951	1,170	**21,121**	**9,741**
Fund Balance Carried Forward	18	**20,285**	**1,457**	**21,742**	**21,121**

Velindre University NHS Charitable Funds Balance Sheet as at 31 March 2025

	Note	Unrestricted funds £000	Restricted funds £000	Total 31 March 2025 £000	Total 31 March 2024 £000
Fixed assets:					
Investments	12	8,572	599	**9,172**	6,169
Other non-current assets:					
Debtors: Amounts receivable after more than one year	13	59	0	**59**	0
Total non-current assets		**8,631**	**599**	**9,231**	**6,169**
Current assets:					
Debtors	13	537	8	**545**	8,361
Cash at bank and in hand	14	12,142	849	**12,991**	6,660
Total current assets		**12,679**	**857**	**13,536**	**15,021**
Liabilities:					
Creditors: Amounts falling due within one year	15	(1,025)	0	**(1,025)**	(69)
Net current assets / (liabilities)		**11,654**	**857**	**12,511**	**14,952**
Total assets less current liabilities		**20,285**	**1,457**	**21,742**	**21,121**
Creditors: Amounts falling due after more than one year	15	0	0	0	0
Total net assets / (liabilities)		**20,285**	**1,457**	**21,742**	**21,121**
The funds of the charity:					
Restricted funds	18		1,457	**1,457**	1,170
Unrestricted funds	18	20,285		**20,285**	19,951
Total funds		**20,285**	**1,457**	**21,742**	**21,121**

The notes on pages 35 to 47 form part of these accounts



Signed : ....

Name : Sara Moseley (Trust Chair, as the Corporate Trustee)

Date : 27th January 2026

Signed : ....

Name : Matthew Bunce (Executive Director of Finance)

Date : 27th January 2026

Velindre University NHS Charitable Funds
Statement of Cash Flows for the Year ending 31 March 2025

	Note	**Total Funds 2024-25 £000**	Total Funds 2023-24 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	16	**8,950**	**4,181**
Cash flows from investing activities:			
Dividend, interest and rents from investments	5	559	249
Proceeds from the sale of investments	12	4,720	4,889
Purchase of investments	12	(7,981)	(4,999)
(Increase)/ Decrease in Cash held in Investments	12	83	(23)
Net cash provided by (used in) investing activities		**(2,619)**	**116**
Change in cash and cash equivalents in the reporting period		**6,331**	**4,297**
Cash and cash equivalents at the beginning of the reporting period	14	6,660	2,363
Cash and cash equivalents at the end of the reporting period	14	**12,991**	**6,660**

Note on the accounts

1 Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it is effective and applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS 102.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:
-A restricted fund or
-An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from appeals or legacies for specified purposes.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the Trustees have the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment).

The charity does not currently hold any endowment funds.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors, and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the charity's reserves. The major funds held in each of these categories are disclosed in note 18.

(c) Incoming resources

Income consists of donations, legacies, income from charitable activities and investment income.

Donations are accounted for when received by the charity. All other income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable, whichever falls sooner.

Receipt is probable when:
-Confirmation has been received from the representatives of the estate(s) that probate has been granted
-The executors have established that there are sufficient assets in the estate to pay the legacy and
-All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:
-There is a present legal or constructive obligation resulting from a past event
-It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
-The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Investment Income

Income from investments is re-invested into the investment portfolio.

(g) Recognition of expenditure and associated liabilities as a result of grants

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:
-We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant
-We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
-There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

(h) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 9.

(i) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objectives. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to the related party for salaries and overhead costs of the NHS Trust's fundraising office.

(j) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objectives of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 7.

(k) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount. Prepayments relating to items receivable in more than one year are shown as long term debtors.

(l) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

(m) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

(n) Investment Fixed Assets

Listed Investments are stated at market value.

The SOFA includes realised gains and losses on investments sold in the year, and unrealised gains and losses on the revaluation of investments.

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later).

Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

Investments are subject to review of impairment when there is an indication of a reduction in their carrying value. Any impairment is recognised in the year in which it occurs.

2. Related party transactions

Related Party Transactions 24-25	Expenditure to Related Party £000	Income from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Velindre University NHS Trust				
- Donations to charitable funds	0	0	0	0
- Grants from charitable funds	2,330	0	891	22
- Recharges for services provided to the charity	644	0	28	15
Total	**2,974**	**0**	**919**	**37**
Cardiff University				
- Grants from Charitable Funds	**16**	**0**	**0**	**0**

There were no donated assets purchased by the Trust in the year ended 31st March 2025 (2024: £322,000).

3. Income from donations, legacies & trading activities

	Unrestricted funds £000	Restricted funds £000	Total 2024-25 £000	Total 2023-24 £000
Donations	1,629	142	**1,771**	9,850
Legacies	609	24	**633**	2,450
Other Trading Activities:				
- Trading	0	0	**0**	0
- Fundraising Events	1,052	0	**1,052**	1,595
-Grants	0	359	**359**	323
	3,290	**525**	**3,815**	**14,218**

4. Role of volunteers

Like all charities, Velindre University NHS Charitable Funds relies on the dedication and commitment of volunteers to ensure the smooth running of our activities. Our volunteers contribute in two key ways:

1. Fund Advisors
Around 36 members of Velindre staff act as Fund Advisors, overseeing how the charity's designated funds are spent. These funds are earmarked by the Trustees for specific purposes, wards, or departments. Each Fund Advisor has delegated authority to manage the use of these funds in line with the Trustees' intentions. Where expenditure exceeds £5,000, Fund Advisors are required to report to the Trustees, outlining both the planned use of the funds and the expected impact for patients, staff, or research undertaken at Velindre.

2. Fundraisers
In addition, hundreds of local volunteers actively raise funds for Velindre through a wide variety of events. These include coffee mornings, open garden days, sports tournaments, sponsored walks, balls, and gala dinners. Volunteers also support the charity by organising collections at supermarkets and community events, helping to raise awareness as well as vital income.

Together, our Fund Advisors and Fundraisers play a vital role in ensuring that charitable funds are used effectively and that the charity continues to make a meaningful difference to the lives of our patients, their families, and the wider community.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

5. Gross investment income

	Unrestricted funds £000	Restricted funds £000	Total 2024-25 £000	Total 2023-24 £000
Income from Investments	559	0	**559**	249
	559	**0**	**559**	**249**

6. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2024-25 £000	Total 2023-24 £000
Fundraising Office	399	0	**399**	224
Fundraising Costs, Donation Charges, & Events	484	1	**485**	531
Investment management	44	0	**44**	30
Support Costs	38	3	**41**	31
	965	**4**	**969**	**816**

7. Analysis of charitable activity

	Grant funded activity £000	Support costs £000	Total 2024-25 £000	Total 2023-24 £000
Patient Welfare and Amenities	809	105	**914**	**999**
Staff Welfare and Amenities	36	2	**38**	**3**
Research	1,560	97	**1,657**	**1,495**
	2,405	**204**	**2,609**	**2,497**

8. Analysis of grants

The charity does not make grants to individuals. The majority of grants are made to Velindre University NHS Trust to provide for the care of NHS patients in furtherance of our charitable aims. The charity also awards grants to Cardiff University to undertake research in partnership with Velindre University NHS Trust. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 7.

The trustees operate a scheme of delegation for the majority of the charitable funds, under which fund advisors manage the day to day disbursements on their projects in accordance with the directions set out by the trustees in charity standing orders and financial instructions. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards.

The significant grants made to institutions are:

	Total 2024-25 £000	Total 2023-24 £000
Velindre University NHS Trust	**2,330**	1,888
Other NHS Bodies	**43**	356
Cardiff University	**16**	63
Other	**16**	32
	2,405	**2,339**

9. Allocation of support costs

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity.

	Raising funds £000	Charitable activities £000	**Total 2024-25 £000**	Total 2023-24 £000
Governance				
External audit	7	35	**42**	22
Finance and administration	14	67	**81**	65
Other professional fees	0	0	**0**	0
Total Governance	**21**	**102**	**123**	**87**
Finance and administration	21	102	**123**	102
Other professional fees	0	0	**0**	0
Other costs	0	0	**0**	0
	42	**204**	**246**	**189**

	Unrestricted funds £000	Restricted funds £000	Total 2024-25 £000	Total 2023-24 £000
Raising funds	35	3	**38**	31
Charitable activities	177	14	**191**	158
	212	**17**	**229**	**189**

Support costs are allocated based on actual expenditure incurred across the various activities of the Charity

10. Staff Costs, Trustees' remuneration, benefits and expenses

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustee.

The charity has no employees. Staff services are provided to the charity from Velindre University NHS Trust, the corporate Trustee of the charitable trust.

11. Auditors remuneration

The auditors remuneration of £25,000 (2023/2024: £26,951: increased from the £22,000 estimated in the 2023/2024 accounts) related solely to the audit of the statutory annual report and accounts.

12. Fixed asset investments

Movement in fixed assets investments

	Total 2024-25 £000	Total 2023-24 £000
Market value brought forward	**6,169**	5,810
Add: additions to investments at cost	**7,981**	4,999
Less disposals at carrying value	**(4,720)**	(4,889)
Change in Cash Held within Investment Portfolio	**(83)**	23
Add net gain / (loss) on revaluation	**(175)**	226
Market value as at 31st March	**9,172**	**6,169**

At Market Value

	Total 2024-25 £000	Total **2023-24** £000
Cash	169	449
Bonds	2,342	1,703
Equities	6,097	3,497
Real Estate & Infrastructure	0	0
Absolute Return	0	0
Commodities	0	0
Alternatives	564	519
Other	0	0
Total Investments	**9,172**	**6,169**

All investments are carried at their fair value.

The valuations are provided by the investment managers LGT Wealth Management.

Risk

The Trustees recognise that all investments involve an element of risk. The level of risk that is appropriate for the Trust will be influenced by various factors, including the Trustees' attitude to risk, the Trust's capacity to afford potential investment losses, and its investment objectives.

The Trustees, in order to mitigate the Capital Risk, have agreed to request the investment advisor/manager to maintain a diversified portfolio of assets in order to protect the charity's investments from sudden variations in the market. Additionally, the Trustees have considered investing only, or substantially, in markets where financial services are closely regulated and compensation schemes are in place.

The Trustees have determined that the purpose of the Velindre University NHS Trust Charity investment has been categorised as GENERAL with no specific investment purpose. The time horizon for the Trust general investment account is between 5 to 7 years.

The Trustees have requested that the Assets allocation should be distributed following the best advice from the Investment Manager and its direct effect in having an Investment Risk Tolerance Category of MEDIUM.

13. Analysis of debtors

Debtors under 1 year	Total 31 March 2025 £000	Total 31 March 2024 £000
Amount Due from fellow subsidiary *	37	7,352
Accrued income	6	0
Other debtors	455	949
Prepayments	47	60
	545	8,361

Debtors over 1 year	Total 31 March 2025 £000	Total 31 March 2024 £000
Amount due from fellow subsidiary *	0	0
Accrued income	0	0
Other debtors	0	0
Prepayments	59	0
	59	0
Total Debtors	604	8,361

* Velindre University NHS Trust

During 2023-24 Velindre UNHS Trust had received £7.350m from the sale of drug trials data and with WG ministerial approval the income was transferred into the Charity. The income was provided from Velindre UNHS Trust to Charity during the period but was outstanding as at 31st March 2024. Payment was made by the Trust on 31st July 2024.

14. Analysis of cash and cash equivalents

	Total 31 March 2025 £000	Total 31 March 2024 £000
Cash and Bank Balances	12,991	6,660
	12,991	6,660

The cash balances are held on interest bearing deposit within NatWest bank account and represent restricted appeals to fund specific equipment or funds held to facilitate cash flow and the fulfilment of obligations to make grant payments. The funds are held below a 90 day notice account and are therefore classified as cash and cash equivalents.

Cash balances also includes cash held on a high interest bearing liquidity investment account facilitated by the Charity investment managers LGT Wealth Management. The funds are held below a 90 day notice account and therefore classified as cash and cash equivalents

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

All of the amounts held on interest bearing deposit are available to spend on charitable activities.

15. Analysis of liabilities

	Total 31 March 2025 £000	Total 31 March 2024 £000
Creditors under 1 year		
Trade creditors	**97**	**45**
Amount due to fellow subsidiary *	**919**	**24**
Deferred income	**9**	**0**
	1,025	**69**
Creditors over 1 year		
Trade creditors	**0**	**0**
Other creditors	**0**	**0**
Accruals	**0**	**0**
	0	**0**
	1,025	**69**

* Velindre University NHS Trust

16. Reconciliation of net income / expenditure to net cash flow from operating activities

	Total 2024-25 £000	Total **2023-24** £000
Net income / (expenditure) (per Statement of Financial Activities)	**621**	**11,380**
Adjustment for:		
Depreciation charges	**0**	**0**
(Gains) / losses on investments	**175**	**(226)**
Dividends, interest and rents from investments	**(559)**	**(249)**
Loss / (profit) on the sale of fixed assets	**0**	**0**
(Increase) / decrease in stocks	**0**	**0**
(Increase) / decrease in debtors	**7,757**	**(6,691)**
Increase / (decrease) in creditors	**956**	**(33)**
Net cash provided by (used in) operating activities	**8,950**	**4,181**

17. Transfer between funds

During the year no values were transferred from unrestricted funds to restricted funds (2024: £0). Following approval of funding requests by the Trustees, £54,118 was transferred from unrestricted funds to unrestricted designated funds (2024: £70,000).

18. Analysis of funds

a. Analysis of restricted fund movements

	Balance 1 April 2024 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2025 £000
Patient Welfare & Amenities	74	17	(79)	0	0	12
Staff Welfare & Amenities	72	18	(36)	0	0	54
Research	1,024	490	(123)	0	0	1,391
	1,170	**525**	**(238)**	**0**	**0**	**1,457**

b. Analysis of unrestricted and material designated fund movements

	Balance 1 April 2024 £000	Income £000	Expenditure £000	Transfers £000	Gains and losses £000	Balance 31 March 2025 £000
Unrestricted Funds						
General 'umbrella' Fund	8,391	3,678	(2,825)	(54)	(175)	9,015
Designated Funds						
Patient Welfare & Amenities	201	45	(22)	0	0	224
Staff Welfare & Amenities	63	2	0	0	0	65
Research	11,296	123	(493)	54	0	10,980
	19,951	**3,849**	**(3,339)**	**0**	**(175)**	**20,285**
Total	**21,121**	**4,374**	**(3,578)**	**0**	**(175)**	**21,742**

There are a number of commitments where bids have been made against the Charity which are provided in note 20.

19. Post Balance Sheet Events

The charity was notified about several legacies from the representatives to estates prior to the year end. These have not been included in the accounts as there are uncertainties as to the amounts which cannot be reliably estimated.

20. Commitments

Project	Items Relating to these projects included within the SOFA for year ended March 2025 £000	Commitments						
		Commitments Relating to 2025/26 £000s	Commitments Relating to 2026/27 £000s	Commitments Relating to 2027/28 £000s	Commitments Relating to 2028/29 £000s	Commitments Relating to 2029/30 £000s	Outstanding Commitments as at 31/03/2025 £000	Outstanding Commitment as at 31/03/2024
Advancing Radiotherapy Programme	149	271	252	135	0	0	**658**	866
Professor in Nursing & Interdisciplinary Cancer Care & Clinical Research Fellow	15	0	0	0	0	0	**0**	0
Therapies Data Manager	22	0	0	0	0	0	**0**	31
Early Phase Trial: Medical Session for the Future	58	0	0	0	0	0	**0**	0
Pump Priming Velindre's Innovation Team	(21)	0	0	0	0	0	**0**	28
Pilot Patient Engagement Hub	34	0	0	0	0	0	**0**	109
Early Phase Trials: Medical sessions for the future appointment of a new academic medical oncologist in partnership with Cardiff University.	85	85	21	0	0	0	**106**	160
Clinical Psychology & Counselling Service and the Complementary Therapy Service	147	332	0	0	0	0	**332**	658
Wigs	14	32	0	0	0	0	**32**	61
Spiritual and Pastoral Care Services	16	33	0	0	0	0	**33**	66
Patient & Carer Information & support services Manager	27	59	0	0	0	0	**59**	108
Lead Welfare Rights Advisor	16	34	0	0	0	0	**34**	64
Clinical Nurse Specialist CNS Team Cont	316	753	0	0	0	0	**753**	1,348
Implementing the Velindre Cancer R&D Ambitions - An Integrated Business Case	949	2,946	122	0	0	0	**3,068**	4,848
Scalp Cooling Machines for SACT Day Case Units	(80)	9	39	9	3	0	**60**	96
Proposal for the Creation of a Replacement Website (linked to the current WBS website) for the Welsh Bone Marrow Donor Registry (WBMDR) Funded by the WBMDR Charitable Funds	0	25	0	0	0	0	**25**	25
Arts Co-ordinator Role	6	29	8	0	0	0	**37**	65
Business Case for Co-Funding (25%) of a Clinical Research Fellow (Brain Radiotherapy) from the Headfirst Appeal/Brain Research Sub Fund	0	20	20	0	0	0	**40**	40
CNS - Navigators	91	212	0	0	0	0	**212**	388
BUSINESS CASE: advancing radiotherapy cymru (arc) academy, application for match funding	121	338	635	646	658	0	**2,277**	2,477
Radiotherapy Consultant and Advanced Practice for Prostate Cancer	119	0	0	0	0	0	**0**	107
Lung cancer PHD – Stepping Stones Co-Funding	30	30	0	0	0	0	**30**	79
Velindre Cancer Centre Volunteer Management and Support	0	15	15	15	0	0	**45**	45
Oncology Academy	106	150	50	0	0	0	**200**	526
Innovation Small Grants Scheme	0	135	135	135	0	0	**405**	0
Arts in Health programme	0	102	102	102	0	0	**306**	0
Generic Oncology Clinical Nurse Specialists (CNS)	0	172	172	0	0	0	**344**	0
Clinical Scientist Post	0	221	229	225	0	0	**675**	0
Welsh Bone Marrow Donor Registry (WBMDR)	0	21	10	0	0	0	**31**	0
Head of Patient Engagement Role	13	77	58	0	0	0	**135**	0
Patient Area Improvements.	0	0	0	0	0	0	**0**	0
Total Commitments	**2,233**	**6,101**	**1,868**	**1,267**	**661**	**0**	**9,897**	**12,195**

The charity has not entered into any contractual arrangement for the approved expenditure, the funds remain the charities and are drawn down based on activity.

The items have been recognised on the SOFA and/or Balance sheet to the extent to which the project has been delivered.

The trustees hold the charity funds on trust to apply the income at their discretion, so far as is permissible by the charity's purposes and objects, unless they are restricted funds which can only be spent within the terms of the restriction. As an NHS charity the objects are NHS wide and for the benefit of NHS patients and public benefit.

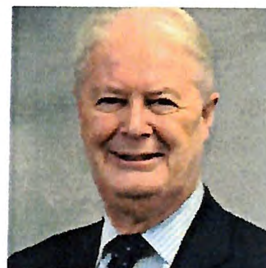
During 2024-25 Velindre UNHS Trust had accumulated £2m of non-recurrent income from several sources which reduced the requirement to draw down on Charitable funding to support these services during the period.

Meet Our Trustee

The Velindre University NHS Trust Board as a Corporate Trustee is ultimately accountable for charitable funds donated to Velindre University NHS Trust Charity. Further details on each member of the board are below, covering the period of April 2024 - March 2025.

Professor Donna Mead, OBE
Chair

Mr. Stephen Harries
Vice Chair and Independent Member


Mr. Gareth Jones
Independent Member (Legal)

Professor Andrew Westwell
Independent Member (University)

Mrs. Hilary Jones
Independent Member (Planning and Estates)

Ms. Lindsay Foyster
Independent Member (Diversity and Inclusion)

Mrs. Vicky Morris
Independent Member (Quality and Safety)

Mr. David Donegan
Chief Executive and Accountable Officer
From 1st December 2024

Mrs. Nicola Williams
Executive Director of Nursing, Allied Health Professionals and Health Scientists

Mr. Matthew Bunce
Executive Director of Finance

Dr. Jacinta Abraham
Executive Medical Director

Ms. Sarah Morley
Executive Director of Organisational Development & Workforce

Mrs. Lauren Fear
Director of Corporate Governance
1 April 2024 – 1 July 2024
Executive Director of Transformation (Interim)
From 1 July 2024

Mrs. Non Gwilym
Director of Corporate Governance
From 1 August 2024

Mr. Carl James
Interim Chief Executive (Accountable Officer)
1 July 2024 – 30 November 2024
Executive Director of Strategy & Planning / Deputy Chief Executive (Interim)
From 1st December 2024

Sara Moseley
Chair
From 1 September 2025

Changes to Board Members and the Executive Team during 2024-2025 Independent Members:

- Prof. Donna Mead OBE, Chair was reappointed on 1st May 2024.
- Mrs. Hilary Jones, Independent Member (Estates and Planning) was reappointed on 1st April 2024.
- Mrs. Vicky Morris, Independent Member (Quality and Safety) was reappointed on 12th November 2024. Executive Team Members
- Mr. Steve Ham, Chief Executive and Accountable Officer left on 30th June 2024.
- Mr. David Donegan began his appointment as Chief Executive and Accountable Officer on 1st of December 2024.
- Mr. Carl James, Executive Director of Strategic Transformation, Planning & Digital was appointed Interim Chief Executive Officer on 1st July 2024 and subsequently returned to his substantive role as Executive Director of Strategic Transformation, Planning and Digital on 1st of December 2024.
- Dr Jacinta Abraham, Executive Medical Director was appointed as the Deputy Chief Executive on 1st July 2024 until 1st December 2024.
- Mrs. Lauren Fear, Director of Corporate Governance and Chief of Staff was appointed Interim Executive Director of Strategic Transformation, Planning and Digital on 1st July 2024 until 1st December 2024. On 2nd December 2024, Mrs. Lauren Fear was appointed as Interim Director of Transformation.
- Dr Non Gwilym, Assistant Director of Communications and Engagement was appointed as Interim Director of Corporate Governance on 1st August 2024.

In terms of Board composition, as highlighted above, during 2024-2025, Mr. Steve Ham, Chief Executive and Accountable Officer retired on 30th June 2024. Whilst the recruitment of a permanent replacement was completed, interim arrangements were put in place to ensure continuity of business and effective governance arrangements. Such arrangements continued to support the Trust in maintaining stability and ensure the Board's duties could be discharged during the period of absence of a substantive post holder.

Despite attempts to substantively recruit into the Finance Independent Member's role since February 2024, the position remained vacant. Lindsay Foyster agreed to become an interim member of the Audit Committee in May 2024. The Independent Member (Finance) will join the committee when appointed.

Interim arrangements for the role of Chief Operating Officer were put in place until the substantive appointment commenced. Ms. Anne Carey was appointed into the role of Chief Operating Officer on an interim basis from 29th July 2024 until 31st March 2025. There has been no adverse impact on the balance of the Board and decision making during the reporting period. Further details on the Trust Board appointments are provided in the Trust Remuneration Report on page 144.

During financial year 2025-2026, the tenure of both the Trust Chair and Vice Chair will come to an end. The appointment of a new Vice Chair concluded in March 2025 with the successful candidate, Lindsay Foyster, commencing in post on 1st May 2025. The recruitment of a Trust Chair is in progress and expected to conclude in early June. If successful, the Senedd Pre-Appointments Hearing and Appointment confirmation are expected to take place in July 2025. The Trust will continue to ensure a stable Board is maintained and enable robust handover arrangements.

The tenure of the Chair of Health Technology Wales Appraisal Panel concluded on 31st March 2025.

Changes to Board Members and the Executive Team since 2024-2025:

- Mrs. Lauren Fear, Director of Corporate Governance and Chief of Staff, was appointed Director of Place, Portfolio and Partnerships on 1st September 2025.
- Mr David Donegan, Chief Executive and Accountable Officer left on 18th November 2025.
- Mr Carl James, Executive Director of Strategic Transformation, Planning & Digital was appointed Interim Chief Executive Officer on 18th November 2025.
- Dr Jacinta Abraham, Executive Medical Director, was appointed as Interim Deputy Chief Executive Officer on 18th December 2025.
- Ms. Sara Moseley was appointed as Chair on 1st September 2025.
- Mrs Sarah Morely, Executive Director of People and Organisational Development left on 31st October 2025.
- Mrs Sarah Jenkins was appointed as Interim Executive Director of People and Organisational Development on 1st October 2025.
- Mr John Union was appointed Independent Member (Finance) on 1st October 2025.
- Ms Linsay Foyster, Independent Member (Diversity and Inclusion) was appointed Vice-Chair on 1st May 2025.
- Ms Ceri Doyle was appointed as an Independent Member on 27th October 2025.

Public interest declaration:
Each Velindre University NHS Trust Board Member is required and has completed a public interest declaration which is reviewed every six months and presented to the Trust's Audit Committee. All Trust Board Members and Senior Managers within the Trust, including the hosted services, have declared any interests in companies or matters which may result in a conflict with their managerial responsibilities. A full register of interests for 2024-2025 is available on the Trust's website

Legal and administrative details

This Trustee's report and its Financial Statements have been prepared in accordance with the Statement of Recommended Practice on Accounting and Reporting for Charities (SORP), Charity Commission's general guidance and with applicable United Kingdom accounting standards.

The Governing Document of the Charity has been registered with the Charity Commission. This document encompasses the main objectives of the charity for the provision of patient care, staff welfare, research and Welsh Blood Service at the Velindre University NHS Trust, with the Board of Directors acting as a Trustee. The Velindre University NHS Trust Charitable Funds is a registered charity with the Charity Commission.

Contact details

029 2031 6211
info@velindrefundraising.com Velindre Fundraising, Velindre Cancer Centre, Velindre Road, Whitchurch, Cardiff, CF14 2TL.

Electronic versions of this document can be accessed via the Trust website at; www.velindre-tr.wales.nhs.uk.

If you require additional copies of this document or an alternative format, such as audio, large print or Braille, please contact;

Head of Corporate Governance
Velindre University NHS Trust Headquarters 2 Charnwood Court, Parc Nantgarw, Cardiff. CF15 7QZ.

VUHNST.CorporateGovernance@wales.nhs.uk or Telephone: 029 2019 6161.

Reference and administration details:

Registered name:
Velindre University NHS Trust Charity

Previous names:
Velindre NHS Trust Charitable Fund

Principal office address:
Velindre NHS Trust Headquarters, Unit 2, Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ.

Registration Charity Number: 1052501

Velindre University NHS Trust Charity is registered with the Fundraising Regulator.

We are a member of the Association of NHS Charities and the Institute of Fundraising

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

ISA 260 – AUDIT WALES REPORT

DATE OF MEETING	29/01/2026
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden, Head of Financial Planning & Reporting Steve Wyndham, Audit Manager, Audit Wales
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The ISA 260 is produced by the Audit Wales following the audit of the financial statements for 2024-25 and it provides an opinion on the statements.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the Audit Wales Report which provides an opinion of the financial statements for 2024-25.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
APPROVED at Charitable Funds Committee	**27.01.26**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Audit Wales Report – ISA 260
Appendix 2	Letter of Representation

1. SITUATION / BACKGROUND

1.1 The Trustee's report and its Financial Statements are prepared in accordance with the Statement of Recommended Practice on Accounting and Reporting for Charities SORP FRS 102, Charity Commission's general guidance and with applicable United Kingdom accounting standards.

1.2 The ISA 260 is produced by the Audit Wales following the audit of the financial statements for 2024-25 and it provides an opinion on the statements.

2. ASSESSMENT

2.1 Refer to the Audit Wales report attached as appendix 1 which details the findings and recommendations from the audit of the Charitable funds.

3. SUMMARY MATTERS FOR CONSIDERATION

3.1 The Trust Board is asked to **NOTE** the Wales Audit Report which provides an opinion of the financial statements for 2024-25 and **NOTE** that the Letter of Representation has been signed at appendix 2.

4. IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety, and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
• A beacon for research, development, and innovation in our stated areas of priority ☐
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>10 - Governance</td></tr>
</table>

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed, and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text**
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** Choose an item

	Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required Click or tap here to enter text.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Archwilio Cymru
Audit Wales

Audit of Accounts Report – Velindre University NHS Trust Charity

Audit year: 2024-25

Date issued: January 2026

Document reference: 5195A2025

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This document has been prepared as part of work performed in accordance with statutory functions.

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For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

Adrian Crompton

Auditor General for Wales

I am pleased to share my Audit of Accounts Report. The Report summarises the main findings from my audit of your 2024-25 annual report and accounts. My team have already discussed these findings with the Head of Financial Planning & Reporting and the Executive Director of Finance.

My team have substantially completed the audit work as set out in my Audit Plan dated November 2025.

My response to the identified risks as set out in the Plan is at **Appendix 1**.

I am required to provide an opinion on whether the accounts have been properly prepared, and give a true and fair view, in all material aspects. My proposed audit opinion and basis for it is outlined on page 8.

It is the responsibility of the those charged with governance, i.e. the Trust's Charitable Funds Committee, to address any matters raised in my report and provide me with a Letter of Representation.

I would like to extend my gratitude to the officers and staff of the Trust for their cooperation throughout the audit process which has been invaluable in completing this audit effectively.

Your audit at a glance

We intend to issue an **unqualified opinion** on the accounts

See **Appendix 4**

There are **no other significant matters** to report

See **Audit findings**

There are **no uncorrected misstatements** in the accounts

See **Audit findings**

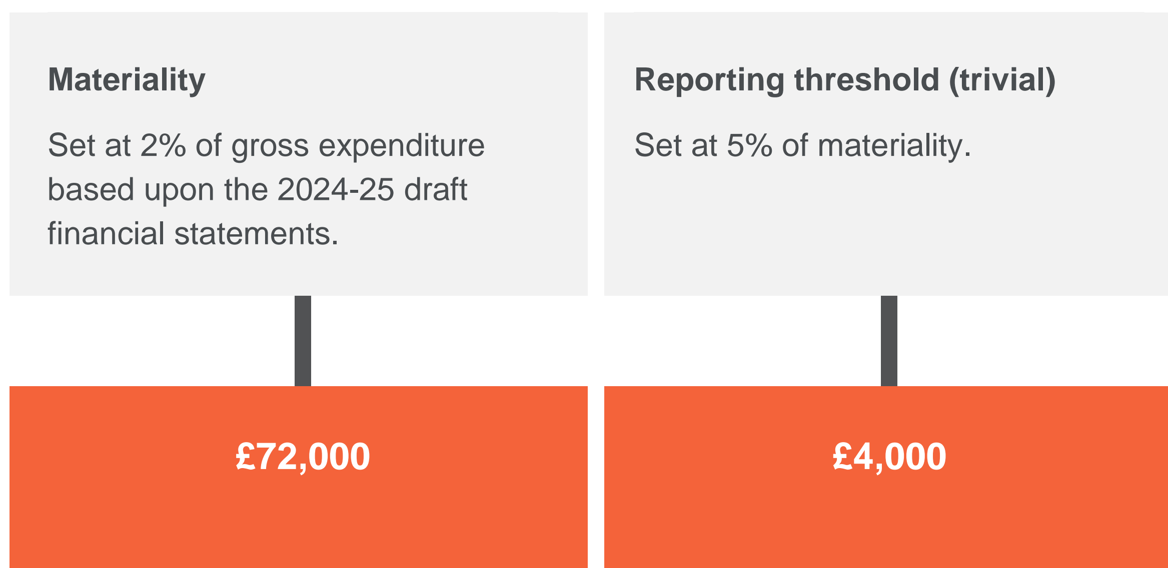
There are **no recommendations** as a result of our work.

See **Appendix 5**

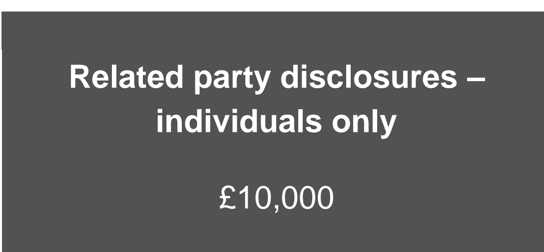
We are aiming to certify your accounts on **30 January 2026**, which is within the Charity Commission deadline of the same date.

Materiality

I use professional judgement to set a materiality threshold to identify and correct misstatements that could affect users' decisions, considering both financial errors and disclosure requirements according to the applicable accounting framework and laws. My team updates materiality throughout the audit and I include in this report matters that exceed my reporting threshold, as set out below:



There are some areas of the accounts that may be of more importance to the user of the accounts. We confirm a lower materiality levels for:



Audit Findings

Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Uncorrected misstatements

There are no uncorrected misstatements.

Corrected misstatements

During our audit, we identified a small number of misstatements that have been corrected by management. These are set out in **Appendix 2.**

Other significant issues

International Standard on Auditing 260 requires us to communicate with those charged with governance. We must tell you significant findings from the audit and other matters if they are significant to your oversight of the charity's financial reporting process.

There were no such issues identified during the audit.

Proposed audit opinion

Audit opinion

We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation (see below).

Our proposed audit report is set out in **Appendix 3**.

Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is required by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 4**, the contents of which are in line with our standard request for representations.

Recommendations

There are no recommendations arising from our audit and we are pleased to confirm that the recommendations made following our 2023-24 audit have been effectively actioned by the Trust.

Audit team and ethical compliance

The main members of my team who carried out the audit work, together with their contact details, are summarised in **Exhibit 1**.

Exhibit 1: my local audit team

Engagement Lead	Richard Harries Richard.harries@audit.wales
Audit Manager	Steven Wyndham Steve.wyndham@audit.wales
Audit Lead	David Burridge David.burridge@audit.wales

Compliance with ethical standards

We confirm that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

Appendix 1 – Audit risks and outcomes

My Audit Plan set out the risks of material misstatement for the audit of the charitable fund accounts. **Exhibit 2** lists these audit risks and sets out how they were addressed as part of the audit. No additional audit risks have been identified since that need to be brought to your attention.

Exhibit 2: audit risks reported previously, work done and outcome

Audit risk	Work done	Outcome
Risk of management override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team: • tested the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewed accounting estimates for bias; and • evaluated the rationale for any significant transactions outside the normal course of business.	My audit work did not identify any instances of management override of controls.

Related party disclosures Where related party relationships arise via individual relationships, these transactions are of high interest and so are considered to be material by their nature. There is therefore a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.	The audit team will: • review management's process for identifying related party relationships and associated transactions and balances; • undertake procedures to confirm the completeness of related party relationships; and • ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.	One omission was identified – see **Appendix 2**.
Categorisation of income Last year's audit resulted in a number of material adjustments being made to the financial statements due to income being incorrectly classified. These errors were exacerbated due to a lack of evidence being retained, and therefore available, to support the income to support its categorisation.	My audit team will undertake increased sample testing of donations, legacies, fundraising income and grants and also review the supporting evidence to ensure that income has been correctly classified in line with the Charity SORP.	No income received in 2024-25 was found to be misclassified. However, note a misclassification error adjustment was identified relating to the 2023-24 financial year (see **Appendix 2**).

Appendix 2 – Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management. Many of these misstatements are of a reclassification or narrative nature and therefore they have not substantially amended the closing position of the charity. The net effect of these adjustments has resulted in a £11,000 increase in the closing fund balance of the charity compared to that presented within the draft financial statements.

Value of correction	Accounts area	Explanation
£1,416,000	Analysis of Grants (Note 8)	The value of grants paid to Velindre NHS Trust was overstated due to an error in collating this note.
£571,000	Cash at Bank and Creditors	Cash at bank and creditors understated due to an error in the year end bank reconciliation.
£341,000	Movement in Fixed Assets Investments (Note 8)	The additions and disposals in year were both understated due to an error in collating this note from fund manager reports.
£32,000	Trade Creditors (Note 15)	Audit Fee accruals in relation to prior years' audits were understated.
£57,000	Grant income and Donations (Note 3)	An adjustment was made to reclassify income received in

		2023-24 resulting in 2024-25 being misstated.
£54,000	Restricted Funds (Note 18)	The balance of restricted funds was overstated due to an error made in the categorisation of a transfer between funds.
£30,000	Creditors (Note 15)	As notified to us by the Charity the creditor figure with the NHS Trust was overstated by this amount due to the failure to raise a journal.
£22,000	Related Parties (Note 2)	The amounts due to the Charity from the NHS Trust were incorrectly disclosed within the note.
£15,000	Amount due from fellow subsidiary (Note 13)	Understatement due to audit fees previously paid to the NHS Trust now being recoverable.
Various	Analysis of Funds (Note 18)	Total in year movements corrected to be consistent with the Statement of Financial Activities
Various	Capital Commitments (Note 20)	Several errors were identified in the prior year comparative figures due to a clerical error when producing this note.

Appendix 3 – Proposed audit report

The independent auditor's report of the Auditor General for Wales to the trustees of the Velindre University NHS Trust Charity

Opinion on financial statements

I have audited the financial statements of the Velindre University NHS Trust Charity for the year ended 31 March 2025 under the Charities Act 2011.

The financial statements comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cashflows and related notes, including the significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2025 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report.

My staff and I are independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or

- the information given in the financial statements is inconsistent in any material respect with the trustee report.

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee's responsibilities, the trustee is responsible for:

- maintaining sufficient accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the trustee determine is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustee anticipates that the services provided by the charity will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, internal audit and those charged with governance, including obtaining and reviewing supporting

documentation relating to the charity's policies and procedures concerned with:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and the posting of unusual journals;
- Obtaining an understanding of the charity's framework of authority as well as other legal and regulatory frameworks that the charity operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the charity; and
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the charity's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Adrian Crompton
Auditor General for Wales
30 January 2026

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 4 – Letter of representation

Auditor General for Wales

Wales Audit Office

1 Capital Quarter

Tyndall Street

Cardiff

CF10 4BZ

28 January 2026

Representations regarding the 2024-25 financial statements

This letter is provided in connection with your audit of the financial statements of the Velindre University NHS Trust Charity for the year ended 31 March 2025 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- The preparation of the financial statements in accordance with legislative requirements of the Charities Act 2011 and the 2019 Charities SoRP (FRS102); in particular the financial statements give a true and fair view in accordance therewith.

- The design, implementation, maintenance and review of internal control to prevent and detect fraud and error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects the Charity and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.

Financial statement representations

- All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.
- The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is

reasonable in the context of the applicable financial reporting framework.

- Related party relationships and transactions have been appropriately accounted for and disclosed.
- All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.
- All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.
- The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by those charged with governance

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Trust's Charitable Funds Committee on 28 January 2026.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of Trustees
Date: 28 January 2026	Date: 28 January 2026

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

Our People

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality Selection of right team

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

- EQRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

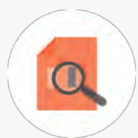
Supporting you

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

Our publications which cover our audit work at public bodies.

Information on our upcoming work and forward work programme for performance audit.



Data tools to help you better understand public spending trends.

Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.

Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust Headquarters
2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

27 January 2026

Representations regarding the 2024-25 financial statements

This letter is provided in connection with your audit of the financial statements of the Velindre University NHS Trust Charity for the year ended 31 March 2025 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- The preparation of the financial statements in accordance with legislative requirements of the Charities Act 2011 and the 2019 Charities SoRP (FRS102); in particular the financial statements give a true and fair view in accordance therewith.

- The design, implementation, maintenance and review of internal control to prevent and detect fraud and error.

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn hapus i dderbyn gohebiaeth yn y Gymraeg neu'r Saesneg.
Velindre University NHS Trust is happy to receive communication in Welsh or English.

Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust Headquarters
2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects the Charity and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn hapus i dderbyn gohebiaeth yn y Gymraeg neu'r Saesneg.
Velindre University NHS Trust is happy to receive communication in Welsh or English.

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust Headquarters
2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Financial statement representations

- All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.
- The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.
- Related party relationships and transactions have been appropriately accounted for and disclosed.
- All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.
- All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.
- The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

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Representations by those charged with governance

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Trust's Charitable Funds Committee on 28 January 2026.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:

Chief Executive

Date: 27 January 2026

Signed by:

Chair of Trustees

Date: 27 January 2026

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn hapus i dderbyn gohebiaeth yn y Gymraeg neu'r Saesneg.
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Technoleg Iechyd Cymru
Health Technology Wales

2026-2030
STRATEGIC PLAN

Mae'r ddogfen hon hefyd ar gael yn Gymraeg
This document is available in Welsh

HTW Strategic Plan 2026-2030

Developed by Health Technology Wales (HTW) in consultation with key stakeholders

The HTW Strategic Plan 2026-2030 sets out our organisation's immediate and medium-term strategic goals and objectives.

This Strategic Plan was developed iteratively, using a mixed methods approach, inviting contributions from key HTW stakeholders including: Welsh Government; key opinion leaders within the Welsh health and social care system; and members of key HTW decision-making groups including the Executive Group, Appraisal Panel, Assessment Group, Patient and Public Involvement Group and Stakeholder Forum. A development session was also held with the HTW team. Finally, the Strategic Plan was posted for public consultation on the HTW website with communications activities to encourage feedback.

The HTW Strategic Plan should be regarded as a living document. It will be continually refined to reflect changing priorities and demands on HTW resources and any changes to the health and social care policy agenda for Wales.

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P3 Strategic context

P4 About HTW

P5 Mission, vision and values

P6 Strategic goals and objectives

P8 Implementation proposals

Our partners:

1. Strategic context

Health Technology Wales (HTW) was established and operates in the context of an ambitious and evolving health and social care policy agenda for Wales, which sets out a clear plan to:

- Deliver a whole system approach as outlined in A Healthier Wales, focused on preventative, person-centred, sustainable, equitable, high quality and safe services for the people of Wales. (AHW 2019)

- Prioritise the focus on: utilising digital and data developments; optimising the workforce; strengthening research, development and innovation; ensuring co-production and partnership working; and integrating services in communities across Wales. (AHW 2024-25)

- Improve performance by: reducing waiting times, care pathways delays and improving women's health; strengthening services through improved leadership and culture, regional working, openness, accountability and collaboration; and future proofing services by focusing on prevention, shifting care into the community and realising the potential of digital and innovation. (WG statement 2025/26)

- Improve the well-being of people and carers who need support, and transfigure social services in Wales. (SSWBA 2014)

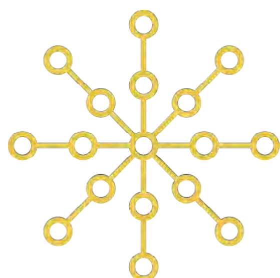
- Enhance the future social, economic, environmental and cultural well-being of citizens. (WFGA 2015)

- Embed a socio-economic duty, requiring public bodies to have due regard to the need to reduce the inequalities of outcome that result from socio-economic disadvantage. (WA45 2017)

- Transform services to provide care of the highest quality that is seamless, proactive and delivered as close to people's home as possible. (PRHSCW 2018)

- Re-design a whole system approach emphasising prevention, encuraging self-management, supported by integrated health and social care services that utilise the benefits new technologies offer. (AHW 2019)

HTW will contribute significantly to delivering this plan for health and social care in Wales by appraising the scientific evidence to inform technology adoption and disinvestment decisions. This will encourage best use of the scarce resources available to invest in health and social care technologies, and maximise the health gain they offer for the people of Wales.



2. About HTW

HTW is a national health technology assessment (HTA) body working to improve the quality of health and social care in Wales. Established in 2017, our remit is to "**provide a strategic, streamlined and nationally coordinated approach for the identification, appraisal and adoption of medical technologies into practice across Wales.**" (MHSS 2015). HTW's remit covers assessment of any care technology that isn't a medicine such as medical devices, diagnostic tests, implants, surgical procedures, assistive technologies, digtal innovations and changes in care pathways.

HTA is a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its lifecycle. The purpose is to inform decision-making in order to promote an equitable, efficient, and high-quality health system.

INAHTA 2020

HTW was established to address recommendation 3 of the 2014 Inquiry into Access to Medical Technologies in Wales, which recommended establishment of **"...an all-Wales medical technologies appraisal mechanism..."** (HSCC 2014).

HTW's unique contribution is its clear focus on evidence. We research and appraise the best available evidence to assess the value of technologies for Wales. Based on this evidence, we publish authoritative evidence-based national guidance to support decisions on technology adoption. We support those innovations that are proven to offer value and suggest disinvestment in those that do not.

HTW values our independence. We have no ties to industry or other organisations that could result in conflict of interest. We are funded by Welsh Government and hosted within NHS Wales, but are independent of both. We are transparent in our goals and methods and have an unerring focus on improving outcomes for the people of Wales.

An **independent expert review** of HTW's progress in its first five years in operation concluded that **"HTW is a distinct, trusted and valued part of the innovation landscape in Wales and its Strategic Plan provides an excellent foundation for future development..."** The review made improvement suggestions, which have helped to inform the 2026-2030 trategic objectives.

3. Vision, mission and values

3.1 Vision

A healthier Wales through the responsible adoption of innovative health and care technoloies. We envision a future where every person in Wales benefits from timely, evidence-based innovations that improve outcomes, reduce inequalities and support sustainable services.

3.2 Mission

To identify, evaluate, and pomote the adoption of health and care technologies that offer the greatest value for the people of Wales. We work collaboratively across sectors to provide independent, high-quality evidence that informs policy and practice, ensuring that innovation leads to real world impact.

3.3 Values

The core values underpinning our work include:

People First

We put the needs and experiences of patients, service users, and the public at the heart of everything we do.

Evidence-Driven

We are committed to rigorous, transparent and independent evidence appraisal to support informed decision-making.

Collaboration

We work in partnership across health, social care, academia, industry and the third sector to maximise impact.

Innovation with purpose

We champion technologies that are not only novel but also impactful, equitable, and sustainable.

Equality and Inclusion

We strive to reduce health inequalities and ensure that diverse voices are heard and valued.

4. Strategic goals and objectives

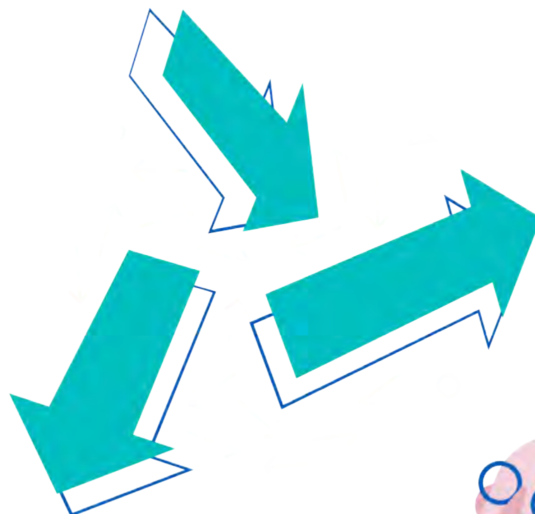
Our four strategic goals for 2026-2030 are outlined below, alongside our top five priority objectives.

4.1 Strategic goal: Identification

Identify the technologies that are expected to have major impact on health and social care services and offer the most benefit for the people of Wales.

Objectives

- Ensure alignment with Ministerial, policy and health and social care system priorities.
- Work in partnership with key stakeholders to continually improve approaches to horizon scanning, topic identification and prioritisation.
- Ensure a technology life-cycle approach, identifying technology investment and disinvestment topics.
- Offer the Scientific Advice Service (SAS) to support the Welsh life science sector and innovation landscape.
- Explore opportunities to encourage the submission of topics from patient organisations.



4.2 Strategic goal: Appraisal

Deliver high quality, inclusive HTW evidence outputs, promoting a co-ordinated national approach to evidence-informed decision making on care technologies across Wales.

Objectives

- Produce and disseminate high quality inclusive HTW evidence apppraisal and guidance outputs.
- Support time-critical health and social care policy decision-making via Welsh and UK initiatives, programmes and groups
- Continually improve and develop HTW appraisal methods to ensure compliance with best international practice.
- Strengthen HTW's committment to ensuring that equality, diversity and inclusion are considered in the appraisal of all topics
- Continuously evolve HTW's process for patient and public involvement within the appraisal process.

4.3 Strategic goal: Adoption & Impact

Improve the quality of health and social care in Wales, by encouraging and monitoring the adoption of HTW guidance recommendations expected to have a major impact in Wales.

Objectives

- Undertake an annual adoption audit of HTW and select NICE guidance.
- Adapt the HTW adoption audit to ensure effective audit of all types of HTW guidance.
- Assess the impact of HTW national guidance and associated learning for health and social care organisations.
- Work with the National Institute for Health and Care Research to identify and highlight research gaps and support research of national importance.
- Consider ways to build patient and public voices into impact work.

4.4 Strategic goal: Engagement

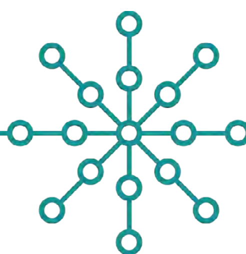
Promote greater understanding and use of HTW's HTA outputs with key Welsh, UK and international stakeholders.

Objectives

- Collaborate with Welsh health and care system partners to support relevant Welsh Government innovation and MedTech policy.
- Continue to ensure the patient and public voice is central within all of our work.
- Build understanding of HTA and promote awareness of HTW outputs in health and social care systems.
- Engage with other HTA bodies both nationally and internationally to share best practice and prevent duplication.

4.5 Top five Priority Objectives 2026-2030

- Ensure alignment with Ministerial, policy and health and social care system priorities.
- Support time-critical health and social care policy decision making via Welsh and UK initiatives, programmes and groups.
- Produce and disseminate high quality, inclusive HTW evidence appraisal and guidance outputs.
- Undertake an annual adoption audit of HTW and select NICE guidance.
- Collaborate with Welsh health and social care ecosystem partners to support relevant Welsh Government innovation and MedTech policy.



Detailed implementation proposals – outlining key activities proposed to deliver the HTW Strategic Plan and a prioritised timeline – are available on request.

Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our website.

Technoleg Iechyd Cymru
Health Technology Wales

healthtechnology.wales

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Unit 2 Charnwood Court, Park Nantgarw, CF15 7QZ, United Kingdom